SONORA
BEHAVIORAL HEALTH

Due to COVID -19 at this time our top priority is your safety. We are unable to permit on site visitation of friends and families.

We currently are not inviting any visitors in except Clergy, and lawyers

Thank you for your anticipated cooperation.

SONORA
BEHAVIORAL HEALTH

Permissible Patient Belongings List

Clothing

- 3 Outfits
  *1 outfit includes 1 top, 1 bottom, 1 undergarment and 1 pair of socks
- 1Pair of Pajamas
- 1 Pair of shoes without laces
- 1 Sweatshirt or Jacket
  *** Drawstrings, hoods and metal pieces are not permitted on any clothing item

Toiletries

- All items must be unopened and may not include alcohol as the main ingredient

Miscellaneous

- Notebooks without staples or spiral binding
- Books (paperbacks only)
- Hairbrush or /Comb
- 1-2 small hair ties without metal

SONORA BEHAVIORAL HEALTH

Patient Belongings

DEFINITIONS

- **Valuables:** a negotiable item such as cash, credit cards, wallet, cell phone, driver's license and jewelry
- **Belongings:** Any item such as clothing, reading materials, personal items such as dentures, retainers, eyeglasses, hearing aids, canes and walkers.
- **Contraband**: Potentially harmful objects or materials which are not allowed on the premises of Sonora Behavioral Hospital

A. Contraband:

1. All valuables is to be sent home at the time of admission or picked up by a trusted friend or family member as soon as possible. Valuables not sent home will be in a safe bag and not accessible during your visit.
2. **Items that are never permitted are**:
   - **a.** All glass, metal or ceramic objects
   - **b.** All sharp objects, whether metal, wire or hard plastic including tweezers, scissors, knives, hair picks, barrettes, hair clips/pins, razors, nail clippers, spiral notebooks, hangers, sewing/knitting needles, hooks, guns, letter openers, nail files or other items identified.
   - **c.** Any electronic items including CD players, I pads, cell phones, I PODS, electric toothbrushes, radios, tapes, CD's. Computers, batteries, hair dryers, curling irons, flat irons and anything with an electric cord.
   - **d.** Aerosols or sprays
   - **e.** Personal hygiene articles containing alcohol including mouthwash and hand sanitizer products.
   - **f.** Any smoking materials tobacco, matches, lighters, pipes or paraphernalia
   - **g.** Sonora provides food and drink while you are here We cannot allow outside food into the hospital
   - **h.** Staples and materials with staples are not permitted
   - **i.** Belts, shoe laces, cloth sashes, handkerchiefs, scarves, cord strung clothing of any kind, drawstrings suspenders, head bands and hairbands, Underwire bras are not permitted. Clothing that is not permitted includes halter tops, low cut necklines, spaghetti straps, short shorts, mid drift tops, spandex and no metal zippers or hoodies
   - **j.** Stuffed animals, blankets personal pillow or any bedding is not permitted on the units
   - **k.** Sonora provides pencils, crayons and markers while you are here
   - **l.** Alcohol or illegal drugs
   - **m.** Clothing that glorifies drugs, alcohol, cigarettes, pornography, gangs or violence.
   - **n.** Hats, skull caps, bandannas or bandannas or hoodies
   - **o.** Weapons or firearms
   - **p.** Plastic bags, or bags with handles or long straps

q. Money of any kind
r. Dental floss,, rope or twine
s. Backpacks

3. **Limited access list**
   a. Jewelry that cannot be removed from your body (includes piercings)
   b. Over the counter medications, prescribed by your doctor and properly labeled may be used at Sonora. Our pharmacist will determine eligibility
   c. Any sunglasses – must be prescription
   d. Personal reading books are not recommended

Our number one goal is to keep you safe here at Sonora!

Thank you for helping us keep you and other patients safe

SONORA BEHAVIORAL HEALTH

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure an timely manner.

What information is available through Health current?
The following types of health information may be available:

- Hospital records
- Medical History
- Medications
- Allergies
- Lab test results
- Radiology
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other health providers and health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, and transition of care planning and population health services.

You may permit other to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purpose stated on that form. Health Current may also use your information as required by law and as necessary to preform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitteduse.

Does Health Current receive behavioral health information and if so, who can access it?

SONORA BEHAVIORAL HEALTH

Notice of Health Information Practices

(Participant) participants in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinator your care by securely sharing your health information.

I acknowledge that I receive and read the Notice of Health Information Practices. I understand that my healthcare provider participants in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return and Opt Out Form to my healthcare provider.

