Valley Institute of
Primary Medical Care
of Alabama

1103 15th Ave SE
Decatur, Alabama, 35601
Phone: 256-909-4004 • Fax: 833-794-1841

New Patient Packet

Dear Patient,

Thank you for choosing Valley Institute of Primary Medical Care of AL, we look forward to providing you with excellent care. Enclosed you will find our clinic policies and our New Patient Forms. Please fill these forms out completely prior to your appointment and return them by fax, mail, or in person.

At your first visit, please bring the following:

- Completed New Patient Forms (If you have not already submitted them)
- Your Photo ID
- Your Insurance Card(s)
- The bottles of all your medications, both prescription and over-the-counter medications (not just list, please bring the actual bottles) •

You will be responsible for your co-pay on arrival.

We ask that all new patients arrive at least 15 minutes early, so that we can confirm your medical history information.

If you are unable to keep your appointment, or need to reschedule for any reason, we ask for a minimum 24-hour notice.

Our waiting room is open with limited seating, and we ask that only the patient enter the clinic unless a visitor is needed to assist the patient. If you are more comfortable waiting in your car, please let us know at check-in, and we will call you once we have your room ready.
Please wear a mask while inside the clinic if you have symptoms, a positive test, or exposure to someone with COVID-19.

Sincerely,

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Privacy Policies:

Valley Institute of Primary Medical Care of AL, LLC is committed to protecting your health information.

This Notice of Privacy Practice describes the personal care, treatment, and billing information we collect for your medical record and how and when we may use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

Each time you visit VIP Medical Care of AL, a record of your visit is made. Typically, this record contains your symptoms, examinations, test results, diagnosis, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care. This may include, but is not limited to physicians, nurses, medical assistants, technicians, staff, and other personnel utilized by our practice.
- Legal document describing the care you received.
- Means by which you or a third-party payor can verify that services billed were provided.
- A tool in educating health professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our business planning
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understand what is in your record and how your health information is used helps you to:
Ensure its accuracy.
Better understand who, what, when, where, and why others may access your health information
Make informed decisions when authorizing disclosure to others.

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Your Health Information Rights:

You have the following rights regarding your Medical Record:

- Inspect and copy your health information including medical and billing records. We require in writing and will respond to this request within 14 business days. We have legal right to deny this request for specific limited circumstances. You have the right to request an appeal of a denied request. Also, a reasonable fee can be charged, as allowed by law, for copies of your record.
- Request an amendment to your records if you feel they are incorrect or incomplete. Request must be made in writing and must contain information that supports your request. We must respond to an amendment request within 30 days. We have the right to deny a request if we do not feel your request is supported, if we feel the original documentation is accurate and correct or if the information was not originally created by us.
- Obtain an accounting of certain disclosures of your health information. The right applies to disclosures for purposes other than treatment, payment, or healthcare operations only.
- Request communications of your health information. The right applies to disclosures of your information. This request must be in writing to VIP Medical Care of AL and must include specific restrictions of uses and/or disclosures to whom and of what information. We are not required to provide you with emergency care or required by law.
- Obtain a printed copy of this notice of information practices upon request at any time.
- Detailed information regarding these policies is available and questions can be directed the Privacy Office.

Our Responsibilities:

VIP Medical Care of AL is required to:

- Maintain the privacy of your health information and provide you with this notice (upon request) as to our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of the Notice of Privacy Policies currently in effect.

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Valley Institute of Primary Medical Care of Alabama
OFFICE POLICIES AND PROCEEDURES FOR PATIENTS

RECEIPT ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received, reviewed, understood, and will comply with the polies and procedures explained in the VIP Medical Care of Alabama Office Policies and Procedures for patients form.

