Sun Integrated Care

NEW PATIENT INTAKE PAPERWORK

Today's Date: _____

Primary Care Physician: _____ Ph: _____ Fax: _____

Your Name: _____ Gender: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other: _____

Social Security Number: _____-_____-_____ Date of Birth: _____ Age _____

Mailing Address: _____

City/State/Zip: _____

Employer: _____ Occupation: _____

Your Email Address: _____

Daytime Phone # _____ Phone Type: □ Home □ Mobile □ Work

Emergency Contact Name: _____Relationship: _____

Phone Number: _____ Phone Type: □ Home □ Work □ Cell

How did you hear about us? □ Insurance Co □ Employer □ Facebook □Instagram
□ Linkd In □ Internet Search □ Family/Friend □Other: _____

Primary Insurance: _____ Policy/ID #: _____

Group #: _____ Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Policy Holder Name (If Not Self): _____ DOB: _____ SS# _____

Address: _____

Secondary Insurance: _____ Policy/ID #:_____

Group #_____ Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Policy Holder Name (If Not Self): _____ DOB: _____ SS# _____

Address: _____

PHARMACY

Pharmacy: _____ Phone: _____

Address/Cross Streets: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sun Integrated care, PLLC or insurance company to release any information required to process my claims.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Patient or Legal Representative Name (Printed) Date

Sun Integrated Care

EMERGENCY CONTACT AND CONSENT TO DISCLOSE IN CRISIS

Patient Information:

Name:_____ DOB:_____ Phone:_____

Emergency Contact Information:

Name:_____ Relationship to Patient:_____

Phone Number:_____ Email: _____

Consent to Disclose Information During Crisis

In accordance with HIPAA and applicable federal and state laws, I authorize Sun Integrate Care, PLLC, to disclose necessary health or mental health information to the emergency contact listed above only in the event of a crisis, emergency, or situation in which I may be at risk of harm to self or others.

This may include but is not limited to:

- Notification of hospitalization or emergency room visits
- Contact in case of an acute psychiatric episode or suicide risk.
- Disclosure of necessary health information to ensure safety
- Coordination of emergency services or crisis response

Initial below to acknowledge consent:

_____ I authorize the release of necessary information to the emergency contact listed above in the event of a crisis.

_____ I understand I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on it.

_____ _____

Patient Signature Date

Sun Integrated Care

GENERAL MEDICAL AND BEHAVIORAL HEALTH HISTORY FORM

All information is confidential and used to support your care.

Patient Name: _____ **DOB:** _____

Past Medical History:

Please check the box if you had, or currently have, any of the following medial conditions (Listed are examples and not a complete list of possible conditions):

Head/Neck: □ Headaches □Sinusitis □Tinnitus □Other_____
Heart: □ High Blood Pressure □ Coronary Artery Disease □ Heart Attack □ Chest Pain
Lungs: □ Emphysema □ Chronic Bronchitis □ COPD □ Asthma □ Other_____
Kidney: □ Stones □ Insufficiency □ Cysts □ Pain □ Other _____
Liver: □ Cirrhosis □ Hepatitis □ Fatty □ Other _____
Muscles/Bones: □ Osteoarthritis □ Rheumatoid Arthritis □ Other _____
Skin/Breasts: □ Psoriasis □ Skin Cancer □ Fibrocystic Disease □ Other _____
Nervous System: □ Stroke □ TIA □ Seizures □ Multiple Sclerosis □ Other _____
Blood System: □ Anemia □ Hemophilia □ Clotting □ Other _____
Endocrine: □ Diabetes □ Cushing □ Addison □ Other _____
Immune System: □ HIV □ AIDS □ Infections □ Other _____
Any Other: _____

Medications: (Check here if you attached a copy of your medication list □)

Name of Medication	Strength	# of Pills Per Day	Date Last Prescribed

Allergies: (No Known Allergies □)

Name	Side Effects

Past Surgical History:

Date:	Type:	Date:	Type:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Behavioral Health History

Do you currently receive or have your previously received mental health treatment? □ Yes □ No

If yes, when and with whom?