Signature Date

Aviso de Prácticas de Información de Salud

(Participante) participa en una organización sin ánimo de lucero, organización no gubernamental de intercambio de información sobre la salud (HIE- por sus siglas en inglés) llamada Health Current. Esto no le generara ningún costo y puede ayudar a su médico, proveedores de salud y planes de salud a coordinar mejor su cuidado compartiendo de forma segura su información médica. Este aviso explica cómo funciona el programa HIE y le ayudara a entender sus derechos con respeto al mismo bajo las leyes estatales y federales.

Yo reconosco que he recibido y leído el Aviso de Practicas de Información de la Salud. Yo estoy consciente que mi proveedor participa en el HIE (Arizona's Health Information Exchange). Yo estoy consiente que mi información de la salud será compartida de manera segura atravez del sistema HIE, al menor de que llene un forma de Optar Por No.

Firma Fecha

SONORA BEHAVIORAL HEALTH

Patient Demographic Sheet

Admission Date	Admit Time	Registrar Initials	Social Security Number	Date of Birth	

Patient Information **No Speical Characters**

*NAME (Last, First, Middle Initial)	*SEX	*RACE	*ETHNICITY	*Primary Language
	□ Female □ Male	□ Asian □ White □ Black □ Unknown □ Indian □ Pt Declined	□ Hispanic / Latino □ Not Hispanic/Latino □ Pt Declined	□ English □ Spanish □ Unknow

*Address	City, State & Zip Code	*Phone	*Martial Status	
			□ Single	□ Married
			□ Married	□ Life Partner
			□ Divorced	□ Widowed
			□ Legally Seperated	□ Unknown

Email Address: _____

Patients Employer Information

Employment Status	Employer Name:	Employer Phone Number:
□ Full - time □ Part - time □ Retired □ Unemployed □ Unknown	Employer Address:	Occupation/Job:

Emergency Contact #1

Name:	Address:	City/State/Zip:

Primary Phone #	Alternate Phone #	Relationship to Patient:

Emergency Contact #2

Name:	Address:	City/State/Zip

Primary Phone #	Alternate Phone #	Relationship to Patient

Name of Agency or Person who referred you to our Facility

Primary Insurance: _____ **Subscriber (check One** **□ Patient □ Other - If "Other" complee Subscriber information**

*Subscriber Name: _____ *Date of Birth: _____ *Patients Relationship to Sut _____

Subscriber Address: _____ *Subsriber Social Security Number _____ ____

*Insurance Company Name	Insruance Company Address	Insurance Company Phone Number
		( ) _____

Policy Number	Group Numnber	Authorization Number	*Employer Name

Do you have or have you had within the past 6 month any other health insurance? □ Yes or □ No

If YES, Provide Insurance carrier: Name: Policy #: Group #:

Have you notified your current insurance provider that you no longer have this previous coverage □ YES or □ NO

PATIENT IDENTIFICATION STICKER

SONORA BEHAVIORAL HEALTH

Patient Demographic Sheet

Secondary Insurance: _____ **Subscriber (check One** □ Patient □ Other - If "Other" complee Subscriber information
*Subscriber Name: _____ *Date of Birth: _____ *Patients Relationship to Sut _____
Subscriber Address: _____ _____ *Subsriber Social Security Number _____ ____

*Insurance Company Name | Insruance Company Address | Insurance Company Phone Number ( ) _____

Policy Number	Group Numnber	Authorization Number	*Employer Name

Notes/Comments:

Tertiary Insurance: _____ **Subscriber (check One** □ **Patient** □ **Other - If "Other" complee Subscriber information**
*Subscriber Name: _____ *Date of Birth _____ *Patients Relationship to Sut _____
Subscriber Address: _____ *Subsriber Social Security Number _____ ____

*Insurance Company Name | Insruance Company Address | Insurance Company Phone Number ( ) _____

Policy Number	Group Number	Authorization Number	*Employer Name

Notes/Comments:

Guarantor Information: (Check One) □ **Patient** □ **Other - If "Other" coplete Guarantor Section**
*Relationship to Patient: _____ *Name (Last, First, Middle Initial) Date of Birth ___/___/____

Social Security Number | Address: | City/State/Zip Code

*Guar. Empl. Statu	*Guarantor Employer Name:	Street Address:
□ Full - time		City/State/Zip Code:
□ Part - time	Employer Phone Number:	
□ Retired		
□ Unemployed		
□ Unknown	Occupation/Job:	

PHARMACY NAME: _____ ADDRESS: _____
PHONE #: _____ FAX #: _____

**** I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABLOVE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE****