Printed name Signed named Date

Thank you,

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Date: _____

Patient Name: _____Date of Birth: _____
Address: _____City: _____State: _____
Zip:_____
Phone Number: _____ Secondary Contact Number:_____
Email: _____ SSN: _____-____-_____
Marital Status of Patient: _____ Gender: [ ] Male [ ] Female
Employer:_____

Emergency Contact Name: _____
Relation to Patient: _____ Emergency Contact Phone Number: _____

Insurance Information

Primary Insurance Provider: _____
Policy Number: _____Group Number:_____
Policy Holder's Name and Date of Birth (if different from patient):
_____

Secondary Insurance Provider (if applicable):
_____
Secondary Policy Number: _____

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Consent For Treatment and Conditions of Treatment

Initial_____ Consent For Treatment:

- This is my authorization and consent for care and treatment by Valley Institute of Primary Medical Care of AL and it's agents. I acknowledge that no guarantees have been to rue as to the effect of such examination or treatment on my condition.

Initial_____ Personal Valuables:

- I acknowledge that Valley Institute of Primary Medical Care of AL shall not be liable for the loss or damage to any personal property.

Initial_____ Permission for Disclosure of Information:

- This authorizes Valley Institute of Primary Medical Care and its representatives and employees to release all information, including, but not limited to copies of medical and other records relative to this treatment, testing, and diagnosis to all insurers, third party payors, and other health care institutions or entities involved in patient transport or continuing patient care, CAMPUS, physicians or agencies performing review functions authorized by contract, law, or regulations.

Initial_____ Financial Agreement and Assignment of Insurance Benefits:

- The undersigned agree(s), whether signing as agent or as patient that in consideration of services to be rendered to patient, the undersigned is obligated to pay for the same in accordance with the regular rates and terms Valley Institute of Primary Medical Care of AL, and that should the account be referred by Valley Institute of Primary Medical Care of AL to and attorney or collection agency for collection, the undersigning shall pay all reasonable fees, interest, and costs of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of Alabama or any other state as to his personal property.
- In event the undersigned and/ or patient is entitled to benefits of any type, whatsoever, arising out of any Insurance or any other party liable to the patient, then the undersigned assigns such benefits to Valley Institute of Primary Medical Care of AL. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to Valley Institute of Primary Medical Care of AL for respective services rendered. The undersigned and/or patient agrees and understands that acceptance of Insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient.
- The undersigned and/or patient is responsible for the compliance with any precertification and/or other requirements of any Insurance company or third-party payors. The undersigned and/or third-party payors versus that of the medical provider.

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OFFICE POLICIES AND PROCEDURES FOR PATIENTS

We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff here at VIP Medical care strive to provide the best possible care and service to our patients to make them as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy for our clinic. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

Initial_____OFFICE HOURS

Our office is open Monday-Thursday 8:00AM-5:00PM, Friday 8:00AM-Noon. We are closed for lunch from Noon1:00PM. You can reach our office at 256-909-4004 during office hours. Our Physicians are available after hours 24 hours per day/365 days per year by calling our phone and following the prompts after hours. **If you need an appointment, prescription refill or test results, please call during regular business hours.**

Initial_____APPOINTMENTS

We are committed to providing quality care to our patients. To ensure that, VIP Medical Care of Al, does not treat patients we have not seen (i.e., we will not call-in prescriptions or offer medical advice for patients prior to their initial visit). Follow-up visits may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate treatment plan may be determined.
If you are 15 minutes late or more for your appointment, you may be asked to reschedule.

Initial_____CANCELLATION OF APPOINTMENT

Please be courteous and call promptly if you are unable to make your appointment. The time will be reallocated to someone who is in need of treatment. This is how we can best service the needs of our patients.
If it is necessary that you cancel your appointment, **we require a 24-hour notice** prior to the start of your appointment time. **If notice is provided for less than 24 hours, a fee will be charged.**

Initial_____NO SHOW POLICY

A “no show” is someone who misses an appointment without cancelling it within 24-hours in advance.
No shows inconvenience those individuals who need access to medical care in a timely manner. **Failure to be present at the time of a scheduled appointment will be recorded in your medical chart as a “no show”. An administrative fee of $30.00 will be billed to your account. Three (3) or more “no shows” within one (1) calendar year will result in dismissal as a patient.**
** *Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.*

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Initial_____INSURANCE

We accept most, but not all, insurance plans. Please ask our staff if you are unsure if we accept your INSURANCE.

It is patient responsibility to inform our office of any changes regarding your insurance coverage. Failure to do so could result in delay or denial of insurance payment.

