



0000103134

Mrs. RAYE E. STILES  
P.O. Box 1626  
Tucson, AZ 85702

ORIGINAL

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RECEIVED

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ARIZONA CORP. COMM.  
TUCSON, AZ

AZ CORP COMMISSION  
IN THE ARIZONA CORPORATION COMMISSION

RAYE STILES,

Docket No. T-01051B-02-0021

Complainant,

v.

**MOTION TO STAY  
PROCEDURAL ORDER**

Arizona Corporation Commission

QWEST CORPORATION,

**DOCKETED**

Respondent.

SEP 26 2002

DOCKETED BY 

COMES NOW, RAYE E. STILES, Complainant, who moves this commission to stay its procedural order requiring her to make payments in increments of \$50.00 every other week on the following grounds:

Ms. Stiles entered into agreement with Qwest, pursuant to the court's order to make payments of \$50.00 every other week<sup>1</sup> and to pay current charges. Ms. Stiles made the first payment scheduled for payment by September 11, 2002, as ordered on September 10, 2002.

On September 12, 2002, at approximately 10:00 pm, Ms. Stiles called 911 and was transported to Tucson Heart Hospital and was admitted. The following day she left the hospital, but was re-admitted on the evening of September 13, 2002 and remained there until the evening of September 16, 2002 when she was discharged. Ms. Stiles condition was life-threatening, which is why she returned to the hospital to be

<sup>1</sup> This, even though she disputes that she owes Qwest any payment at all.

readmitted. She was discharged on medication with admonishments to continue process via medical procedures within the same week.

On September 17, 2002, Ms. Stiles spent the day obtaining assistance from an agency to pay for the \$81.00 prescription which she was successful at doing.

On September 19, 2002, Ms. Stiles kept appointment to commence the required medical procedures as the condition remains life threatening to date, and is only being suppressed temporarily via medication. She was referred to a specialist for a consult on grounds that the procedure would require said consult.

Ms. Stiles contacted Qwest for an extension to pay, but Mr. Duffy stated that he was "not willing" to consider a delay in payment based upon Ms. Stiles sudden illness.

This sudden emergency illness has affected Ms. Stiles ability to work at this time.

Ms. Stiles is therefore requesting that the procedural order be stayed for a period of 30 days to allow Ms. Stiles the opportunity to recuperate and to begin working again on a regular basis.<sup>2</sup>

Additionally, during a conversation, Ms. Dwyer stated that she was "aware of a lack of paying rent". There is no such lack, and in fact, the primary reason for being in arrears with all of her creditors is due to her having paid \$815.00 pursuant to an A.R.S. statute which prevents forcible eviction, which is money that came from other sources and minimal from Ms. Stiles. Ms. Stiles utility bill was paid by an agency prior to the most recent emergency illness based upon this fact and the fact that she is also under the care of three other doctors for another medical problem.

Attached hereto and incorporated herein and marked as Exhibit 'A' is a true

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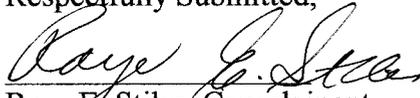
<sup>2</sup> The September 10<sup>th</sup> payment was made based upon Ms. Stiles self-employment income and is the income upon which she would rely to make any sort of payments.

and correct copy of the ambulance bill which shows the date of the transport. Also attached is Exhibit 'B' which is a true and correct copy of the admission slips to the hospital. The commission can check the website of the Pima Consolidated Justice Court to verify the fact that there was other litigation and the second filing in August, 2002, despite the landlord being in receipt of the full amount, requiring a court appearance and filing of papers when I could have been working.

WHEREFORE, Ms. Stiles respectfully requests that this court grant her motion staying the procedural order and continuing the October 2, 2002 hearing for an equal amount of time.

DATED this the 23<sup>rd</sup> day of September, 2002.