Signatue: _____ **Date:** _____

FACILITY USE ONLY

*Admission Type	* Admission Status	* Admission Source			
□ Emergency	□ Involuntary	□ Non Healthcare Facility	□ Transfer from Hospital	*HSV: _____	
□ Elective	□ Voluntary	□ Clinic or Physican Office	□ Transfer from SNF or ICF	*Accom Code: _____	
□ Urgent		□ Court/Law Enforcement	□ Info not available	* Room/Bed: _____/___	
				* Diagnosis (ICD-10)	
Admitting Doctor	***Attending Doctor**	***Therapist Information**		_____	
				_____	
				_____	

PATIENT IDENTIFICATION STICKER

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____

I hereby authorize: ☐ **release information to:** ☐ **exchange information**

SONORA BEHAVIORAL HEALTH HOSPITAL	**NAME:**
6050 N. CORONA RD.	**ADDRESS:**
TUCSON, AZ 85704	
PHONE: 520-469-8700 **Fax: Main – 520-469-8708 Medical Records – 520-229-8418** **Adult – 520-742-6826 Adolescent – 520-878-6710** **IOP – 520-389-8532**	**PHONE: FAX:**

By signing below, I hereby authorize Sonora Behavioral Health Hospital or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: (patient* or legal guardian √ items to be released).

__Psychiatric Evaluation
__History & Physical
__Practitioner Orders
__Practitioner Progress Notes
__Discharge Summary
__Laboratory Reports
__Immunization Records
__Medication Records
__Treatment/Individualized Service Plan
__Discharge Instructions
___Financial Account information
___Other (specify)_____

The Purpose or Need for Disclosure is:

__To Transfer Client Care
__For Follow Up Care
__To Inform Family
__Referral Source
__Legal/Court System
__To Aid in Treatment
__For Discharge Planning
__To Update Medical Records
__Employer
__Application for Provider Coverage
__Psychological Report
__To Aid in financial account activity
__Other (specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, 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. ***State and federal law protect the following information. If this information applies to you, please (√) indicate if you would like this information released/obtained*** (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records __ Yes __ No Dates: _____
HIV Testing and Results __ Yes __ No Dates: _____
Mental Health Records Dates: __ Yes __ No Dates: _____

Disclosure Format (Paper/US Mail or Fax is default if not marked.): Specify "E-mail" or other Electronic format": _____

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on _____ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and ay no longer be protected by federal and state privacy laws and regulations.
- I understand that Sonora Behavioral Health Hospital will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

_____ _____
Patient or Authorized Representative Signature Date

_____
Print Name Relationship to Patient (if applicable).

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.

ORGAN DONATION/ADVANCE DIRECTIVES

Organ Donation:

Is the patient an Organ, Tissue, or Eye Donor? Yes_____ No _____
If not, would the patient like information on becoming a donor? Yes_____ No _____

Medical Power of Attorney/Mental Health Power of Attorney:

- ☐ Patient has formulated a Medical Power of Attorney, but has not brought a copy to this hospital. Staff have requested the document be provided.
- ☐ Patient has formulated a Medical Power of Attorney and has provided a copy of the following to hospital staff.
- ☐ Patient has formulated a Mental Health Power of Attorney, but has not brought a copy to this hospital. Staff have requested the document be provided.
- ☐ Patient has formulated a Mental Health Power of Attorney and has provided a copy of the following to hospital staff.

Living Will and Advance Directives

____ Medical Power of Attorney
____ Mental Health Power of Attorney
____ Living Will

Does the patient wish to formulate Medical Power of Attorney? Yes*_____ No _____
*The patient was provided information on formulating an Advanced Directives.

Does the patient wish to formulate Mental Health Power of Attorney? Yes*_____ No _____
*The patient was provided information on formulating an Advanced Directives.

Does the patient have a surrogate decision maker? Yes*_____ No _____
*Name_____ Contact Number_____

Patient/Legal Representative Signature: _____Date_____Time _____

Staff Signature: _____Date_____Time _____

ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of Sonora Behavioral Health's HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Legally Authorized Representative **Date**

If signed by legal representative, relationship to patient:

- ☐ Legal Guardian / Parent
- ☐ Power of Attorney
- ☐ Other:_____

Please Note: It is your right to refuse to sign this Acknowledgement.

An attempt was made to obtain the written Acknowledgement of Receipt of Sonora Behavioral Health's HIPAA Notice of Privacy Practices of the patient noted above but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The patient was unwilling to sign.
- ☐ Involuntary Status
- ☐ Other:_____

_____ _____

Staff Member Signature/Credentials **Date**

Sonora Behavioral Health
PRIVACY NOTICE

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.

