ACTIVE VITAL CARE

REGISTRATION FORM

PATIENT REGISTRATION FORM

Please complete it thoroughly and accurately. All fields in asterisk (*) are REQUIRED. Any paperwork that is incompleted may cause delays in registration and response time and a registration representative may ask you to redo the registration.

TODAY DATE ________________ **AVC REP** ____ **FAX: 602-767-5063**

Services Needed (Please check)* ☐**PCP** ☐Podiatry ☐Cardiology ☐Psychology ☐Psychiatrist ☐Pain Management ☐Nephrology ☐Endocrinology

PATIENT INFORMATION

Last Name*:__________________________ **First Name*:** __________________________ **Middle Initial*:**__________

Community/Home Address*:____ **APT/RM #*:**______________

City*:__________________________ **State*:**______________ **Zip*:**______________ **Date of Birth*:**________________

Home Phone #*:______________________ **Cell Phone #:**______________________ **Social Sec. #:**______________________

Community Name (If not home address)*: ____

Community Manager*:______________________________ **Contact #*:** ______________________

Community E-mail*:______________________________ **Fax #:** ______________________

Do you have a legal POA? ☐Yes ☐No
Please attach POA's documents to our office for record.

POA Name:______________________________________

POA Address:____________________________________

POA Phone #: ___________________________________

Please attach POA's documents to our office for record.

Who is involved in my medical decision? (Check all that apply)
- ☐ Doctor
- ☐ POA
- ☐ Community
- ☐ Manager/staff
- ☐ Caregiver
- ☐ Legal

Marital Status* (check one):
☐ Single ☐ Divorced
☐ Married ☐ Widowed

Living Status? ☐ Independent
☐ Assisted
☐ Memory
☐ Private Home

Do Not Resuscitate (DNR): ☐Yes ☐No **Living Will:** ☐Yes ☐No ***Please attach documents to our office for record.***

List people to be contacted prior to medical visit here:* ____

Gender: ☐Male ☐Female **Preference Language:** ☐English ☐Spanish **SMS Messages:** ☐Yes ☐No

INCASE OF EMERGENCY

Full Name *:______________________________ **Relationship*:**______________________

Phone #*:______________________ **E-mail #*:**______________________________

PREFERRED PHARMACY*

Pharmacy Name*:______________________ Cross Street: Patient*:______________________________

PREFERRED HOME HEALTH (If apply)

Preferred Home Health:______________________________________ **Phone #:**______________________

Admission to hospital or SNF in the last 30 days? ☐Yes ☐No

If YES, Which Hospital/SNF?________________________ **Discharge Date:**________________

Address:____

INSURANCE INFORMATION

We MUST be made the primary care physician (PCP) on file with your insurance company **BEFORE SEEN**. In order to change your PCP, simply call the insurance company and provide us the reference number and effective date for the change.

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name*:________________	Insurance Name*:________________
Policy/Subscriber ID #*: ________________	Policy/Subscriber ID #*: ________________
Group #*: ________________	Group #*: ________________
Address: ________________	Address: ________________
Main Policy Holder*:________________	Main Policy Holder*:________________
Relationship to Patient: ________________	Relationship to Patient:________________

MEDICARE # (If applicable):________________________

RESPONSIBLE PARTY (If different from patient)

Person Responsible for the bill*:________________________ **Relationship to Patient:**________________

Address:____

Phone #*:________________________ **E-mail #*:**________________________

ATTESTATION: The ABOVE information is true to the best of my knowledge. I authorize my insurance benefit to be paid directly to the AVC's physician. I understand that I am financially responsible for any balance if my insurance does not pay.

Signature: ________________________ **Date:**________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN, AND OTHERS.

I hereby authorize medical providers and personnel of AVC to discuss and /or release my protected health information with: (Please list the names (s) of the person(s) below who you give us permission to communicate your health information. If the patient is a minor, each parent or guardian needs to be listed.)

Full Name: ________________________ **Relationship:**________________

Phone #*:________________________ E-mail #*:________________________

Full Name: ________________________ **Relationship:**________________

Phone #*:________________________ E-mail #*:________________________

I understand that I have the right to revoke this authorization, in writing at any time. I understand that such revocation is not effective to the extent that the AVC has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization. By signing here, I consent to AVC to release my health information to carry out my recent treatments.