Respectfully Submitted,

  
Raye E. Stiles, Complainant

cc: D. Renfro-Qwest

**STATEMENT**

**SERVICE PROVIDED BY:  
SOUTHWEST AMBULANCE  
Federal Employer ID: 86-0203618**

**CALL SOURCE: FIRE DEPARTMENT  
PICK-UP: 734 E ROGER RD.201  
DESTINATION: 2303-TUCSON HEART HOSPITAL**

DATE OF SERVICE	PAYMENT/ ADJUST DATE	DESCRIPTION OF SERVICE	QTY/ UNITS	CHARGE RATE	AMOUNT
09/12/02		BLS EMERGENCY BASE	1	525.00	525.00
09/12/02		BLS MILEAGE	1	10.00	10.00
09/12/02		BEDDING PACK	1	15.99	15.99
09/12/02		GLOVES	3	0.50	1.50

We recently had the opportunity to serve you by providing medical services and/or transportation as required by your medical situation.

At this time, the balance for the above account is now due and payable. We request that you remit the balance in full today, or that you contact our office to make payment arrangements.

If you provide us with insurance information, we may be able to submit a claim on your behalf; however, payment in full is due upon receipt of this bill.

Visa, Mastercard, Discover, or American Express is accepted by phone.

CUST ACCT #	INVOICE #	SERVICE DATE	TIME OF CALL	INCIDENT #	TOTAL PAID	TOTAL CHARGES
AZ2212456	AZ2898924	9/12/02	22:41:09	02109557	\$ .00	\$552.49

INQUIRES CALL: 480/627-6000 OR: 1 800/645-9902

<b>PLEASE PAY THIS AMOUNT</b>	<b>\$552.49</b>
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PB

**THIS BILL IS YOUR RESPONSIBILITY**

*Exhibit A*

**CONDITIONS OF TREATMENT / ADMISSION**

- Medical Testing and Treatment Consent:** The undersigned consents to customary X-ray examination, nursing, therapy services, technical services, and laboratory services or any other related procedure. The undersigned further consents to the use of anesthesia, sedation, medical and surgical treatment, and Hospital services rendered to the patient under the general and special instructions of the physician. Hospital employed personnel will provide care based on appropriate standards to meet the individual patient needs. The undersigned recognizes that all physicians furnishing services to the patient (including radiologists, pathologists, and anesthesiologists) are independent contractors, not employees or agents, of the Hospital. The Hospital is not liable for the actions or omissions of independent contractors. The patient's care is under the control of his attending physician(s). The Hospital is not liable for following the instructions of those physicians.
- General Duty Nursing:** The Hospital furnishes only general duty nursing care. If the patient needs continuous or special duty nursing care, the patient, his or her legally authorized representative, or physician(s) must arrange this care. The undersigned releases the Hospital from any liability arising from the fact that the Hospital does not provide additional nursing care.
- Personal Valuables:** The Hospital strongly encourages all patients to make other arrangements for the security of personal valuables. The Hospital will not be responsible for the security of personal valuables and cannot be held liable for the loss or damage to same. Only in the event of an emergency situation will the Hospital maintain patients' personal valuables in the safe.
- Patient Rights and Responsibilities:** I have been given information regarding patient rights and responsibilities.
- Release of Information:** Any physician, hospital, medical Hospital, insurer, employer, or governmental agency having information relating to the patient's medical status is authorized to release such information to the Hospital and/or its representative and to confer with them as necessary and appropriate to provide and manage the patient's care. The Hospital may release all or any part of the patient's record pertaining to this or any hospitalization or treatment (INCLUDING ALCOHOL OR DRUG ABUSE, HIV-RELATED, OR COMMUNICABLE DISEASE INFORMATION) to persons or entities engaged in the activities stated below:
  - Insurance and Quality Review:** Persons or corporations (including but not limited to third party payers, insurance companies, workers' compensation payers, managed care organizations, hospital or medical service corporations, welfare funds, governmental agencies, or the patient's employer), or their designees, which may be liable to the Hospital, any other party, the patient, a family member, or employer of the patient, for purposes of securing payment for all or part of the Hospital's charges, and quality assurance, utilization review, and peer review committees, accrediting agencies, and Hospital and physician liability insurance carriers to enable them to carry out their functions.
  - Billing and Collection:** Agents or employees of the Hospital that process or duplicate medical records for billing and reimbursement purposes.
  - Medical Audit:** Persons or entities authorized by the Hospital for purposes of conducting medical audit activities.
  - Health Professionals and Other Hospitals:** Physicians and personnel involved in the patient's care to enable them to provide and manage the patient's health care.
  - Organ Donation:** Health facilities, Hospitals, or their designees for the purpose of procuring, processing, or distributing human body or body parts for use in medical education, research, therapy, or transplantation.

