Hello,

Please find the enclosed information Meza Post-Acute and Long-Term Care will need to be able to provide care to you or your loved one. MezaCare, under the direction of Dr. Michael Meza, appreciates our relationship with the Skilled Nursing, Assisted Living, and Independent Living Facilities in our community. We are here to partner with your care team to provide the healthcare care you deserve.

With the completion of this packet, please include the following:

- Copy of Photo ID
- Copy of Insurance cards
- Copy of Power of Attorney/Guardianship paperwork (if applicable)
- COVID Vaccination Card/ Status

For Assisted Living Patients Only

- History and Physical Note (Most Recent)
- Current Medication List
- POST/POLST Form

If you have any issues or concerns as you are completing this information, please do not hesitate to call our office. Our team is always here to serve you.

Please return the forms via one of the options below:

- **Fax:** 208-209-6063
- **Mail:** PO Box 3687 Coeur d'Alene, ID 83816

Sincerely,

Taryn Steinberg
Clinic Director
Phone: 208-819-2183
Fax: 208-209-6063
WWW.MezaCare.com

PATIENT DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Information

Full Legal Name: _____ Nickname:_____

Date of Birth:_____ SSN:_____ Height: _____ ☐ Male ☐ Female

Mailing Address: _____

Street or PO Box City State Zip Code

Home Phone: (_____)_____ Cell Phone: (_____)_____

Which Number is preferred? (Please choose one) ☐ Home ☐ Cell

Email: _____

Marital Status: (Please choose one) ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Single ☐ Widowed ☐ Other

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Guarantor Information: *(person responsible for the bill)*

Full Name:_____

Relationship to the patient: _____

Mailing Address: _____

Street or PO Box City State Zip Code

Primary Phone: (_____)_____ Secondary Phone: (_____)_____

Email: _____

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

What is "Protected Health Information" or "PHI"?

"Protected Health Information" or "PHI" for short, is information that identifies who you are and relates to , your past, present, and future physical or mental health or condition, the provision of health care to you, or past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available or that is in a summary form that does not identify who you are. If you are an employee of our participating physician's office, PHI does not include your health information in your personal life.

Purpose of This Notice

In the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How we protect your PHI?

We restrict access to your PHI to those employees who need access in order to provider service to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguard to protect you PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

Types of use and disclosure of PHI we may make without your authorization

Federal and state law allows us to use and disclose your PHI in order to provide health care services to you as well as to bill and collect payments for the health care services provided to you by our physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our physician. We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer or to contact you to remind you of our appointments. We conduct these activities to provide health care to you and not as marketing.

Federal and state law also allow us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use our PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.

We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law- In some circumstances, we are required by federal or state law to disclose certain PHI to other, such as public agencies for various reasons.
2. For public health activities- Such as report about communicable diseases, defective medical devices to the FDA or work-related issues.
3. Reports about any types of abuse, neglect, or domestic violence against any persons.
4. For health oversight activities- Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers.
5. For lawsuits and other legal disputes- In connection with court proceedings before administrative agencies or to defend us or our participating physicians in a legal dispute.
6. For law enforcement purposes- such as responding to a warrant or reporting a crime.
7. Reports to coroners, medical examiners, or funeral directors- To assist them in performance of their legal duties.
8. For tissue or organ donations- To organ procurement or transplant organizations to assist them.
9. For research- To Medical researchers with an approval of an institution review board (IRB) or privacy board that oversees studies on human subjects. Researches are also required to safeguard out PHI.
10. To avert a serious threat to the health or safety of you or other members of the public.
11. For national security and intelligence/ military activities- Such as protection of the President or foreign dignitaries.
12. In connection with services provided under workers' compensation law.

CONSENT TO TREAT

Please be sure to read the following information. Your signature below applies to the services rendered in conjunction with your visits while in the Skilled Nursing Home, Assisted Living Facility, or Independent Living.

Patient Name: _____ **DOB:** _____

CONSENT TO TREAT:

I, the undersigned, consent to the outpatient and/or telehealth care provided by Meza Post-Acute and Long-Term Care, PLLC, encompassing routine diagnostic procedures, examination and medical treatment including but not limited to: routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider. I further consent to the performance of those diagnostics procedures, examinations and referring of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgment. I authorize Meza Post-Acute and Long-Term Care, PLLC to release any information necessary to file and settle insurance claims, including any third-party insurances. I understand I am personally financially responsible to Meza Post-Acute and Long-Term Care, PLLC for all charges not covered by assignment including co-pays, co-insurance and ineligibility.

PAYMENTS:

Co-pays, nominal fees or other patient responsibility is due within 60 days of service. If you are unable to provide payment, arrangements will need to be made with the office and/or billing department.

PRESCRIPTION REFILL POLICY:

If you need a refill on a previously prescribed medication, please contact your pharmacy. The pharmacist will fax us your request along with current dosages and medications for your healthcare providers approval. Please allow 3-5 business days from the time we receive the fax from the pharmacist for your refill request to be processed.

PATIENT RIGHTS & RESPONSIBILITIES:

I, the undersigned, have received the Patient Rights and Responsibility Form. I understand and agree to abide by the conditions for treatment with Meza Post-Acute and Long-Term Care, PLLC.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

PO BOX 3687, Coeur d'Alene ID 83816

Office: 208-819-2183 | Fax: 208-209-6063 | www.Mezacare.com

MezaCare Clinic
208-819-2183

HIPAA AND RELEASE OF INFORMATION

ACKNOWLEDGMENT OF PRIVACY PRACTICES:
I, the undersigned, have received a copy of the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI):
This is to certify that I, the undersigned, authorize Meza Post-Acute and Long-Term Care to disclose Protected Health Information (PHI) to family members and friends. Please note that the below list will replace any previous authorization, list all parties you wish to grant access. Please identify individual(s) and relationship(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ Date of Birth: _____
Address: _____
Primary Phone Number: (____)_____ Secondary Phone Number: (____)_____

Information to be Released from:

Primary Physician: _____
Address:_____
Office Phone Number: (____)_____ Fax Number: (____)_____

Specialist Physician: _____
Address:_____
Office Phone Number: (____)_____ Fax Number: (____)_____

Information to be Released to:

Meza Post-Acute and Long-Term Care
PO Box 3687, Coeur d'Alene, ID 83816
Fax Number: (208)209-6063 Office Phone Number: (208) 819-2183
Email: medical.records@mezacare.com

What kind of information do you want released?

☐ Information from the most recent 1 year
☐ Specific Information: (please specify): _____
☐ I authorize verbal communication about my medical history to the party listed above

This record is requested for the following reason (REQUIRED):

☐ Transfer of Care to Meza Post-Acute and Long-Term Care as primary care provider
☐ Other (please specify):_____

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information. Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

_____*HIV/AIDS related health information and/or records	_____*Sexually Transmitted Disease information and/or records
_____*Birth Control/Pregnancy information and/or records	_____*Drug/Alcohol diagnosis, treatment and/or referral information
_____*Mental Health information and/or records	_____*Genetic testing information and/or records
_____ Other:_____	_____*Restricted protected health information

*I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirement.
*I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used disclosed under this authorization.
*This authorization will automatically expire six months from the date signed. I understand that I may revoke this authorization at any time to the extent that action has been taking in reliance thereon. To revoke this authorization, I must submit my request in writing to the practice's office.

SIGNATURE OF PATIENT
OR LEGAL GUARDIAN: _____ **DATE:** _____