Acadia Healthcare will be referred to in this Notice of Privacy Practices ("Notice") as "Acadia". This Notice is given to you by an Acadia Facility to describe the ways in which Acadia may use and disclose your medical information (called "protected health information" or "PHI") and to notify you of your rights with respect to PHI in the possession of Acadia. Acadia protects the privacy of PHI, which also is protected from disclosure by state and federal law. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Acadia or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

Uses and Disclosures for Treatment, Payment and Health Care Operations

Acadia may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

FOR TREATMENT: Acadia may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities at another healthcare facility. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

FOR PAYMENT: Acadia may use and disclose PHI in order to collect payment for the health care services provided to you. For example, Acadia may need to give PHI to your health plan in order to be reimbursed for the services provided to you. Acadia may also disclose PHI to their business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. Acadia may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

FOR HEALTH CARE OPERATIONS: Acadia may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include hospital training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. Acadia may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes. These disclosures help make sure that Acadia is complying

OTHER USES AND DISCLOSURES FOR WHICH AUTHORIZATION IS NOT REQUIRED: In addition to using or disclosing PHI for treatment, payment and health care operations, Acadia may use and disclose PHI without your written authorization under the following circumstances:

AS REQUIRED BY LAW AND LAW ENFORCEMENT: Acadia may use or disclose PHI when required by law, Acadia also may disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identify, description or location of a person who committed a crime, or for other law enforcement purposes.

FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS: Acadia may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

FOR HEALTH OVERSIGHT ACTIVITIES: Acadia may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: Acadia may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

ORGAN, EYE, AND TISSUE DONATION: Acadia may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

RESEARCH: Under certain circumstances, Acadia may use and disclose PHI for medical research purposes.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: Acadia may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: Acadia may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

admitting areas. You have the following rights regarding your PHI:

You may request the Acadia restrict the use and disclosure of your PHI. Acadia is not required to agree to any restrictions you request, but if the entity does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from Acadia be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be in writing and sent to the Privacy Officer. Acadia will accommodate your reasonable requests without requiring you to provide a reason.

Generally, you have the right to inspect and copy your PHI in the possession of Acadia if you make a request in writing to the applicable Acadia Hospital's Medical Records Department. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), Acadia will inform you of the extent to which your request has or has not been granted. In some cases, Acadia may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, Acadia may impose a reasonable fee to cover copying, postage, and related costs. If Acadia denies access to your PHI, it will explain the basis for denial and your opportunity to have the denial reviewed by a licensed health care professional (not involved in the initial denial decision) designated as a reviewing official. If Acadia does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

electronically. You can view a copy of this notice on Acadia's website, www.acadiahealthcare.com. To obtain a paper copy of this notice, please contact the Privacy Officer.

You may complain to Acadia if you believe your privacy rights with respect to your PHI have been violated by contacting Acadia's Privacy Officer and submitting a written complaint. Acadia will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.E., Washington, DC 20201.

If you have any questions about this notice, please contact Acadia Healthcare's Compliance Hotline toll-free 866-500-0333, or email to corporatecompliance@acadiahealthcare.com or write to 6100 Tower Circle, Suite 1000, Franklin, TN 37067

CONDITIONS OF ADMISSION/ADMISSION CONSENT

_____ Initials

APPLICATION FOR VOLUNTARY ADMISSION

I request to admit myself as a patient to the Hospital for diagnostic observation, care, treatment, medications, and services (which in this document will be referred as the "Care").

_____ Initials

CONSENT FOR TREATMENT

I agree to accept the Care for myself as ordered by the Hospital physician or practitioner. I understand that I may refuse certain treatments and agree to discuss the refusal with the attending physician. The Hospital explained, and I consented to, the proposed Care. The Hospital told me of reasonable alternatives to the proposed Care, as well as the risks, benefits, and side effects related to those alternatives, including the risks of refusing any care. The Hospital told me that I have the right to revoke this consent at any time, which could result in my discharge from the Hospital, unless the Hospital has a legal obligation to treat me on an involuntary basis.

_____ Initials

CONSENT TO TRANSFER FOR TREATMENT

I authorize my attending or covering physician to order my transfer to another healthcare facility for emergency care, medical treatment, acute psychiatric treatment, or medical procedure, as my attending physician deems advisable and necessary during my Care here. I have read and fully understand this consent for transfer and agree that I will not seek to hold the referring physician, the Hospital, or its staff liable as a result of the transfer.