I understand that I may revoke this authorization at any time, except to the extent the Hospital has acted in reliance upon it or the disclosure is authorized by law. This consent to release patient information remains valid until expressly revoked in writing and delivered to Hospital's authorized representative.

- Assignment of Benefits:** If I am entitled to benefits arising out of any insurance policy insuring the patient or any other party liable to the patient, I assign such benefits to the Hospital or any person or entity rendering services to the patient to pay the patient's bill. I understand that I am responsible for any charges not covered by this assignment. If I am eligible for Medicare benefits, I assign the benefits payable to the physician or organization (including Hospital) furnishing the services and authorize those entities (including Hospital) to bill and collect from Medicare directly.
- Financial Agreement:** The undersigned agrees that in consideration of the services to be rendered to the patient, the patient and other individual with financial responsibility hereby individually obligates himself/herself to pay the patient's account at the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred for collection, the undersigned shall pay reasonable collection expenses, including attorney's fees.
- Medicare Benefits:** If applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.
 

I have been given information regarding my rights as a Medicare patient. Mark N/A if not applicable.  N/A

I have answered the Medicare Secondary Payer questionnaire (MSP). Mark N/A if not applicable.  N/A
- I have Advance Medical Directives:  Yes  No <sup>WA</sup> If yes, placed in chart  Yes  No  
I acknowledge the following:
 

I have received written information about the Advance Medical Directives.

I waive my rights to be provided with information about the Advance Medical Directives.
- At times, members of the Tucson Heart Hospital Medical Staff, who are principal investigators in medical research and investigational studies, seek to identify potential participants for those studies by reviewing medical records of patients admitted to our Hospital. Tucson Heart Hospital does not sponsor nor conduct the studies, rather, the Hospital supports the concept of clinical research and medical advances. Federal and State laws permit this activity of reviewing medical records provided that the patient signs a consent giving permission to the Hospital to allow the investigators or their staff to review the records for research purposes.
 

Yes, I give permission to Tucson Heart Hospital to permit review of my medical information to identify me as a potential study participant.

No, I do not give permission to Tucson Heart Hospital to permit review of my medical information to identify me as a potential study participant.

I have read and understand this form, received a copy thereof, and I certify that I am the patient, or am a person authorized to act on the patient's behalf.

Witness: S. Perez

[Signature]  
Patient's Signature

Witness (optional):

Signature of Legally Authorized Representative

Date/Time: 9-13-02 @ 10:05

Relationship to Patient

FORM 4069 Rev. 5/01



**CONDITIONS OF TREATMENT / ADMISSION**

[Signature]  
Relationship to Patient

# Patient Rights and Responsibilities

## Patient Rights

As a health care consumer, you and the person who may have legal responsibility to make decisions regarding your health care are entitled to certain rights.

The following statement of Patient Rights has been adopted by the Tucson Heart Hospital and its medical staff. As a patient at Tucson Heart Hospital, you have the right to:

- ♥ Receive impartial access and exercise these rights to treatment without regard to sex or sexual preference, culture, economic, educational or religious background, age, gender and other differences (i.e., individual with disabilities), or the source of payment for care;
- ♥ Considerate and respectful care in a safe environment including freedom from all forms of abuse or harassment;
- ♥ Have knowledge of the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and health care providers who will see you as a patient;
- ♥ Receive information from the physician about your illness, your course of treatment and your prospects for recovery in terms that you can understand;
- ♥ Have a family member or representative of your choice and your own physician promptly notified of your admission to the hospital;
- ♥ Receive as much information as you may need about any proposed treatment or procedure, including costs of care, in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment;
- ♥ Actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment;
- ♥ Formulate an advance directive and have the hospital comply with these directives to the extent permitted by law and hospital policy;
- ♥ Full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual;
- ♥ Access to information contained in your medical record within a reasonable timeframe. Confidential treatment of all communications and records pertaining to your care and your stay in the hospital. Your written permission will be obtained before your medical records can be made available to anyone not directly concerned with your care;
- ♥ Pain relief, including information about pain and pain relief measures. Timely response by staff to reports of pain;
- ♥ Reasonable responses to any reasonable request you may make for service;
- ♥ Leave the hospital even against the advice of your physician;
- ♥ Be advised if the hospital or your personal physician proposes to engage in or perform human experimentation affecting your care or treatment, and have the right to refuse to participate in such research projects;
- ♥ Freedom from seclusion and restraints unless clinically necessary;
- ♥ Be informed by your physician or a designee of your physician of the continuing health care requirements following your discharge from the hospital;

