PLEASE READ COMPLETE INSTRUCTIONS:

Program: Heart Screening & Wellness program based on the New England Journal Study and pilot program conducted by Chandler Regional, Mercy Gilbert Medical Center and CHW benefiting the Chandler, Gilbert and Queen Creek Fire Departments.

Screening Includes:

- Boston Heart Diagnostics Panel
- Consultation/follow-up – Mountain Heart includes
  History/Medications/Last results of physicals & panel results
  BMI/Waist Hip measurement & EKG

Note: Variation of test may be subject to change at any time
Goal: To provide a Heart Screening & Wellness Program to Northern Arizona First Responders with the hope of improving the early detection, prevention and treatment of this high-risk population.

Screening: This program is provided through the partnership of Mountain Heart and Boston Heart Diagnostics.

Who does it include: ALL First Responders within the Northern Arizona Region
Cost: Participants **will not be** responsible for any out of pocket costs for screening listed in the outline of this program. Cardiologist follow up appointment to review screening results is included through the partnership of Mountain Heart.

NOTE: Should your screening result in further suggested OR required testing by Mountain Heart, it could result in out of pocket costs to you depending on your insurance coverage and deductible. Any other tests needed and not included in this program will be discussed with you first before proceeding.

Billing: All costs for this program are billed directly to the Shadows Foundation. As noted above, should this screening and follow up visit result in further testing or follow up this could result in the billing of your insurance or result in out of pocket expenses to you.

Enclosed please find the paperwork that you will need to fill out prior to the testing date. In order to participate all paperwork must be filled out and returned to your immediate supervisor.
On the Personal Medical History form, please list your current medication and dosages. Your medication list is vital information needed to complete the testing process.

Forms included in your packet

- Welcome to Mountain Heart
- Patient Medical Information Form RETURN
- Authorization for information release RETURN
- Notice of Privacy Practices RETURN
- Medical Records Release Authorization RETURN

Write down All Important Information

- Any symptoms you are having
- Your health history
- Personal information, including life changes

Bring Note-Taking Material to follow-up

- Notepad
- Pen
- Taking notes home with you can help you remember what you need to know

Screening Blood Draw:
Please return to Shadows Foundation your Mountain Heart acknowledgment of receipt of privacy notice and Mountain Heart medical information registration forms ONLY. Once these have been received a **Boston Heart Diagnostics** blood draw request order form will be issued to you. This form will be dropped off or mailed to you. Please allow at least one week to receive your screening order form. Once you receive your blood screening form **you can go to either of the locations listed below and get your blood drawn. Once you have had your blood drawn please contact Vicki at 928-380-6641. You will then be contacted by Mountain Heart to set up your follow up appointment with Dr. Wani. (Please see instructions below)**

Testing: We recommend you do this first thing in the morning. Please DO NOT eat any solid foods, drink any liquids other than water or take any biotin supplements for at least 8 hours prior to testing (Blood Screening).

BLOOD SCREENING DRAW LOCATIONS:
Flagstaff Medical Center Lab: Monday–Friday 6:30am to 12:00pm. The Lab entrance is located next to the entrance to the ER.

Page Hospital/Laboratory Sciences of Arizona: Monday-Friday from 7am- 10:30am. The lab is located at 501 N. Navajo Dr. Please note they are a level IV trauma facility and you might have to wait to be drawn if they have in house patients.

Follow up Consultation:
Mountain Heart - Dr. Wani * 2000 S. Thompson *St. Flagstaff
You will be contacted by Katie Sutter from Mountain Heart to schedule your follow up consultation. Should you have any questions she can be contacted at 928-226-6415.

Shadows Foundation Contact information
Vicki Burton Phone: 928-380-6641 Fax 928-255-4315
Email vicki@shadowsfoundation.com

Mountain Heart™
Advanced Technologies. Hands On Care.

WELCOME TO MOUNTAIN HEART

Dear New Patient,

Welcome to Mountain Heart Cardiovascular Care Center and Accredited Sleep Facility. It is our pleasure to serve you. Our goal is to provide you with exceptional customer service in a safe healthcare environment that emphasizes the importance of being proactive about your health. We strive to meet all of your heart care needs and provide you with the highest quality care at the lowest price point possible.