Date(s)	Company	Provider Name

If you are currently seeing a behavioral health professional, please select the type of professional you are seeing.

□ Psychiatrist
□ Psychologist
□ Therapist
□ Counselor
□ Case Manager
□ Other: _____

Please check the box if you had, or currently have, any of the following medical diagnosis' (Listed are examples and not a complete list of possible conditions):

□ Depression
□ Anxiety
□PTSD
□ Bipolar Disorder
□ Schizophrenia/Schizoaffective
□ Eating Disorder
□ Substance Use Disorder
□ None
□ Other: _____

Have you ever experienced any of the following:

□ Self-Harm □ Suicidal Thoughts □ Suicide Attempts □ Homicidal Thoughts

□ Trauma/Abuse □ Legal Issues Related to Mental Health/Substance Use □ None Apply

Have you ever been hospitalized for mental health reasons? □ Yes □ No

If yes, when, and where?

Date(s)	Hospital

Sun Integrated Care

INFORMED CONSENT FOR PSYCHIATRIC AND BEHAVIORAL HEALTH ASSESSMENT AND TREATMENT

At Sun Integrated Health PLLC, we are committed to providing integrated, patient-centered care that addresses the physical, emotional, and psychological well-being of every individual. As part of our comprehensive healthcare services, you may be referred to receive behavioral health and/or psychiatric care as an essential component of your overall treatment plan. This consent outlines the nature of these services, the roles of the professionals involved, and your rights and responsibilities as a participant in care.

NATURE AND PURPOSE OF SERVICES

Behavioral health services at Sun Integrated Health PLLC include, but are not limited to diagnostic assessments, therapeutic interventions, substance use counseling, case management, treatment planning, crisis intervention, and coordination of care with medical and other support services. Psychiatric services, when indicated, may include diagnostic evaluation, ongoing psychiatric assessments, and prescription/management of psychotropic medications by a Psychiatric Mental Health Nurse Practitioner (PMHNP) and/or an ABPN Board-Certified MD/DO Psychiatrist. You are being asked to provide informed consent to participate in behavioral health services, which may be recommended based on clinical screening tools, your presenting concerns, referral from your medical provider, or as part of a comprehensive pain management and wellness treatment plan.

PROVIDERS INVOLVED IN CARE

Your care may be provided, supervised, or coordinated by a multidisciplinary team of licensed professionals and supervised staff, including:

- Licensed Addiction Counselor Technician (LACT)
- Licensed Associate Addiction Counselor (LAAC)
- Licensed Independent Addiction Counselor (LIAC)
- Licensed Baccalaureate Social Worker (LBSW)
- Licensed Master Social Worker (LMSW)
- Licensed Clinical Social Worker (LCSW) in a supervisory or consultation role
- Licensed Associate Counselor (LAC)
- Licensed Professional Counselor (LPC) as a clinical supervisor or advanced consultant
- Care Coordinators working within the behavioral health continuum of care
- Graduate-level Interns and Practicum Students enrolled in accredited behavioral health education programs (social work, counseling, psychology, or addiction studies), operating under licensed clinical supervision
- Registered Nurse (RN)
- Registered Nurse Practitioner (RNP) - FNP, PMHNP, AGNP-PC/AC (or any other recognized NP post-nominal)
- Allopathic/Osteopathic Physicians (MD/DO)

Psychiatric services are exclusively provided by Psychiatric Mental Health Nurse Practitioners (PMHNPs) who are credentialed to perform psychiatric evaluations, diagnose mental health conditions, and prescribe and manage medication.