- ♥ Receive and examine an explanation of your bill regardless of source of payment;
- ♥ Know which hospital rules and policies apply to your conduct while you are a patient;
- ♥ Have unresolved concerns or grievances promptly addressed through the patient comment process and/or file a complaint with a State agency;
- ♥ Have all of your patient's rights apply to the person who may have legal responsibility to make decisions for you regarding medical care;
- ♥ Ask questions and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence your treatment and care.

## Patient Responsibilities

Along with your rights as a patient come responsibilities to ensure that you receive the high quality health care that you deserve. As a patient at Tucson Heart Hospital, you have the responsibility to:

- ♥ Provide, to the best of your knowledge, accurate and complete information concerning your present complaints, past illnesses and hospitalizations and other matters relating to your health;
- ♥ Make it known whether you clearly comprehend your course of medical treatment and what is expected of you. You are encouraged to ask questions necessary for a clear understanding of any course of action and what to expect. If your nursing staff is unable to answer questions to your satisfaction, your personal physician will be notified and asked to answer any questions you may have;
- ♥ Report unexpected changes in your condition to your physician or nurse;
- ♥ Follow both the treatment plan recommended by your physician and the hospital's rules and regulations affecting your care and conduct, including the instructions of nurses and other health professionals as they carry out your physician's orders;
- ♥ Accept responsibility for your actions if you refuse treatment or if you choose not to follow your physician's orders;
- ♥ Ask your doctor or nurse what to expect regarding pain, pain management and pain medication, discuss pain relief options and develop a pain management plan that includes asking for pain relief when your pain first begins, helping the doctor or nurse assess your pain and letting them know when your pain is not relieved;
- ♥ Show consideration of the rights of other patients and hospital personnel and for your behavior in the control of noise, and number of visitors;
- ♥ Show respect for your personal property, as well as the property of others and that of the Tucson Heart Hospital;
- ♥ Assure that the financial obligations for your health care are fulfilled as promptly as possible;
- ♥ Follow the established policies and procedures of Tucson Heart Hospital;
- ♥ Express concerns about the care you received at the hospital by contacting the Performance Improvement Coordinator at extension 2312.