Please take a moment to complete the attached patient information and at your convenience, review our complete office policies and learn about additional services we offer online at www.mountainheartcares.com. If there is anything we can do to improve your experience at any point, please do not hesitate to let us know.

In our efforts to maintain cost efficient care and stay on-time during clinic, we need your help. The following policies help us to ensure an on-time visit, and avoid any financial surprises:

1) **CANCELLATION POLICY:** All patients are required to provide 48-hour cancellation notice. This policy allows us to fill any vacant appointments with a patient that needs to be seen urgently. Multiple cancellations without notice may be cause for termination from the practice.
2) **ZERO TOLERANCE NO SHOW POLICY:** Mountain Heart does not permit missed appointments without notification to the practice. No show appointments cause a burden on the practice and limit our provider's ability to see urgent patients. After three no-show appointments within a 12-month period, patient accounts will be reviewed and may result in dismissal from the practice.
3) **CO-PAYS/DEDUCTIBLES:** For the benefit of our patients we accept all insurances. We recommend that you check with your insurance company to verify that our providers are on the contracted provider list. As part of our contract with insurance companies we are legally required to collect co-pays and deductibles from you at the time of service. We ask that you be prepared to pay your co-pay and deductible at the time of the visit. We will accept cash, check, money order or credit card.

Please arrive 15 minutes before your appointment to allow time for registration. If you are late for your appointment, we may need to reschedule.

We appreciate your help in maintaining our low costs and look forward to participating in your healthcare needs. Again, welcome to Mountain Heart.

Sincerely,

Your Mountain Heart /are Team
Dr. Kent Winkler,
MD, FACC, FSCAI
Medical Director

Mountain Heart™

2000 S. Thompson St., Flagstaff, AZ 86001, Ph (928) 226-6400

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students licensing, fundraising and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health Information (fees may apply) - Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in fun. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative i.e. electronically.

You have the right to request an amendment to your protected health Information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Mountain Heart™
Sleep Facility

Patient Bill of Rights and Responsibilities

You the patient have the right to have all of your questions answered prior to the test being done.

You the patient have the right to assistance in completing the forms provided by the sleep program, this may include having a technologist sit with you and discuss the forms, read them to you, and or write your responses for you.

You the patient have the right to have a family member accompany you to the sleep study and stay with you until it is time for the study to begin.

You the patient have the right to feel safe when sleeping in the facility.

You the patient have the right to voice any concerns you have regarding the services, the facility or the staff.

You the patient have the right to participate in decisions made regarding your care.

You the patient have the right to personal privacy while in the facility and to know that any information gathered in the process will be kept private.

Responsibilities

You the patient have a responsibility to provide accurate and complete information regarding your present medical/sleep history, past history, hospitalizations, medications and other matters related to your health.

You the patient have a responsibility to voice any concerns that you have about the care provided to you.

You the patient have a responsibility to ask any and all questions that you might have about the sleep study and follow-up process.

You the patient have a responsibility to follow the treatment plan prescribed; and, if you are unable, or unwilling, you must notify us or your physician.

You the patient have a responsibility to accept consequences when you do not complete the sleep study or follow prescribed treatment.

You the patient have a responsibility to be respectful of the staff and your surroundings while in the facility.

You the patient have a responsibility to meet financial obligations that result from this service.

Mountain Heart™
2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

PATIENT INFORMATION

Last Name First Name M.I.

Mailing Address City State Zip

Date of Birth Sex M F Soc. Sec. # Marital Status S M W D

Hm Ph # Wk Ph # Cell Ph. #

Primary Language Race Ethnicity

This data may be used by healthcare providers and government agencies for benchmarking and other quality improvement measures. Responses are voluntary

Patient Email Address

(We do not sell or advertise personal information) How do you prefer to be contacted for reminders? O Phone O Postal Mail O E-mail

Spouse or Partner's Name Phone

Employers Name Phone

Referring Physician Name Phone

Primary Care Physician Name Phone

Pharmacy Name & Location Phone

How did you hear about us? O Physician O Hospital/ER O Internet O Newspaper O Friend O Television O Dentist O Other_____

INSURANCE INFORMATION (Copy of Insurance Card(s) will be made)

Primary Insurance Info

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

Secondary Insurance Info

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

EMERGENCY CONTACT INFORMATION

Name Phone # Relationship to Patient

To Protect the privacy of all Mountain Heart Patients, I will not electronically record, photograph or duplicate patient health information or identity.

MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION
OFFICE VISIT COPAYS AND DEDUCTIBLES ARE DUE AT CHECK-IN

As a courtesy to our patients, Mountain Heart will submit a claim to your insurance for you. However, this does not guarantee full coverage or non-covered services. I understand and agree that any non-covered charges incurred by me are solely my responsibility.

I hereby authorize Mountain Heart to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the service performed. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. This authorization shall continue and be in full force and effect until revoked in writing by me. I understand that deductible and copays are due at the time of service and I am ultimately responsible for payment of all charges for services rendered and any incurred collection costs (40%) by any outside agency. **We accept VISA, MASTERCARD, AMEX and DISCOVER.**

Patient Signature Date

Guardian Signature (proof of guardianship will be obtained) Date

MountainHeart™
2000 S. Thompson St., Flagstaff, AZ 86001, Ph (928) 226-6400

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Mountain Heart's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)	Name/Relationship if signed by other than patient
Signature	Date

Kent D. Winkler, MD, FACC, FSCAI
Medical Director

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2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

AUTHORIZATION FOR INFORMATION RELEASE

Patients/Legal Guardians:

By signing this form, you are giving our office staff permission to discuss (either by phone or in person) personal medical information with persons whom you have given permission to know your private medical history.

Name	Relationship
Name	Relationship
Name	Relationship

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Patient Name:_____ DOB:_____

Please check one of the following Statements:

- O Five Wishes
- O I Have Executed an Advance Directive
- O A Living Will
- O Designation of a Health Care Surrogate
- O Durable Power of Attorney
- O I Have Not executed an Advanced Directive, a Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.

Name of Designee:

Address:_____

_____

Relationship:_____

Telephone:_____

(Please bring in a copy of any of the above documents for our records.)

Patient Signature:_____ Date: _____

Mountain Heart™
A Northern Arizona Healthcare partner

Medical Records Release Authorization

2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

Patient Name_____ Maiden Name_____ SS#_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address:_____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip_____

Phone #_____ Fax#_____

B) To be released TO:

Name Mountain Heart

Address 2000 S. Thompson St.

City/State/Zip Flagstaff, AZ 86001

Phone # 928-226-6400 Fax# 928-226-6410

C) For the purpose of:

___Litigation
___Insurance
___Self/Personal Copy
___Transfer or Continuity of Care
___Disability
___Work Comp
___Other

Date Range_____ to_____

☐ Physician Office Notes
☐ Immunizations
☐ Operative/Procedure Reports
☐ Other_____
☐ Cardiology/EKG Reports
☐ Lab/Path Reports
☐ Radiology/XRay/MRI Reports
☐ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date:_____

(Expiration date of authorization)

Mountain Heart™
Advanced Technologies. Hands On Care.

2000 S. Thompson St.
Flagstaff, AZ 86001
928.226.6400

From Page and the North:
take 89 South into Flagstaff, continue onto the Business Loop 40 (you will see signs for I-40 W/US-66, W/Los Angeles). Turn left onto S Woodlands Village Blvd, at the light, turn right onto W University Ave, 3 blocks up, turn right into the parking lot at Mountain Heart.

From Winslow and East:
take I-40 West to I-17/89A North, keep right at the fork, continue on S Milton Rd. At W University Ave. take a left (there will be a Burger King where you will be turning), follow W University straight through the stop sign and traffic signal, 3 blocks up, turn right into the parking lot at Mountain Heart.

From Williams and West:
take I-40 East to I-17/89A (exit 195) North, bear left on the off ramp, continue on S Milton Rd. At W University Ave. take a left (there will be a Burger King where you will be turning), follow W University straight through the stop sign and traffic signal, 3 blocks up, turn right into the parking lot at Mountain Heart.