Valley Internal Medicine & Pediatrics

Patient Information:

First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ] Male [ ] Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_

City, State, & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]Home [ ] Cell [ ] Work Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]Home [ ] Cell [ ] Work Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment: [ ] Employed [ ] Unemployed [ ] Retired Valley Internal Medicine & Pediatrics has

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permission to discuss my medical billing

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ information with:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]spouse [ ]other

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]relative [ ]other

Insurance Policy and Guarantor Information:

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Home [ ] Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]Home [ ]Cell

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignments of Benefits and/or Guarantee of Account: I hereby authorize payment directly to Valley Internal Medicine & Pediatrics for the benefits payable under the terms of my policy for my illnesses. I understand that I am financially responsible for the charges not covered by my insurance including all cost of collection and reasonable attorney’s fees. Release of information: I hereby authorize Valley Internal Medicine & Pediatrics to release to my insurer full information including copies of the records relative to my illness.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **VALLEY INTERNAL MEDICINE & PEDIATRICS**

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

**DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NONE: [ ]**

**MEDICATIONS** (Prescription & Over the counter) Include Name, Dosage & Frequency: **NONE []**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY** (Medical Conditions, Injuries, Hospitalizations):

Problem/Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Problem/Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Problem/Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Problem/Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST SURGICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY:**

Do you use any tobacco products [ ] yes [ ] no If yes, how much? \_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? [ ] yes [ ] no If yes, how much? [ ] daily [ ] weekly [ ] socially Do you use any street drugs or substance Abuse? [ ] yes [ ] no Do you drink caffeine? [ ] yes [ ] no If yes, how much? \_\_\_\_\_\_\_\_\_\_\_ Do you have children [ ] yes [ ] no If yes, how many? \_\_\_\_\_\_\_\_\_\_\_ Marital status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated Education: (Circle) Jr. High School High School/GED Vocational School College Other Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have an Advance Directive? [ ] yes [ ] no Do you routinely exercise? [ ] yes [ ] no If yes, how often do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Mother Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair Father Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair Brother/Sister Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair Brother/Sister Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair Brother/Sister Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair Brother/Sister Age: \_\_\_\_\_\_\_\_\_ [] Alive [] Deceased Health: [] Good [] Bad [] Fair

**HEALTH MAINTENANCE:**

Colonoscopy: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Mammogram: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Bone Density: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Pap Smear: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Routine Labs: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Prostate Exam: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal PSA: [ ] Yes [ ] No Date: \_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal

**Immunizations:** (Date received) Influenza: (Flu) \_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia: \_\_\_\_\_\_\_\_\_\_\_\_ Shingles: \_\_\_\_\_\_\_\_\_\_\_\_

**Review list of symptoms** (Check any problems that you currently have/had in the last 6 months) **CONSTITUTIONAL** **CARDIOVASCULAR**  **HEMATOLOGY/ONCOLOGY** [] Unexplained weight loss [] Angina [] Anemia [] Unexplained weight gain [] Heart problems [] Bruise Easily [] Fevers [] Chest pain [] Swollen lymph nodes [] Chills [] Leg pain with walking [] Cancers [] Fatigue [] Problems with exercise **PSYCHIATRIC** [] Nausea or Vomiting [] Swelling in legs [] Depression **EYES** [] Problems lying flat [] Feel like hurting someone/yourself [] Cataract [] Heart skipping beats [] Problems with memory [] Change in vision [] Short of breath at night [] Anxiety [] Glasses **SKIN** [] Problems concentrating [] Red eye [] Skin changes [] Problems sleeping  **ENT** [] Skin lesions **Neurology** [] Bleeding from gums [] Skin itching [] Change in memory [] Problems hearing [] Rashes [] Dizziness [] Difficulty swallowing [] Dry skin [] Headaches [] Dentures **GASTROINTESTINAL** [] Imbalance [] Nose bleeds [] Blood in stool [] Numbness [] Hoarse voice [] Constipation [] Weakness [] Sinus problems [] Diarrhea [] Tremors [] Ringing in ears [] Heart burn [] Seizures [] Mouth Ulcers [] Hemorrhoids **GENITOURINARY** **RESPIRATORY**  [] Black tarry stool [] Problems urinating[] Bronchitis [] Stomach ulcers [] Sexually transmitted Dz [] Cough **MUSCULAR SKELETAL** **WOMEN ONLY** [] Coughing up blood [] Neck pain [] Problems with period [] Shortness of breath [] Gout [] Vaginal dryness **ENDOCRINE** [] Injury to limbs [] Vaginal discharge [] Problems with heat/cold [] Joint pain [] Pain/lump in breast [] Hair loss [] Joint stiffness **MEN ONLY** [] Swelling in neck [] Back pain [] Problem with erections [] Frequent urination [] Red/Swollen joints [] Testicular pain