COORDINATION OF CARE

Our behavioral health team works in close collaboration with your medical and pain management providers to ensure integrated, holistic treatment. Care Coordinators serve as a central point of communication to support your access to services, ensure continuity of care, and provide case management support as appropriate. You understand that your behavioral health information may be shared internally among your treatment team at Sun Integrated Health PLLC, Sun Pain Management PLLC, and/or any other "DOING BUSINESS AS " (DBA) subsidiaries for the purposes of care

coordination, unless you request otherwise. This may include communication between Care Coordinators, behavioral health professionals, medical staff, and the psychiatric team.

CONFIDENTIALITY AND LIMITS

All services provided are confidential and in compliance with the Health Insurance Portability and Accountability Act (HIPAA), state laws, and applicable licensing board regulations. Your treatment information will not be shared without your written consent except in cases where disclosure is required by law, such as:

- If there is reason to believe you are at risk of harming yourself or others.
- If there is suspected abuse or neglect of a child, elderly, or vulnerable adult.
- If ordered by a court or regulatory agency.

RISKS AND BENEFITS

Participating in behavioral health or psychiatric treatment may involve discussing emotionally difficult topics and may temporarily increase psychological distress. However, these services have been shown to provide significant benefits, including symptom relief, improved coping skills, and enhanced quality of life. Medication management may involve side effects and ongoing monitoring, which will be discussed in detail during psychiatric consultations.

VOLUNTARY PARTICIPATION

Your participation in behavioral health or psychiatric treatment is voluntary, and you have the right to accept or decline services at any time. Declining services will not affect your access to other medical care provided by Sun Integrated Health PLLC. You may also request to discontinue services or seek a referral to another provider at any time.

ACKNOWLEDGEMENT AND CONSENT

By signing below, you acknowledge that you have read, understand, and voluntarily consent to receive behavioral health and/or psychiatric services as outlined above. You understand the roles of the care providers involved, the scope and limits of confidentiality, and your right to discontinue treatment at any time.

_____ _____

Print Name: DOB:

_____ _____

Patient Signature: Date:

Sun Integrated Care

CONSENT TO RECEIVE SERVICES VIA TELEHEALTH

This form provides information about the use of telehealth as a mode of service delivery and documents your consent to participate in medical, behavioral health, psychiatric, or care coordination services via secure, HIPAA-compliant remote communication technologies.

What is Telehealth?

Telehealth is the use of interactive, secure audio, video, and/or electronic communication to deliver healthcare services when you and your provider are not in the same physical location. At Sun Integrated Health PLLC, this includes services provided by pain management clinicians, psychiatric mental health nurse practitioners (PMHNPs), licensed behavioral health professionals, and care coordinators.

Telehealth may be used for, but is not limited to, psychiatric medication management, individual or group therapy, behavioral health assessments, follow-up and check-in appointments, care coordination, or case management.

Confidentiality and Security

All telehealth sessions are conducted through HIPAA-compliant platforms. Reasonable and appropriate efforts are made to protect the security and confidentiality of your information, including the use of encryption, secure servers, and password-protected systems. However, just as with in-person care, there is always a risk of unauthorized access or technical failure that could compromise privacy. You are responsible for ensuring privacy on your end of the telehealth session (e.g., using a private space, securing your device, and refraining from using public Wi-Fi during sessions).

Risk and Limitations of Telehealth

While telehealth offers many advantages, including increased access to care, it has limitations, such as potential for service disruption due to technological issues (e.g., poor internet connection, platform failure), limited ability for providers to respond to certain medical or psychiatric emergencies remotely, possible difficulty interpreting body language or non-verbal cues, and risk of data breaches if proper cybersecurity practices are not followed by the patient

If technical difficulties prevent the completion of a session, your provider will attempt to contact you via phone or reschedule as appropriate.

Emergency and Crisis Protocols

Telehealth is not appropriate for crisis situations requiring immediate intervention. If you are experiencing a medical or psychiatric emergency, you must call 911 or go to the nearest emergency room.

You are required to provide your physical location and a reliable contact number at the start of each session and identify an emergency contact and/or local emergency services available in your area.

If a provider determines that you are at risk of harm to yourself or others during a telehealth session, they may initiate emergency services or wellness checks, consistent with clinic policy and professional responsibilities.