BCBS BEG/PGX plans- It is patient responsibility for these plans to contact the insurance company prior to the patients initial visit and select the provider you will be seeing as your PCP. If our providers have not been selected prior to your visit, you may be asked to reschedule until doing so. **Patients are responsible for co-pays at time of service.**

Initial_____PAYMENTS

We accept cash, debit, credit cards, and personal checks. Checks can be made out to Valley Institute of Primary Medical Care of Al (VIP Medical care of Al). It is policy to make all reasonable attempts to collect outstanding balances should they accrue. Please ask our office if you need to set up a payment plan. **Self-pay patients are responsible for paying in full at time of service each visit.**

Initial_____FORMS/LETTERS/PAPERWORK

We understand at times, various forms, letters, and paperwork may be required to assist with your healthcare needs. We will be happy to complete forms as necessary upon your request. However, this can be time consuming, please allow 7-10 business days for competition of requested forms/letters/paperwork. This includes FMLA paperwork.

An administrative fee of $25.00 will be billed to your account for all forms to be completed.

*** Please note that this admin fee is patient responsibility and will not be billed to your insurance company.*

Initial_____MEDICAL RECORDS

To ensure your privacy, a form for release of medical records or to obtain must be completed and signed in the office.

Initial_____PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform our office of which Pharmacy you use and update us if this should change. Please call 5 days prior to your medication needing to be refilled. Allow 48-72 hours for prescriptions to be refilled, longer if the medication is a controlled substance. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Please note that we do not refill Narcotic medications or antibiotics over the phone. Therefore you may be asked to come into the office or be required to obtain these medications through Pain Management.

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CONSENT FOR ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR PAYMENT

Patient Information:

Insurance Provider: _____
Insurance Policy Number: _____
Group Number (if applicable): _____

Assignment of Benefits: I, the undersigned patient or legally authorized representative, hereby assign to **Valley Institute of Primary Medical Care of Alabama**, all insurance benefits, including health insurance benefits, workers' compensation, or other applicable third-party insurance benefits, that are due or payable to me for any treatments or services rendered to me by **Valley Institute of Primary Medical Care of Alabama**.

This assignment includes, but is not limited to, medical treatment, office visits, diagnostic testing, procedures, and any related services provided during my treatment. I understand that this assignment will direct my insurance company to make payments directly to the provider (Valley Institute of Primary Medical Care of Alabama) for all claims related to these services.

Authorization for Payment: I authorize **Valley Institute of Primary Medical Care of Alabama** to submit claims for services provided to me, and I further authorize the release of any necessary medical or billing information to my insurance company, health plan, or other third-party payer for purposes of processing and paying claims.

I authorize my insurance provider to pay directly to **Valley Institute of Primary Medical Care of Alabama** the benefits due to me for covered services provided by the healthcare providers at this facility.

Understanding of Financial Responsibility: I understand that I am financially responsible for any portion of the treatment not covered by my insurance or health plan, including but not limited to co-pays, deductibles, and coinsurance. If my insurance company does not make payment, I agree to pay any remaining balance owed to **Valley Institute of Primary Medical Care of Alabama** promptly.

Revocation of Assignment: I understand that I have the right to revoke this assignment of benefits at any time, provided I notify the office of **Valley Institute of Primary Medical Care of Alabama** in

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writing. However, any revocation will not affect the payment of claims for services rendered prior to such revocation.

Patient Acknowledgment: I acknowledge that I have had the opportunity to ask questions regarding this consent form, and I understand its contents. I understand that my refusal to assign benefits may delay or prevent my insurance company from making direct payment to the healthcare provider. By signing below, I consent to the assignment of benefits and authorize the payment of insurance benefits to **Valley Institute of Primary Medical Care of Alabama** as described above.

Statements to Permit Payment of Medicare/Medicaid Benefits to Provider:

- The undersigned and/or patient certifies that the information given by him/her in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. The undersigned and/or patients request that payment of authorized benefits be made to Valley Institute of Primary Medical Care of AL for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to Health Care Financing Administration, the State of Alabama, their Intermediaries carriers, or agents any information needed to determine these benefits or benefits related service.
- It is understood that the undersigned and/or patient is responsible to Valley Institute of Primary Medical Care of AL for any health insurance deductibles and coinsurance.
- The undersigned and/or patient certifies that he/she has read the forgoing and agrees and accepts.