_____ Initials

ASSIGNMENT OF INSURANCE BENEFITS

I understand that the Hospital files health benefit claims as a courtesy to patients. I authorize my health insurance or health benefit plan(s) ("Health Plan") to pay the Hospital or attending physician directly, up to the maximum of the Hospital's and physician's regular charges for the Care. I understand and agree that I am financially responsible to the Hospital for any charges related to my treatment and not covered by my Health Plan unless otherwise dictated by applicable law. I irrevocably assign and convey to the Hospital all rights, title, and interest in any benefits under the terms of the Health Plan and I promise to remit to the Hospital any payment that I may inadvertently receive from my Health Plan for the Care. I also designate, authorize, and convey to the Hospital to the fullest extent permissible under the law and any applicable Health Plan the right and ability to act on my behalf: (1) in connection with any claim, right, or cause of action, including to bring litigation against my Health Plan, that I may have under the Health Plan (including, but not limited to, naming me as a plaintiff in such an action); and (2) to pursue such claim, right, or cause of action in connection with the Health Plan, including but not limited to, with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act ("ERISA") – as provided in 29 CFR § 2560.5031(b)(4) – in relation to any expense incurred as a result of the Care, and to claim on my behalf any relevant benefits, claims, or reimbursement, and any other applicable remedy, including fines. I expressly and knowingly assign and convey to the Hospital all rights, title, and interest in any and all causes of action I may have under ERISA for breach of fiduciary duty or to recover benefits, as well as any other legal and/or administrative causes of action.

_____ Initials

RELEASE FOR PATIENT VALUABLES

I understand and agree that the Hospital maintains an area for safekeeping of money and valuables, that I will not hold the Hospital liable for loss or damage to any money, personal valuables or other articles unless I gave those items to the Hospital for safekeeping.

_____ Initials

RIGHT TO SEARCH

I agree that the Hospital may search my belongings and remove any items that the Hospital believes may be potentially dangerous to me or others.

_____ Initials

RELEASE FROM RESPONSIBILITY OF ELOPEMENT

If I leave the Hospital without discharge ordered by my attending physician or without knowledge or supervision of the Hospital staff, I release the Hospital from liability for whatever happens to me or my condition as a result of my leaving the Hospital.

_____ Initials

CONSENT TO PHOTOGRAPH

I permit the Hospital to take photographs of me as identification.

Initials

SMOKING POLICY

If you wish to smoke during your stay, you must adhere to the smoking policy. You may smoke only in the designated smoking areas. The schedule for smoking times is posted on the units and smoking breaks are only allowed during the scheduled times. There are no smoking breaks during any of the groups or planned activities. Lighters and

PATIENT IDENTIFICATION STICKER

matches are not allowed on the unit. Electric cigarettes lighters are available in each designated smoking area. As patients have a variety of treatment plans, please do not share cigarettes with other patient. If you are a tobacco user and desire to quit, smoking cessation information is available.

SATISFACTION SURVEY

The Hospital will give me a Satisfaction Survey around the time of discharge. The Hospital will not publicize my responses to the survey in a way that identifies me as a patient or as the source of the survey results. The Hospital may contact me by telephone or in writing to follow up on that survey, or for any other reason post-discharge.

_____ Initials

RECEIPT OF NON-DISCRIMINATION NOTICE

I have received the Hospital Nondiscrimination policy. The Hospital has explained the policy to me during the admission process in a language that I understand.

_____ Initials

RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES INFORMATION

I have received my Patient Rights and Responsibilities information.

_____ Initials

RECEIPT OF THE PATIENT GRIEVANCE INFORMATION

I have received the Hospital Patient Grievance information. The Hospital has explained process to me during the admission process in a language that I understand.

_____ Initials

INTERPRETERS

(As applicable) Patients with language, vision, hearing, or speech barriers have a right to special arrangements designed to enhance communication and comfort. The hospital will furnish, at no cost to the patient, interpreters and auxiliary aids. I hereby give my permission for the hospital to use a language interpreter for the purposes of communicating treatment information. I understand the interpreter will have access to my medical/psychiatric information only through the interpretation of this information. I understand the interpreter will NOT have access to my medical records.

_____ Initials

NO PHYSICIAN AVAILABLE 24/7 NOTIFICATION

I understand that a physician is not present 24 hours/day, seven days a week. If an emergency medical condition occurs, a Registered Nurse will assess the situation, provide basic life support, and call the on-call physician and/or EMS-911.

HIPAA - CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS: I understand and have been provided with a Notice of HIPAA Privacy practices and provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance, thereon. I understand by signing below I was given or asked if I wanted a copy of my HIPAA rights.

_____

My initials on the items show that I have read, understood, and agree to them.

Patient:	**Legal Representative: (if applicable):**	**Hospital Staff Member:**
_____ Signature	_____ Signature	_____ Signature
_____ Date Time	_____ Date Time	_____ Date Time

PATIENT IDENTIFICATION STICKER

CONSENT FOR VERBAL COORDINATION OF CARE

I, hereby authorize Sonora Behavioral Health Hospital to contact the following person(s), institution, or agency for coordination of care purposes:

This Consent for Verbal Coordination of Care
is not valid unless signed and dated on the back of this form.