Consent and Voluntary Participation

Your participation in telehealth is voluntary. You may choose to decline or withdraw consent at any time without affecting your access to in-person services (when available and applicable). You have the right to:

- Ask questions about the telehealth process
- Request alternative methods of communication if appropriate
- Receive a copy of this consent form upon request

By signing below, you acknowledge that you have read and understand the information provided above. You consent to receive services via telehealth, including evaluation, diagnosis, treatment, and follow-up. You understand the risks, benefits, and limitations of telehealth .You authorize Sun Integrated Health PLLC to use telehealth technologies in the course of your care.

_____ _____

Print Name: DOB:

_____ _____

Patient Signature: Date:

Sun Integrated Care

PATIENT RIGHTS AND RESPONSIBILITIES

At Sun Integrated Health PLLC, we are committed to delivering high-quality, patient-centered care. We believe that understanding your rights and responsibilities is essential to fostering a respectful, safe, and collaborative environment for healing and wellness.

PATIENT RIGHTS

As a patient receiving care from Sun Integrated Health PLLC, you have the right to:

1. Access to Care
    a. Receive services regardless of race, color, national origin, religion, sex, gender identity, age, disability, sexual orientation, marital status, veteran status, or ability to pay.
    b. Be treated with dignity, respect, and compassion at all times.
2. Informed Participation
    a. Be informed about your diagnosis, recommended treatments, potential risks/benefits, and alternatives in understandable terms.
    b. Participate actively in decisions regarding your care, including the development of your treatment plan and recovery goals.
3. Confidentiality and Privacy
    a. Have your medical and behavioral health information kept private in accordance with HIPAA and state laws.
    b. Receive a copy of the Notice of Privacy Practices and request restrictions on how your information is used or disclosed.
4. Consent and Refusal
    a. Give or withhold informed consent for treatment, including medication, telehealth services, and assessments.
    b. Refuse treatment or services (with understanding of potential consequences) and be informed of alternative options.
5. Access to Records
    a. Request access to your medical records and receive a copy within the timeframe allowed by law.
    b. Request amendments to your records if you believe they are incorrect or incomplete.
6. Safe and Respectful Environment
    a. Be free from abuse, neglect, exploitation, or harassment—physical, emotional, sexual, or financial.
    b. Receive services in a clean, safe, and supportive setting.
7. Continuity and Coordination of Care
    a. Receive coordinated care between pain management, behavioral health, psychiatric, and care coordination teams.
    b. Request assistance with referrals, second opinions, or transitions of care.
8. Voice Complaints or Concerns
    a. File a complaint or grievance without fear of retaliation.
    b. Receive a prompt and fair review of your concerns through our Grievance Policy.

PATIENT RESPONSIBILITIES

To ensure the best possible care experience, you agree to:

1. Engagement in Care
    a. Provide accurate and complete information about your health history, medications, allergies, and any changes in your condition.
    b. Participate actively in your treatment and recovery plan.
2. Respect and Safety
    a. Treat staff, other patients, and clinic property with respect.
    b. Refrain from abusive, threatening, or disruptive behavior (including in-person or telehealth interactions).
3. Compliance and Attendance
    a. Follow agreed-upon care plans, medication instructions, and safety agreements (including crisis plans or relapse prevention).
    b. Attend scheduled appointments on time and notify staff promptly of cancellations or delays.
4. Financial Responsibility
    a. Provide accurate insurance and billing information.
    b. Pay co-pays, deductibles, and fees as applicable, and communicate openly about financial concerns.

5. Confidentiality of Others
    a. Respect the privacy of other patients, especially during group therapy or shared appointments.
6. Use of Telehealth
    a. Ensure a private and distraction-free space when participating in telehealth services.
    b. Refrain from recording or distributing telehealth sessions without written consent from all parties.