Patient/Representative Relationship

_____ _____ _____

Policy Holder Date

_____ _____ _____

Policy Holder Representative Patient's Agent or Date

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No Chronic Pain Management Policy

Valley Institute of Primary Medical Care of Alabama is committed to providing high-quality, compassionate care to our patients. As part of our mission to ensure the well-being and safety of all those we serve, we have established a **No Chronic Pain Management Policy**. This policy outlines our approach to the management of chronic pain and specifies the types of treatments we do not provide.

Policy Overview: Our practice does not prescribe or manage treatments for chronic pain conditions. This includes, but is not limited to, the use of:

- Opiates (including prescription opioids)
- Benzodiazepines
- Long-term narcotic pain medications
- Chronic pain management procedures (e.g., nerve blocks, spinal injections)

Patients who require chronic pain management will be referred to a licensed pain management specialist or physician who is equipped to handle such care in a specialized setting.

Guiding Principles:

1. **Patient Safety**: We are committed to ensuring that our patients receive the highest standard of care, including the safe and responsible use of medications. Chronic opioid and benzodiazepine prescriptions carry significant risks, including dependency, overdose, and other severe complications, which our practice does not manage.
2. **Referral to Pain Management Specialists**: When a patient presents with chronic pain that requires ongoing or specialized treatment, they will be referred to a certified pain management physician or specialist who can provide the appropriate level of care.
3. **Evidence-Based Care**: Our practice focuses on non-pharmacologic treatment options for acute pain, such as physical therapy, therapeutic exercises, lifestyle modifications, and other alternatives to chronic pain medications.
4. **Clear Communication**: All patients will be informed at the time of their initial visit that our practice does not offer chronic pain management services, and that they may need to seek specialized care. Our staff will assist with the referral process to ensure continuity of care.

Patient Expectations: Patients seeking chronic pain treatment may be required to:

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- Sign an acknowledgment of understanding regarding the nature of our practice's policy.
- Acknowledge that ongoing prescriptions for opioids, benzodiazepines, or chronic pain medications will not be provided by our office.
- Accept a referral to a licensed pain management specialist or physician if deemed appropriate by the attending physician.

Exceptions: In some cases, acute pain conditions may require short-term prescription medications, which will be managed on a case-by-case basis in accordance with appropriate medical guidelines. However, any patient requiring long-term pain management or opioid therapy will be referred for specialized care.

We believe that this policy will help us provide the best care for our patients, keeping their safety and health as our top priorities. We appreciate our patients' understanding and cooperation in adhering to these guidelines.

If you have any questions or need assistance with a referral, please speak with a member of our team.

Patient Name: _____

Patient Signature: _____

Date: _____

Medical Information Release Consent Form

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Patient Information:

Full Name: _____ Date of Birth: _____

Release of Information Authorization: I, the undersigned, hereby authorize Valley Institute of Primary Medical Care of Alabama to release my medical information to the individual named below.

Recipient Information:

Name of Authorized Individual: _____

Relationship to Patient: _____

Phone Number: _____

Details of Information to Be Released: I authorize the release of the following types of medical information:

- Medical Records (all records)
- Diagnosis and Treatment Information
- Test Results (e.g., lab work, imaging)
- Prescription/Medication Information
- Other: _____

Purpose of Release:

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- Medical treatment coordination
- Insurance purposes
- Legal purposes
- Personal/Other: _____

Expiration and Revocation: This consent is valid until the following date or event: _____. I understand that I can revoke this authorization at any time by providing written notice to Valley Institute of Primary Medical Care of Alabama, except for any information that has already been disclosed in reliance on this authorization.

Acknowledgment: I understand that:

I am under no obligation to sign this consent form, and my refusal to sign will not affect my medical treatment, payment, or benefits eligibility. The information released may include sensitive information, including but not limited to mental health, HIV/AIDS status, or substance abuse records. I specifically authorize the release of this information. *I have the right to request a copy of this consent form.*

By signing below, I authorize the release of the specified medical information as outlined above.

Patient Signature: _____Date: _____