REQUIRES PATIENT INITIALS AND DATE FOR EACH CONSENT

Significant Other/Emergency Contact:	Relationship:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
CPS WORKER:		
Address:		
Phone#:	***Patient Initials:**	**Date:**
Psychiatrist	Name of Practice/Agency:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
Primary Care Physician	Name of Practice:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
Therapist:	Name of Practice/Agency:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
Employer:	Company:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
Other (Probation, School, etc.):	Relationship:	
Address:		
Phone#:	***Patient Initials:**	**Date:**
Support Person	Relationship:	
Phone#:	**Patient Initials:**	**Date:**
Support Person	Relationship:	
Phone#:	***Patient Initials:**	**Date:**

(Release of Medical Records requires additional authorization)

FOR THE RECIPIENT OF THE INFORMATION: This authorization is given in compliance with the federal consent requirements for release of alcohol or drug records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand that information to be discussed may indicate that I may have a communicable, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), psychological/mental health or psychiatric conditions or that I have or have been treated for substance abuse. This information is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed and is valid at all levels of care within Sonora Behavioral Health Hospital.

MY RIGHTS: I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I have a right to receive a copy of this Authorization.

Patient Signature	Date	Parent or Legally Authorized Representative	Date
Staff Member / Witness Signature	Date	2nd Witness Signature Required for Verbal Consents	Date

PHONE AND VISITOR AUTHORIZATION *PATIENT IDENTIFICATION STICKER*

Name _____ **Phone Code** _____

I have authorized **ONLY** the following individuals permission to visit or telephone during my hospitalization. I understand that only immediate family or significant persons pertaining to my treatment should be on the list. **Note**: No one may add contacts to this list without my permission. I may withdraw my consent at any time.

Name	Relationship	Phone Number	Date/Time Added	Date/Time Removed	Patient Initials	Staff Initials
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Patient Signature _____ **Date:** _____ **Time:** _____

Staff Initials: _____ **Signature:** _____ **Date:** _____ **Time:** _____

Staff Initials: _____ **Signature:** _____ **Date:** _____ **Time:** _____

Staff Initials: _____ **Signature:** _____ **Date:** _____ **Time:** _____

Staff Initials: _____ **Signature:** _____ **Date:** _____ **Time:** _____

Staff Initials: _____ **Signature:** _____ **Date:** _____ **Time:** _____

PATIENT PHONE AGREEMENT *PATIENT IDENTIFICATION STICKER*

The Hospital recognizes the impact support from family and friends can provide while a person transitions into recovery. The hospital provides participants in our programs with phones to use for communication with family and friends. In order to maintain confidentiality and still allow open communication for our patients, we ask you to agree to our phone conduct standards:

- I will inform family, friends, and other support of my phone number and I understand the Hospital staff will not transfer calls in order to protect my confidentiality.
- I will answer the phone with courtesy and make every attempt to locate the person the caller is asking for.
- I will never provide information about another patient to a caller.
- I will use the phone for a reasonable amount of time to ensure others are also able to have phone time.
- I will not call the patient phone once I have left the Hospital to contact individuals I met while inpatient.

I agree to the above phone conduct standards and understand phone privileges may be restricted if I do not comply with them.

_____ _____ _____

Patient Signature Date Time

Patient Phone Number _____

Sonora Behavioral Health

PATIENT LABEL

COORDINATION OF BENEFITS QUESTIONNAIRE

It is important that you complete this questionnaire. This information is requested by insurance providers usually yearly to update their records and provide timely and accurate processing of claims.

SECTION A – INSURANCE COVERAGE

What is your primary insurance? _____ Member ID/SSN: _____

Policy Holders Name: _____ Relation to Insured: _____

Are you or any dependent (spouse or children) covered by another medical, or governmental insurance policy (Medicare, Medicaid, etc.)?

☐ Yes, continue to the next SECTION ☐ No other insurance for policyholder, spouse, and/or children. Sign and date below.