REPORTING CONCERNS AND/OR VIOLATIONS

If you believe your rights have been violated or have a complaint about your care, you may contact:

Privacy Officer
Sun Integrated Health PLLC
11047 North 19th Ave, Phoenix, Arizona 85029
(602) 589-0500

You may also contact:

- Arizona Department of Health Services (AZDHS): https://www.azdhs.gov
- Arizona Health Care Cost Containment System (AHCCCS) Office of Grievance & Appeals
- U.S. Department of Health & Human Services — Office for Civil Rights

ACKNOWLEDGEMENT OF RECEIPT

By signing, you acknowledge that you have received and understand this Patient Rights and Responsibilities document. A copy is available upon request, is posted in public areas, and can be found on our website.

_____ _____
Print Name: DOB:

_____ _____
Patient Signature: Date:

Sun Integrated Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL, BEHAVIORAL HEALTH, AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Sun Integrated Health PLLC is required by law to maintain the privacy of your protected health information (PHI), provide this notice about our privacy practices, and follow the practices described in this notice. This notice applies to all departments and providers under Sun Integrated Health PLLC, including pain management, behavioral health, psychiatric services, and care coordination. We must comply with the HIPAA Privacy and Security Rules and applicable Arizona state laws.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. Examples include:

1. **Treatment** - We may use your PHI to provide, coordinate, or manage your care, including communication with other providers or specialists (e.g., therapists, psychiatric nurse practitioners, primary care doctors).
2. **Payment** - We may use and disclose your PHI to obtain payment for services provided to you, including billing insurers and processing claims.
3. **Healthcare Operations** -We use your information to improve the quality and efficiency of our services, conduct audits, supervise staff, and engage in care coordination.

OTHER USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION

We may also use and disclose your PHI in these circumstances:

- When Required by Law — Such as court orders, subpoenas, or legal investigations.
- Public Health Activities — Reporting diseases, adverse events, or abuse/neglect.
- Health Oversight Agencies — For audits, inspections, or licensure.
- To Avoid a Serious Threat — If there is a risk of harm to you or others.
- Law Enforcement or Correctional Institutions — For legal or safety reasons.
- Organ and Tissue Donation Requests — If applicable.
- Workers' Compensation Claims — To comply with state laws.
- Military and National Security — When required by federal authorities.
- De-Identified Data Use — We may use data that cannot identify you for quality improvement or research.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

We must obtain your written authorization before using or disclosing your information for:

- Marketing communications
- Sale of health information
- Most disclosures of psychotherapy notes
- Any use or disclosure not listed in this notice

You may revoke an authorization at any time in writing.

YOUR RIGHTS UNDER HIPAA

You have the following rights regarding your health information:

- RIGHT TO INSPECT AND COPY: You may review and request copies of your health information, with some exceptions. Requests must be in writing.
- RIGHT TO REQUEST AMENDMENTS: If you believe your record is incomplete or inaccurate, you may request an amendment.
- RIGHT TO AN ACCOUNTING OF DISCLOSURES: You may request a list of disclosures we have made of your PHI over the past six years, excluding treatment, payment, and operations.

- RIGHT TO REQUEST RESTRICTIONS: You may request limitations on the use or disclosure of your PHI. We are not required to agree, except for restrictions on information sent to insurers when you pay out-of-pocket in full.
- RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You can request that we contact you at a specific address or phone number for privacy reasons.
- RIGHT TO A PAPER COPY: You may request a printed copy of this notice at any time.

TELEHEALTH AND ELECTRONIC COMMUNICATIONS
All telehealth communications at Sun Integrated Health PLLC are conducted via secure, HIPAA-compliant platforms. We may send appointment reminders or treatment-related messages electronically, with appropriate safeguards. You may opt out of certain communications by notifying our office.

CHANGES TO THIS NOTICE
We reserve the right to change our privacy practices and this notice. Changes will apply to all health information we maintain. A revised notice will be posted at our facilities and will be available on our website. You may also request a paper copy at any time.