Patient/Personal Representative Name:________________________ **Date:**________________

Patient/Personal Representative Sign:________________________ **Date:**________________

ACTIVE VITAL CARE

REGISTRATION FORM

NEW PATIENT HEALTH INFORMATION-Please attach more documents if needed.

Name:____ Date of Birth:______________ Today Date:__________________

CURRENT MEDICATION (Prescription, over the counter, and supplements)
Include name, strength, number of pills, frequency. **Example: Ibuprofen, 200mg, 2 tablets, 2 times a day**

1.____
2.____
3.____
4.____

DRUG ALLERGIES OR INTOLERANCES (Include medications you have tried in the past, which did not work for you. Example: Lisinopril: did not help lower blood pressure)

1.______________________ Reaction:______________
2.______________________ Reaction:______________

SURGICAL HISTORY (List any implants you may have had, such as pins, plates, stents, pacemaker, augmentations, etc.)

1.______________________ Date/Year:______________
2.______________________ Date/Year:______________

HOSPITALIZATIONS (List the name of the hospital, reason and duration of stay)

Hospital Name + Reason:__________________________________ # of Days:__________ Date:__________

PAST MEDICAL HISTORY (Previous health problems, check if apply)

☐ Diabetes ☐ Cancer ☐ Asthma
☐ Stroke/Heart Disease ☐ High Blood Pressure ☐ Seizures
☐ High Cholesterol ☐ Alzheimer/Dementia ☐Mental Illness
☐ Other ____________________

SOCIAL HISTORY

Reason:________________ # of Days:_____ Date:________
Reason:________________ # of Days:_____ Date:________

GENERAL HEALTH HISTORY

Last Colonoscopy: Date:____________________
Last Dental Exam: Date:____________________
Last Eye Exam: Date:____________________
Last Physical Exam Date:____________________
Last Mammogram (Women Only) Date:____________________

Last Test for Hidden Blood in Stool: Date:____________________
Last ECHO: Date:____________________
Last EKG: Date:____________________
Last Foot Exam: Date:____________________

VACCINE HISTORY

Last Tetanus: Date:________________ Did the Tetanus vaccine include Whooping Cough/Pertussis: ☐YES ☐NO

Last Pneumovax: Date:____________________
Last Flu Vaccine: Date:____________________
Last Shingles Vaccine: Date:____________________

Last Prevnar 13: Date:____________________
Last TB Test: Date:____________________
Last 3 Covid-19 Date:____________________

Registration Email: | Phone: 602-767-5062 | Fax: 602-767-5063
2375 East Camelback Road, Suite 600, Phoenix AZ 85016
Activevitalcare.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Medical Department)

MEDICAL RECORD REQUEST FORM

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), AVC will keep all of your health information confidential.

Patient Name*:________________________ Phone #:________________________ Date of Birth*:________________

Address:____

I, ________________________________ hereby authorize to release my medical records to AVC physicians for other medial and health care providers listed below.

(Patient Name /Legal Representative)

____

(Name of facility)

____ Date Request:________________

(Address of facility)

AVC

2375 East Camelback Road, Suite 600, Phoenix AZ 85016

Office Phone #: 602-767-5062 **Medical Department Fax #: 602-767-5063** **E-mail:**

☐ Progress Notes ☐ Lab Reports ☐ Imaging Reports ☐ Pathology Reports

☐ Discharge Summary ☐ Other, (please specify) ________________________________

This information will be used for the purpose of, (please check):

Legal Reason ☐ Insurance ☐ Workman's Compensation ☐ Personal Use ☐

Continue Care with Primary Care Physician ☐ Continue care with Specialist ☐ Other ☐

I, the undersigned, have authorized the facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law, I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

My signature below indicates that I authorize medical records to be released to AVC.

Patient's Signature*:________________________________ **Date*:**________________

FINANCIAL POLICY

(Billing Department)

Thank you for choosing AVC for your care. Please read carefully and sign below. This policy has been put in place to ensure that financial payments due are covered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple as straightforward as possible. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY HEALTH INSURANCE.**

1. I understand that if I do not have a referral (specialist), **do not** have my updated insurance card on file, do not pay for co-payment, deductible, and/or coinsurance that my appointment may be rescheduled until I can provide the required documents or payment.