Insured's Signature _____ **Date** _____

SECTION B – YOUR OR DEPENDENTS OTHER INSURANCE COVERAGE IN ADDITION TO THE ABOVE (Group or Governmental insurance)

1. Other insurance _____ Member ID/SSN: _____

Policy Holders Name: _____ Relation to insured: _____

2. Other insurance _____ Member ID/SSN: _____

Policy Holders Name: _____ Relation to insured: _____

3. Other insurance _____ Member ID/SSN: _____

Policy Holders Name: _____ Relation to insured: _____

SECTION C- Complete if policy holder is DIVORCED, LEGALLY SEPARATED, or a SINGLE PARENT and you have dependent children

Dependent	Person with Legal Custody	Relationship to dependent	Person responsible for Dependents Healthcare expense

I certify that the information herein is true and correct. I authorize the administrator of the plan(s) to release information to my insurance carrier regarding health care benefits to which I may be entitled. I understand that the purpose of the release of information is to assure appropriate coordination of benefits of all plans. This authorization shall remain valid for the duration of coverage of the plan for which a claim is submitted. In understand a photo static copy of this authorization shall be valid as the original

Insured's Signature _____ **Date** _____

Hospital Name: Sonora Behavioral Health
Hospital Address: 6050 N. Corona Rd. Tucson, Az 85704

Important Message from Medicare

Patient Identification Sticker

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at:
  LIVANTA BFFCC-Q10 1-877-588-1123 (OR TTY/TTD 1-855-877-6688
  The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on Page 1.
- If you belong to a Medicare health plan: Call your plan at {insert plan name and toll-free number of plan}

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

Signature of Patient or Representative _____ Date _____ Time _____

Medicare Secondary Payor Questionnaire

Part I

1. Are you receiving Black Lung (BL) benefits? (BL is primary only for claims related to BL)
   ____ Yes Date benefits began: _____
   ____ No
2. Are the services to be paid by a government program such as a research grant?
   ___ Yes Government Program will pay primary benefit for these services
   ___ No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ___ Yes DVA is primary for these services
   ___ No
4. Was the illness/injury due to a work related accident/condition?
   ___ Yes Work Comp is primary only for claims related to work related injury/illness
   Date of injury/illness: _____
   Name and address of the work comp plan:
   _____
   _____
   Policy/Identification #: _____
   Name and address of the employer at the time of the injury/illness:
   _____
   _____
   Go to Part III
   ___ No Go to Part II

Part II

1. Was the injury due to a non-work related accident?
   ___ Yes Date of accident: _____
   ___ No Go to Part III
2. What type of accident caused the illness/injury?
   ___ Automobile ___ Non-automobile
   Name and address of no-fault or liability insurer:
   _____
   _____
   Insurance claim #: _____
   No-fault insurer is primary only for those claims related to the accident. Go to Part III
3. Was another party responsible for this accident?
   ___ Yes Name and address of any liability insurer:
   _____
   _____
   Insurance claim number: _____
   Liability insurer is primary only for those claims related to the accident. Go to Part III

Part III

1. Are you entitled to Medicare based on:
   ___ Age Go to Part IV
   ___ Disability Go to Part V
   ___ ESRD Go to Part VI

PATIENT IDENTIFICATION STICKER

Part IV – Age

1. Are you currently employed?
   ___ Yes Name and address of your employer:
   _____
   _____
   ___ No Date of retirement: _____
2. Is your spouse currently employed?
   ___ Yes Name and address of your employer:
   _____
   _____
   ___ No Date of retirement: _____

If the patient answered "NO" to both questions 1 and 2, Medicare is primary unless the patient answered "YES" to questions in Part I and II. Do not proceed any further.

3. Do you have group health plan (GHO) coverage based on your own or a spouse's current employment?
   ___ Yes ___ No ***STOP. Medicare is primary unless the patient answered "YES" to questions in Part I or II.***
4. Does the employer that sponsors your GHP employ 20 or more employees?
   ___ Yes ***STOP. Group Health Plan is primary. Obtain the following info.***
   Name and address of GHP:
   _____
   _____
   Policy Identification Number : _____
   Group Identification Number: _____
   Name of Policy Holder: _____
   Relationship to patient: _____
   ___ No ***STOP. Medicare is primary unless the patient answered "YES" to Questions in Part I or II.***

Part V - Disability

1. Are you currently employed?
   ___ Yes Name and address of employer:
   _____
   _____
   ___ No Date of Retirement: _____
2. Is a family member currently employed?
   ___ Yes Name and address of employer:
   _____
   _____
   ___ No

   If patient answers "NO" to both questions 1 and 2, Medicare is primary unless the patient answered "YES" to questions in Part I and II. Do not proceed any further.
3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
   ___Yes ___ No **STOP. Medicare is primary unless the patient answered "YES" to the questions in Part I and II.**
4. Does the employer that sponsors your GHP employ more than 100 employees?
   ___ Yes **STOP. Group Health Plan is primary. Obtain the following information.**
   Name and address of GHP:
   _____
   _____
   Policy identification number: _____
   Group identification number: _____