QUESTIONS OR COMPLAINTS

If you have concerns about your privacy rights or believe your rights have been violated, you may contact:

Privacy Officer
Sun Integrated Health PLLC
11047 North 19th Ave, Phoenix, Arizona 85029
(602) 589-0500

You may also file a complaint with the U.S. Department of Health and Human Services (HHS). We will not retaliate against you for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT
You will be asked to sign a separate form acknowledging that you received this Notice of Privacy Practices.

Sun Integrated Care

HIPAA ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT INFORMATION

Patient Name:_____ DOB:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge that I have received and reviewed the Notice of Privacy Practices (NPP) provided by Sun Integrated Health PLLC, which explains how my protected health information (PHI) may be used and disclosed, and how I can access my health information.

I understand the following:

- The Notice of Privacy Practices describes my rights as a patient under the Health Insurance Portability and Accountability Act (HIPAA), including the right to access and amend my records, request restrictions, and file complaints.
- Sun Integrated Health may use or disclose my PHI for the purposes of treatment, payment, and healthcare operations, and as otherwise permitted or required by law.
- I may request a printed or digital copy of the NPP at any time, and it is also available on the clinic's website and posted at all care sites.
- I understand that if the NPP is updated, a revised version will be made available to me upon request.

PATIENT RIGHTS SUMMARY (Per HIPAA and state Law of Arizona)

I have the right to:

- Access and obtain copies of my medical records.
- Request amendments to inaccurate or incomplete information.
- Request restrictions on the use or disclosure of my PHI.
- Receive an accounting of certain disclosures.
- Request communications in a confidential manner.
- File a complaint if I believe my privacy rights have been violated.

FOR PATIENTS OR LEGAL GUARDIAN

□ I have received and understand the Notice of Privacy Practices.

□ I decline to sign this acknowledgement; I have been given the opportunity to review the NPP.

SIGNATURE AND AUTHORIZATION

_____ _____

Print Name: DOB:

_____ _____

Patient Signature: Date:

Sun Integrated Care

SUN INTEGRATED CARE FINANCIAL POLICY

As a courtesy, Sun Integrated Care, PLLC ("SIC") verifies benefits with your insurance company. A quote of benefits is never a guarantee of payment. Your insurance company will process your claims according to your Plan Document. If you do not have a copy of your Plan Document you should obtain one as soon as possible, read and understand this contract between you and your insurance company. Should your claims process differently from any estimate you were quoted, your Plan Document will supersede any other information given verbally or in writing from the Practice.

If your Plan Document includes Behavioral Health benefits, we will be happy to bill your insurance. Please provide a current copy of your insurance card to the front office staff. When your insurance claim(s) are processed, you will receive an Explanation of Benefit/Payment from your insurance company. This Explanation will advise your financial responsibility for treatment. You will be held responsible for any unpaid balances by your insurance plan.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT I authorize Sun Integrated Care and any of its third party billing associates to file a claim with my insurance carrier for services rendered. I authorize SIC payment of benefits directly to SIC, for services provided to myself me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance, and I will be billed directly for those services.

Should your insurance company pay you directly for services rendered by our practice or affiliates, you agree to endorse and return all monies to this practice within 7 days of receipt.

