

Valley Internal Medicine, LLC

Health Information Consent • Acknowledgement of Notice of Privacy Practice

Consent to medical treatment:

I hereby consent to the rendering of medical care which may include diagnostic procedures, medical treatment, and possible hospital admission as considered necessary by the treating provider(s) and members of their office staff.

Release of Health Information:

I authorize that my health information may be released to requesting insurance companies and/or other physicians, or medical facilities. This includes medical history, mental and physical condition, diagnosis, prognoses treatment, and reviewing necessary x-ray, lab results, etc....

I understand that Valley Internal Medicine, LLC uses and discloses patient health information to provide treatment, to obtain payment, for health care operations, and administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use of disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Valley Internal Medicine, LLC's Notice of information practices for more information about how my protected health information may be used and disclosed. I understand that Valley Internal Medicine, LLC may change its information practices, but before doing so, a new notice will be posted in the waiting area and each examination room. I may also call Valley Internal Medicine, LLC'S phone number (256) 686-4567 at any time to request a copy of the notice of information practices.

I understand that I have the right to request a restriction on certain uses and disclosures of my health information. Valley Internal Medicine, LLC is not required to agree to such restrictions, but if Valley Internal Medicine, LLC does agree, it must abide by those restrictions. I understand that I have the right to revoke this consent, in writing, except where Valley Internal Medicine, LLC has already made disclosures in reliance on my prior consent.

I understand that by signing this consent I give authority to Valley Internal Medicine to request and use my external prescription history through Prognosis, sure script, Al. PDMP. This consent will allow Valley Internal Medicine LLC to electronically prescribe medications, determine pharmacy benefits, and download a list of all medications prescribed for myself by any provider. I authorize Valley Internal Medicine to leave messages on my answering machine or text for appointment reminder and I have the right to decline receiving appointment reminder in writing for future appointments

Valley Internal Medicine LLC will grant me secure electronic access to my medical records through Prognosis patient portal "a secure website" and I have the right to activate the account, log-in to review my medications, clinical summary, or leave the account inactive.

Payment:

Payment is required at the time of the service. We will provide all the information needed to file your insurance. We will file your Medicare and any supplementary insurance after we hear from Medicare.

Insurance Payment:

I request that payment of insurance benefits be made on my behalf to Physicians of **Valley Internal Medicine, LLC** unless payment is made at the time of service. I understand that regardless of the assignment of benefits or what type of insurance coverage I have, I am responsible for any and all charges incurred by myself or my dependents. I also agree to pay **Valley Internal Medicine, LLC** the part of the fee which is not covered by my insurance plan.

I instruct my doctor to complain on my behalf to the insurance commissioner if he/she deems it necessary.

I have received and read a copy of the notice of privacy practice of Valley Internal Medicine, LLC.

Print Patient Name/Legal representative: _____

Patient Signature: _____ Date: _____