Tucson Heart Hospital

1. **GENERAL DUTY NURSING:** Kino Community Hospital, henceforth known as Hospital, provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care and is not located in the ICU, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians. Hospital is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
2. **AUTHORIZATION FOR TREATMENT:** I hereby authorize the physician or physicians in charge of the care of the patient named herein at Hospital to administer any treatment deemed necessary or advisable. The undersigned consents to customary x-ray examinations, nursing and technical services and laboratory procedures. The undersigned further consents to anesthesia, medical and surgical treatment or hospital services rendered to the patient under the general and special instructions of the physician. The undersigned recognizes that all physicians furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like may be independent contractors and are neither employees nor agents of Hospital. The patient's care is under the control of the attending physicians. **THIS AUTHORIZATION FOR TREATMENT ALSO APPLIES TO ANY CHILD BORN TO THE PATIENT DURING THIS HOSPITALIZATION.**
3. **RELEASE OF INFORMATION:** Hospital may disclose all or any part of the patient's record pertaining to this hospitalization (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE OR HIV RELATED INFORMATION) to any person or corporation which is or may be liable under a contract to Hospital or to the patient or to a family member or employer of the patient for all or part of Hospital's charges, including, but not limited to, hospital or medical service companies, emergency transporters, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer. The Hospital may disclose any information concerning the patient's case that is necessary or appropriate for the provision of past hospital care or the advancement of medical science, medical education, or medical research, or as required by law. Any physician, hospital, other medical care provider or service or any insurer, employer or government agency having information pertaining to the patient's medical status is authorized to release such information and the patient's records to Hospital and/or its representative(s) and to confer with them as necessary.
4. **PERSONAL VALUABLES:** Hospital maintains a safe for the safekeeping of money and valuables. Items placed in the safe may be retrieved ONLY between 9:00 a.m. and 4:30 p.m. Hospital shall not be liable for loss or damage to any money, jewelry or documents unless placed in the safe. For items placed in the hospital safe, the limit of the hospital's liability in case of loss or damage shall be \$500. In addition, the hospital shall not be liable for loss or damage to any personal property such as bridgework, dentures, eyeglasses, or clothing, which is retained in the possession of the patient during his/her stay in the hospital.
5. **PARTICIPATION IN MEDICAL EDUCATION PROGRAM:** It is understood that Hospital is a teaching institution. The patient also consents to observation of the patient during administration of medical treatment, surgical or diagnostic procedures for the purpose of the education of physicians, medical students, student nurses and any other proper student or technician whose presence is deemed to be appropriate by the attending physician.
6. **ASSIGNMENT OF INSURANCE AND SIMILAR BENEFIT TO HOSPITAL:** In the event the patient is entitled to hospital or medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby assigned to Hospital for application to patient's bill. The patient is responsible for charges not covered by this assignment. Notwithstanding any assignment of insurance including as indicated above, if the insurance carrier has not given a confirmation which is satisfactory to the hospital, I agree to pay the hospital bill every five (5) days and the balance in full at the time of discharge and I agree herewith to comply with these arrangements. **IT IS UNDERSTOOD THAT IF AUTHORIZATION FOR TREATMENT IS DENIED BY THE PATIENT'S AHCCCS PLAN PROVIDER, AND PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DECIDES TO OBTAIN TREATMENT FOR PATIENT AT HOSPITAL NONETHELESS, THE PATIENT'S LEGAL REPRESENTATIVE MUST PAY HOSPITAL FOR ALL SERVICES RENDERED.**
7. **ASSIGNMENT OF INSURANCE AND SIMILAR BENEFITS TO PHYSICIAN(S):** In the event the patient is entitled to benefits payable to physician services arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby assigned to the physician providing those services. The undersigned further understands that all physicians do not accept assignment and that independent arrangements may need to be made for payment for physician services related to this admission.
8. **MEDICARE AND MEDICAID:** If the patient is eligible for Medicare benefits, the undersigned hereby authorizes Hospital and patient's attending physician to bill and collect from Medicare directly. Any charges not covered by Medicare or any supplementary insurance are the responsibility of the patient.  
I certify the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. Medicare will now pay for an additional 60 days of hospital care subject to a daily coinsurance payment for which you are responsible. The 60 days are a lifetime maximum and once payment is made the reserve will be reduced by the days used. Do you wish to have payment made under this provision for your hospital stay? \_\_\_\_\_ Yes \_\_\_\_\_ No
9. **FINANCIAL AGREEMENT:** I understand that if authorization to treat me is denied by my Health Benefits Provider, and I choose to be treated at Hospital, I must pay Hospital for services rendered. The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.
10. **SUBROGATION OF RIGHTS AGAINST THIRD PARTIES:** If the patient is indigent and is admitted to Hospital pursuant to A.R.S. §11-291 as a result of an injury caused by a third party, Hospital is subrogated to the patient with reference to any claim the patient may have against a third party for the cost of hospital and medical care furnished to the patient and may file a lien for the cost of said care. If the patient receives reimbursement from any party as a result of said injury, the patient shall pay Hospital for the cost of said care. If the patient does not commence legal action to recover damages from the party causing the injury within six (6) months after the first day upon which said care was furnished, Hospital may commence legal proceedings on its own behalf to recover the cost of said care from the third party. Patient is defined to include the patient's guardian, personal representative, estate, dependents, survivors or other legal representative.

X Kaye E. Stiles  
 PATIENT

9/20/02  
 DATE/TIME

PATIENT'S AGENT OR  
 LEGALLY AUTHORIZED REPRESENTATIVE

DATE/TIME

CM Caval  
 WITNESS

RELATIONSHIP TO PATIENT



**KINO COMMUNITY HOSPITAL**  
 2800 EAST AJO WAY, TUCSON, AZ 85713  
 (520) 294-4471

KA-3 MR (R 6/01)

**CONDITIONS OF ADMISSION**

WHITE - MEDICAL RECORD    YELLOW - PATIENT COPY

NAME: Kaye Stiles

MRN: 630632 / 2204705

DOB: \_\_\_\_\_

PHONE NO.: (H) \_\_\_\_\_ (W) 246.01.13