1. **PAYMENT** - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due balances, etc.). If you are unable to meet your financial responsibility, Sun Integrated Care reserves the right to reschedule your appointment to a later date when you can meet your financial responsibility. If prepayment is made for any services and a refund is due after your insurance pays, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not have insurance or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We require a copy of an ID card and/or license and insurance cards.
2. **INSURANCE** - We are participating providers with several insurance plans. A list of these insurance plans is available upon request. If we submit your claims and your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to call your insurance about your benefits prior to your appointment. We are not responsible for any erroneous information listed on insurance websites and do not guarantee your coverage. You are responsible for obtaining a properly dated referral, prior authorization (if required) from your insurer and responsible for payment if your claim rejects for the lack of specific requirements. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you are responsible for all charges. Payment is due upon receipt of a statement from our office. All procedures billed are considered covered unless limited by your specific insurance policy. If your coverage changes and you have not notified us of these changes in writing and we bill your old carrier, we may miss the time limit to receive payment. In this case, the claim becomes your responsibility for payment. Please notify us immediately if your coverage changes so we can submit your claims for appropriate reimbursement.
3. **COLLECTION** - If you have an outstanding balance over 120 days old and have failed to make payment arrangements or fall delinquent on an existing payment plan, we may turn your balance over to a collection agency and/or an attorney. This may result in reporting to credit bureaus and/or legal action. Sun Integrated Care reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You are responsible for any expenses we incur to collect on your account including attorney fees, collection fees, and/or contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added to your balance and assigned to the collection agency immediately upon your account being assigned to a collection agency of our choice. You agree that for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or

emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device._____initials.

4. **RETURNED CHECKS** - Will incur a $40.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $40.00 service charge to pay the balance prior to receiving any future services from our staff or the physicians. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted by the governing laws in Maricopa County.
5. **ACCOUNTING PRINCIPALS** - Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.
6. **FORMS AND CONSULT FEES** - Completing insurance forms, copying medical records, etc... require office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.
7. **CARE COORDINATION** - Care coordination billing includes clinical staff time per calendar month and is delivered under the overall direction of the billing practitioner. Cost sharing applies for both face-to face and non-face-to-face services even if supplemental insurers cover cost sharing. _____ Initials
8. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours in advance or if you no-show, we will assess a $25.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $25.00 missed procedure fee. Multiple no-shows/missed procedures may result in your formal discharge from the practice. Initials _____
9. **RESPONSIBILITY FOR PAYMENT** - I understand that I personally am financially responsible to Sun Integrated Care for charges not covered by the assignment of insurance benefits. Initials _____
10. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Sun Integrated Care sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Sun Integrated Care to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Sun Integrated Care. I authorize Sun Integrated Care to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.
11. **RELEASE OF INFORMATION** - I hereby authorize the and direct SIC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
12. **AGREEMENT AND UNDERSTANDING:** I have read and understand the practice's financial policy of SIC and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from SIC. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to SIC. This financial policy is binding upon me, my estate, executors, and/or administrators, if applicable. I also understand and agree that such terms may be amended by the practice from time to time and I may be asked to read, understand, and sign any updates.

Signature of Patient or Guardian: _____ Date: _____

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I hereby authorize Sun Integrated Health PLLC to:

□ Release Information To

□ Obtain Information From

□ Exchange Information With

Name of Individual/Organization: _____

Address: _____

Phone: _____ Fax: _____

SCOPE OF INFORMATION TO BE DISCLOSED

I authorize the release of the following protected health information (PHI), including documentation in written, electronic, or verbal form:

□ Complete Medical Record

□ Complete Behavioral Health Record Complete Psychiatric Records

□ History and Physicals

□ Progress Notes & SOAP/DAP Notes

□ Diagnosis & Treatment Summaries

□ Psychological Testing/Evaluations

□ Medication History & Prescriptions

□ Lab Reports, Imaging, and Diagnostic Results

□ Discharge/Transition Summaries

□ Substance Use Treatment Records (including records protected under 42 CFR Part 2)

□ Other (specify):

PURPOSE OF THIS DISCLOSURE

The purpose of this disclosure is: _____

PATIENT ACKNOWLEDGEMENT

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.
- I understand that if the recipient of this information is not a healthcare provider or health plan covered by HIPAA, the information disclosed may no longer be protected by HIPAA regulations.
- I understand that my treatment or eligibility for benefits is not conditioned on my signing this form.
- I understand this authorization may include sensitive data
- This authorization will expire one year from the date signed, unless otherwise specified here:
  Alternative Expiration Date/Event: _____

SIGNATURE AND AUTHORIZATION

_____ _____

Print Name: DOB:

_____ _____

Patient Signature: Date: