Privacy Disclosure & Policies

This notice describes how your medical information may be used and disclosed (provided to others) and how you can gain access to this information. Please review this notice carefully.

As a patient of Gateway Urgent Care (GUC) you have the right to know how your private, confidential healthcare and personal information is being protected.

Under the law you have the right (with certain limitations) to: - Inspect and request copies of your records. GUC may charge a reasonable fee for record copies. You may: 1) Request that your health care provider appends information to your medical record. 2)Receive notice of your privacy rights by your health plan upon enrollment and when privacy practices are amended. 3)Obtain a copy of GUC privacy policy. GUC is required, under specific circumstances, to use or disclose your protected health information without your written authorization, including public health, certain governmental and judicial requests, insurance, worker's compensation, coroners and funeral home directors. GUC and entities such as health plans may use your health information for the following purposes: 1) Consult with other healthcare practitioners and clinical/laboratory specialists. 2)Health Care Operations Your doctor may use or disclose, as needed, your protected health information to support business activities of our practice. These activities include but are not limited to quality assessment; training of students and staff; licensing and conducting or arranging for other business activities. Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent, except as noted above. In some cases, if time does not permit, your verbal approval may be accepted. The notes that are taken during appointments are secured by each individual practitioner of GUC through secure Electronic Medical Record (EMR) services.

General Informed Consent for Care and Treatment: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent continues even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You may discontinue services at any time. You may discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. I voluntarily request a provider and other healthcare providers to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily.

At the time-of-service GUC collects from you the estimated amount of patient responsibility based on your specific insurance plan, our insurance contracts, and the eligibility information provided by your insurance company. While we do our best to verify your insurance coverage, it is your responsibility to ensure that you have an insurance policy in force with benefits that will cover our services. We make no guarantee that your policy will cover any of our services or outside services such as specialists, laboratory or radiology either in network or out-of-network. Following your visit, you should receive an explanation of benefits (EOB) from your insurance company stating the amount paid by your Insurer and the remaining balance owed by you, if any. Patients are financially responsible for all services rendered that are not paid for by their insurance(s). All medical services are billed by GUC, and I authorize payment for insurance benefits, which may otherwise be payable to me, directly to GUC. I authorize the release of Information concerning my (or my dependent's) healthcare, advisement, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I will be billed directly by and agree to pay GUC for any outstanding balances. I understand and agree that my credit card info may be 'stored on file' and charged, with my permission, for any patient liability amounts incurred today or in the future, after my claim is processed by insurance. I understand

that a $10 late fee will be applied to any unpaid balance I owe that is not paid within 30 days. I understand that my account will enter collections after 60 days of non-payment. I agree to reimburse GUC the actual fees of any collection agency, which may be based on a percentage at a maximum of 40% of the unpaid balance, and all costs and expenses, inducing reasonable attorneys' fees Incurred in such collection efforts. If my account is sent to collections, such fees may be assessed by the collection agency on behalf of GUC. I also understand that I may be responsible for my balance due to any charge back, reversal or dispute because of my credit card company's or bank's refusal to remit payment to GUC. I agree to receive text messages including billing, appointments, test results, and post-treatment instructions. I understand that standard message and data rates may apply. I also understand that text messaging may not be entirely secure and that GUC complies with HIPAA regulations. I understand that I can opt-out of receiving these messages at any time by replying 'STOP' to any text message I receive." No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All the above categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

ACKNOWLEDGMENT OF PATIENT CHOICE POLICY

In connection with your care, your GUC provider may recommend certain ancillary services as part of your overall care. GUC offers certain ancillary services that patients may require such as x-ray, limited lab services, and in-house medication and equipment dispensing. You are free to choose to go anywhere you like to receive these services.

PATIENT RIGHTS

Additionally, we shall ensure that you are treated with dignity, respect, and consideration and that you are not subjected to Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse or assault, Except as allowed in AZ R9-10-1012(B), restraint or seclusion, retaliation for submitting a complaint to the Department or another entity, Misappropriation of personal and private property by our personnel member, employee, volunteer, or student. We will ensure that you or your representative, except in an emergency, either consents to or refuses treatment, May refuse or withdraw consent for treatment before treatment is initiated, except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure. We will also ensure that you informed of our policy on health care directives and the patient complaint process which is to write to the medical director at info@gatewayuc.com. We will obtain consent for any photography except that a patient may be photographed when admitted for identification and administrative purposes. Except as otherwise permitted by law, we will provide written consent to the release of medical or financial information. You also have the following rights: **1.** Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; **2.** To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities; **3.** To receive privacy in treatment and care for personal needs; **4.** To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01; **5.** To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient; **6.** To participate or have the patient's representative participate in the development of, or decisions concerning, treatment; **7.** To participate or refuse to participate in research or experimental treatment; and **8.** To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

I have read and understand my right to privacy, as stated above, and agree to have GUC maintain my medical information in accordance with its policies and agree to inform the clinic of any special arrangements I need in pertaining to this issue. I may receive a copy of these rights and agreements by requesting them at the front desk or through the electronic patient portal.

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Patient/Legal Guardian Signature	Printed Name	Date