Name of Policy holder: _____
Relationship to patient: _____

___ No **STOP. Medicare is primary unless the patient answered "YES" to questions in Part I and II.**

Part VI – ESRD

1. Do you have group health plan coverage?
   ___ Yes Name and address of your GHP:
   _____
   _____
   Policy identification number: _____
   Group identification number: _____
   Name of Policy Holder: _____
   Relationship to patient: _____
   Name and address of employer, if any, from which you receive GHP coverage:
   _____
   _____
   ___ No **STOP. Medicare is primary.**
2. Have you received a kidney transplant?
   ___ Yes Date of transplant: _____
   ___ No
3. Have you received maintenance dialysis treatment?
   ___ Yes Date dialysis began _____
   If you participated in a self-dialysis training program, provide the date training started _____
   ___ No
4. Are you within the 30 month coordination period?
   ___ Yes
   ___ No **STOP. Medicare is primary.**
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   ___ Yes
   ___ No **STOP. GHP is primary during the 30 month coordination period.**
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   ___ Yes **STOP. GHP continues to pay primary during the 30 month coordination period.**
   ___ No Initial entitlement based on age or disability.
7. Does the working aged or disability MSP provision apply (i.e. is the GHP primary based on age or disability entitlement)?
   ___ Yes **STOP. GHP continues to pay primary during the 30 month coordination period.**
   ___ No Medicare continues to pay primary.

Patient signature:_____Date:_____Time:_____

Witness signature:_____Date:_____Time:_____

NOTE TO HEALTHCARE PROVIDER

Failure to obtain the information listed in these sections is a violation of your provider agreement with Medicare (see Section 142.3F). The information you must obtain is essential to filing a proper claim with Medicare or a primary payor. Failure to file a proper claim can result in the unnecessary denial or development of claims.

PATIENT IDENTIFICATION STICKER

January 2018

An Important Message From **TRICARE®**

YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "Diagnostic Related Groups (DRGs)" or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and any post-hospital services.

You have the right to request a review by a TRICARE Regional Review Authority (RRA) of any written notice of noncoverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. RRAs employ groups of doctors under contract by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of the RRA for your area are:

East Region

Humana Military
Utilization Management
P.O. Box 740044
Louisville, KY 40201-7444

1-800-334-5612

West Region

Health Net Federal Services, LLC
P.O. Box 9108
Virginia Beach, VA 23450-9108

1-844-866-WEST (1-844-866-9378)

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "notice of noncoverage." You must have this notice of noncoverage if you wish to exercise your right to request a review by the RRA.

The notice of noncoverage will state whether your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care.

- If the hospital and your doctor agree, the RRA does not review your case before a notice of noncoverage is issued. But the RRA will respond to your request for a review of your notice of noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision if you request the review by noon of the first work day after you receive the notice of noncoverage.
- If the hospital and your doctor disagree, the hospital may request the RRA to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation, the RRA must agree with the hospital or the hospital cannot issue a notice of noncoverage. You may request that the RRA reconsider your case after you receive a notice of noncoverage, but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

! IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the notice of noncoverage states that your physician agrees with the hospital's decision:

- You must make your request for review to the RRA by noon of the first work day after you receive the notice of noncoverage by contacting the RRA by phone or in writing.
- The RRA must ask for your views about your case before making its decision. The RRA will inform you by phone and in writing of its decision on the review.
- If the RRA agrees with the notice of noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the RRA's decision.
- Thus, you will not be responsible for the cost of hospital care before you receive the RRA decision.

If the notice of noncoverage states that the RRA agrees with the hospital's decision:

- You should make your request for reconsideration to the RRA immediately upon receipt of the notice of noncoverage by contacting the RRA in writing.
- The RRA can take up to three working days from receipt of your request to complete a review. The RRA will inform you in writing of its decision on the review.
- Since the RRA has already reviewed your case once prior to the issuance of the notice of noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your notice of noncoverage, even if the RRA has not completed its review.
- Thus, if the RRA continues to agree with the notice of noncoverage, you may have to pay for at least one day of hospital care.

Note: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of the TRICARE decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The notice of noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or to home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. TRICARE and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, Beneficiary Counseling and Assistance Coordinator (BCAC), patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

Questions involving billing or specific benefit coverage issues should be addressed to your TRICARE claims processor which is:

East Region

TRICARE East Claims
P.O. Box 7981
Madison, WI 53707-7981

1-800-444-5445

West Region

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 202100
Florence, SC 29502-2100

1-844-866-WEST (1-844-866-9378)

ACKNOWLEDGMENT OF RECEIPT

My signature only acknowledges my receipt of this message from

_____ (Name of Hospital) on _____ (Date)

and does not waive any of my rights to request a review or make me liable for any payment.

_____ _____

Signature Of Beneficiary Or Person Acting On Behalf Of The Beneficiary | Date Signed

FM583BET01180W