 **Valley Internal Medicine & Pediatrics**

 **HIPAA Notice of Privacy Practices**

**This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to help facilitate your treatment, payment or health care operations, and for other purposes that may be required by law. This notice also describes your rights to access and control your PHI. Your Protected Health Information is information about you, including your demographic information, that may identify you and that relates to your past, present or future physical or psychological health in addition to your medical condition and related health care services. The Department of Health and Human Services, Office for Civil Rights enforces the HIPAA Privacy Rule.

**Uses and Disclosures of Protected Health Information:** Your Protected Health Information may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the Physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party as medically necessary. For example, your PHI may be disclosed to a home health agency that provides you care or to another physician to whom you have been referred to. This is to ensure that the third party medical providers have the necessary medical information about you to provide your medical care.

**Payment:** Your Protected Health Information will be used, as needed, to obtain payment for your health care services.

**Healthcare Operations:** We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your Physician’s practice. These activities include, but are not limited to: quality assessment activities, training of medical staff, licensing and credentialing. Some examples include: the training of medical student that see patients at our office. Additionally, we may use a sign-in-sheet at the registration window and we may call you by your name in the waiting room when your Physician is ready to see you. We may also use or disclose your Protected Health Information to contact you in order to remind you of your next appointment. We may use or disclose your Protected Health Information in the following situations without your authorization as required by law. Some examples include: Public Health issues, Communicable Diseases Health Oversight, Abuse or Neglect, Food and Drug Administration (FDA) requirements, Legal Proceedings, Law Enforcement, Coroner’s, Funeral Directors, Organ Donations, Research, Criminal Activity, Military and National Security, and Worker’s Compensation.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization** at any time, in writing, except to the extent that your Physician or the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Additional information about the HIPAA Privacy Rule** may be viewed at eh U.S. Department of Health and Human Services Website: www.hhs.gov/ocr/privacy.

**VALLEY INTERNAL MEDICINE & PEDIATRICS**

**Information and Policies:**

Welcome to our practice. We ask that all our patients review, understand and sign out information and policies.

1. **YOUR HIPAA RIGHTS**

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form you received, please ask to speak with our HIPAA compliance officer. Your signature below is only acknowledgement that you received notice of our privacy practices.

1. **PATIENT MESSAGES:**

Valley Internal Medicine & Pediatrics has permission to leave messages, which pertain to follow up visit , test results, scheduled appointments or calls regarding my account.

Phone messages [ ]Yes [ ]No \_\_\_\_\_\_\_\_\_\_Initial Email Messages [ ]Yes [ ]No\_\_\_\_\_\_\_\_\_\_\_ Initial

I prefer VIMP reach me by the following method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **GUARANTOR ACCOUNT**

The Guarantor is responsible for payment of all charges hereafter incurred by the guarantor and the guarantor family. If the insurance is filed by VIMP the guarantor is responsible for the insurance payment and any remaining balances. If we do not file insurance, the guarantor is responsible for payment of charges at the time of service. If you have a deductible or balance which has not been met by your insurance, or if your insurance deems your visit as a “none Covered “ service, the guarantor will be responsible for the balance. All copayments are due at the time of service. Any charges not paid within 90 days will be turned over to our collection agency. Any fees incurred by VIMP through legal action taken for collection of charges will be the responsibility of the guarantor.

If we do not contract with your insurance carrier, we cannot accept assignments to be reimbursed by your carrier.

Therefore, charges are due and payable by you at the time of service. As a courtesy, we will however bill your insurance plan on your behalf for any service we provide and instructions to reimburse you directly. We will bill your health plan for any hospital services we provide.

**There will be a $25 charge for any returned checks**

1. **APPOINTMENTS:**

If you miss your appointment without **24 hour notification,** a $35 fee will be charged to your account. We strive to stay on schedule, with that said, late arrivals will be asked to reschedule. If you arrive 15 mins late for your new patient appointment you will be rescheduled for the first available appointment. If you are within 15 mins grace period for established patient we will make every effort to work you in but it still may be necessary to reschedule your appointment.

1. **PATIENT MESSAGES:**

In the event of an Emergency, call our office number and the on call Physician will be paged. Any after hour calls will be subject to $20 telephone service charge. Email messages via our website is for none emergent and none medical questions or concerns. The Physician or medical assistant will return your email within 24 hrs.

1. **PRESCRIPTIONS:**
* Routine medication refills will be called in during regular office hours.
* Any prescription not written during scheduled office visits will be charged $25 per medication.
* Prescription requests require 24 hour notice and can be made by calling the office.
* Antibiotics will not be called in without undergoing an evaluation by the physician.
* Narcotics will not be refilled without seeing the physician first.
* Narcotics will not be called in. Patient must hand carry a prescription to the pharmacy.
* Narcotics will only be refilled during regular office hours.

 7.**REFERRALS:**

Our office routinely refer patients to outside specialists, however, referral will not be made without seeing the physician first. This allows the physician to make a proper referral with accurate current information.

 When you come in for your visit we ask all our patients to bring in the following:

* Current driver license or photo ID
* Updated insurance card
* List of all current medications

If you do not bring your insurance card you may be expected to pay in full or reschedule your appointment.

My signature indicates that I have read and understand the policies of VIMP

Signature of Patient or legal guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_

 **VALLEY INTERNAL MEDICINE & PEDIATRICS**

**OFFICE POLICY ON PRESCRIPTION MONITORING AND URINE DRUG TESTING**

To ensure our patients are compliant with their treatment plan we have instituted a policy of urine drug testing. All new patients will require a urine drug screen to avoid possible drug interactions with prescribed medications. All patients who are prescribed scheduled medications may be tested up to 1-2 times per year. We also reserve the right to test any patient at any time. When you are asked to produce a urine sample, you will be asked not to leave the office until the sample is received. Once again, failure to produce a sample at the time of requested may disqualify you from receiving further prescriptions. Please be advised that if your insurance does not cover the full cost of the urine drug screen, you will be responsible for the cost of the test which is $25.00.

We utilize a point of service collection cup that gives us information immediately. We send all of our samples to a lab to be confirmed. If results are inconsistent with your treatment plan at any time, we reserve the right to discontinue treatment. It is your responsibility to take your medications as prescribed. Inconsistent results include the presence of illicit substance, the presence of medications not prescribed to you or the absence of medications prescribed. Do not try to manipulate the test. Current urine drug testing methods are very sophisticated and differentiate between samples that are consistent with treatment plans and samples that have been tampered with. Any confusing results will be interpreted as inconsistent. If you are taking your medications as prescribed there should not be any confusion in the results.

We understand that many of our patients are elderly and obtaining a sample can be inconvenient. Nevertheless, we cannot and do not discriminate on the basis of age, sex, race, nationality or sexual orientation and all patients will be subject to this policy. This policy is not intended to be punitive in any way. As stated before, the intent of this policy is to protect the patient, the physician, the therapy and society.

This policy may be amended from time to time in accordance with new medical findings or legislative measures.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **VALLEY INTERNAL MEDICINE & PEDIATRICS**

708 Will Halsey Way Suite A

 Madison, AL 35758

Due to Federal Privacy Laws we are unable to provide information to anyone except you, the patient regarding medical conditions, prescriptions, appointment times, or any other information held by the practice without your specific permission.

If you desire your spouse, friend, parent, etc. to pick up prescriptions, check on appointments, receive lab results or discuss your private medical information please list him/her/them below and sign/date the authorization.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hereby authorize Valley Internal Medicine and Pediatrics to release information from my medical records to include but not limited to my complete medical records, prescription information, appointment or visit information, x-rays and x-ray results, tests and test results, laboratory results to the above named person/persons.

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Valley Internal Medicine and Pediatrics, it’s employees and officers and attending physicians are released from legal responsibility or liability for release of the above information to the extent authorized herein.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Valley Internal Medicine & Pediatrics**

 **708 Will Halsey Way Suite A**

 **Madison, AL 35758**

 **256-325-7425**

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS.

We strongly feel that all the patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

**PLEASE READ AND SIGN BELOW:**

1. I authorize this office to release or receive information necessary to expedite insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier. I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there are no payments within 60 days, it is my responsibility to pay my doctor bill directly.

I further understand and agree, and if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney’s fee.

There will be a $25.00 charge on all returned checks and a $10.00 charge on all delinquent accounts, which must also be paid.

A photo static copy of these authorizations and agreements shall be as valid as the original.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL RECORDS RELEASE AUTHORIZATION

 I hereby authorize and request you release a complete copy of my medical records to:

 Valley Internal Medicine and Pediatrics 708 Will Halsey Way Suite A Madison, Al 35758

 Phone: 256-325-7425 Fax: 256-325-2765

 Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Patient's guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print your name (if not patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Address, Phone, and Fax of Physician from whom you are requesting records from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Purpose for disclosing information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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