2. **I understand I am financially responsible for any copayment, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits.** My insurance company determines benefit payments. **I understand I will be responsible for the portion not covered by my insurance.** I understand I am responsible for knowing my financial responsibility for all visits, tests and procedures.

3. Your insurance plan MAY OR MAY NOT cover routine preventative services (Annual Wellness/Physical Exam) and I understand that I am responsible for my balance if the insurance doesn't pay for Annual Wellness/Physical Exam Visit.

4. I understand that if I am unable to attend my scheduled appointment I need to contact the office at least **24 hours in advance** prior to my scheduled appointment to cancel the appointment.
   a. **A $25 FEE for PCP or $50 FEE for Speciality** will be applied to any missed appointments (No Show) or cancel appointment.

5. I understand that missed appointments will NOT be rescheduled **until the $25/$50 Fee is paid**

   (Example: If an appointment is confirmed and the visit was a NO SHOW/Cancel on the same day of the appointment, fee will be applied.)

6. If I owe **$500 and over**, I must pay to AVC Med before the visit will be scheduled.
7. If I owe **$1500 and over**, AVC has the right to discharge the patient due to overdue payment.

8. I understand if my account is **not paid in full within 30 days, a $50 collection-processing fee will be added to the outstanding balance** and will be **turned over to a collection agency** for further processing. All services will be suspended until after 15 days of a non-payment account with balances.

9. I understand there is a **$25 charge for a Non-sufficient Funds** (NSF) check

10. I have read and understand the above Financial Policy and I agree to abide by its terms.

CANCELLATIONS AND MISS APPOINTMENT:
Please reach out to our Scheduling Department at 602-767-5062 in case you want to adjust the scheduled appointments. Our provider/medical staff will only **wait 15 minutes past our start time** if you do not show up.

Print Name (Patient) ____________________ **DOB:** ____________________

Signature (Patient/Guardian/POA) ____________________ **Date:** ____________________

ACTIVE VITAL CARE

REGISTRATION FORM

TREATMENT CONSENT FORM

CONSENT FOR TREATMENT:

I recognize that I need medical services. ***I voluntarily consent to treatment by the medical staff of Active Vital Care, LLC***, as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests. I understand that if major diagnostic studies or treatment procedures (such as surgery) are required, I will be asked to give specific consent for those events.

USE OF MEDICAL INFORMATION AND NOTICE OF PRIVACY PRACTICES:

I understand that, consistent with Arizona state and federal laws, AVC, successors and assigns, (referred to as "Provider" from here on) will share all medical information as necessary for continuation of care and with any other institution or person as permitted by law. As an example, I understand that Provider does not have an in-house laboratory and uses an outsourced medical lab, and my lab work and personal information is shared to accomplish testing as required or requested.

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), ***The provider will keep all of your health information confidential.*** Note that for the purposes of medical treatment (e.g. prescriptions, discussing your case with a consulting physician), payment (e.g. insurance paperwork which shows your diagnosis and corresponding diagnostic codes), health care operations (e.g. self auditing our medical records, quality improvement), and medico-legal considerations (e.g. medical examiners, law enforcement officials, public health authorities), your health information may be obtained or disclosed by telephone, e-mail, mail, or facsimile. The Practice may incorporate the limited summary of my health record it receives through State Health Information Exchange - HealthCurrent into the Practice's own clinical record. From then on the Practice may further disclose such information only in accordance with the rules that apply to it as a covered provider under HIPAA and 42 CFR Part 2.

RELEASE OF INFORMATION:

I authorize the ***release of medical information to my primary care or referring physician***, to consultants if needed and as necessary to process insurance claims, insurance application, and prescriptions. I also authorize payment of medical benefits to Providers. I have read and fully understand to my satisfaction, this entire document consisting of consent to treat and use of medical information. I may be asked to update my signatures and personal information annually or not less than once every three years. I am capable of signing this document on my own.

ATTESTATION:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Active Vital Care, LLC. I understand that **I am financially responsible for any balance**. I also authorize the Provider or insurance company to release any information required to process my claims.

CONSENT FOR PAYMENT:

I hereby authorize payment of medical benefits billed to my insurance to Providers/Physicians; I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any serviced) provided to me that is not covered by my insurance. ***I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Providers/Physicians do not participate with my insurance.*** I hereby authorize Provider physicians to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operation.

MEDICAL AND MEDICATION RECORD RELEASE AUTHORIZATION* (Medical Department)

I hereby authorize the release of my medical records to Provider. The Provider requests only the following pertinent and succinct medical record information to be forwarded from other medical and health care providers: 1. Problem Lists, 2. Vaccination History, 3. Past and Current Medical History, 4. Past Surgical History, 5. Current Medications and Past Pertinent Medications, 6. Social History, 7. Allergic History, 8. Recent Physical Exam, 10. Pertinent and Recent Laboratory and Radiology Tests, 11. Additional pertinent information at the health care provider's discretion.

I understand that while this consent is voluntary, if I refuse to sign, the provider may refuse to treat me. I understand the authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any action that the provider takes before receiving my revocation.

ATTESTATION: I AM ______________________________ responsible for Patient Name: ______________________________ that will be informed of all medical decisions and visits.

PATIENT / Patient's Representative, or Patient's POA if applicable-Consent for Treatment:

Print Name (Patient) ______________________________ **DOB:** ______________________________

Signature (Patient/Guardian/POA) ______________________________ **Date:** ______________________________

NOTE: *We require the patient's legal Power ofAttorney to sign all new patient consent forms prior to treatment. In urgent cases we will attempt to contact the patient's POA by phone and fax documents if necessary; however we must have an original, handwritten signature on file. Please sign this form and return the original to:* ***14820 North Cave Creek Rd. Suite #2 Phoenix, AZ 85032 Or Return By Fax to 602-805-4745***

TELEMEDICINE PROGRAM CONSENT FORM

I, (name of patient or parent/guardian) ____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. **Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. **DECLINE ________ (initials of patient)**

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes**. DECLINE ________ (initials of patient)**

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation. **DECLINE ________ (initials of patient)**

PATIENT / Patient's Representative, or Patient's POA if applicable-Telemed:

Print Name (Patient) ____ **DOB:** ______________________________

Signature (Patient/Guardian/POA) ____________________________________ **Date:** ______________________________

CHRONIC CARE MANAGEMENT (CCM) CONSENT FORM

By signing this Agreement you consent to AVC, successors and assigns, (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a healthcare provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.

When providing CCM Services, the Provider must:

1. Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions. Provide to you a written or electronic copy of your care plan.
2. If you revoke this Agreement, provide us with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

1. You consent to the Provider providing CCM Services to you.
2. You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
3. You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month. You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.

You have the following rights with respect to CCM Services:

The Provider will provide you with a written or electronic copy of your care plan.

You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally by calling 602-767-5062 or in writing to **2375 East Camelback Road, Suite 600, Phoenix AZ 85016.** Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

PATIENT / Patient's Representative, or Patient's POA if applicable-CCM:

Print Name (Patient) ______________________________ **DOB:** ______________________

Signature (Patient/Guardian/POA) ______________________________ **Date:** ______________________

REMOTE PATIENT MONITORING (RPM) CONSENT FORM

Consent for Remote Patient Monitoring Program

I hereby confirm that I am voluntarily seeking medical care and treatment from AVC, through its Remote Patient Monitoring program. I likewise confirm that I give voluntary permission to the medical and health staff of AVC Med to examine me, make diagnoses, and provide treatment (collectively, "healthcare services") to me in accordance with the information, explanations and recommendations they provided me. I further confirm that I freely agreed to avail of the remote patient monitoring (RPM) services of AVC and the use of the device for such service.

Patient Responsibilities Include:

•Provide complete and accurate information about your health, including present condition, past illnesses, hospitalizations, medications, natural products and vitamins, and any other matters that pertain to your health or work injury care plan

• Advising the physician of any pain you may be experiencing or continue to experience during your treatment.

• Actively participating in your treatment process, including but not limited to asking questions when you do not understand explanations about your care or services

• Respecting the rights of other patients and OTC personnel.
• Being responsible for your actions if you refuse treatment or do not follow the provider's instruction
• Provide complete and accurate information including your full name, address, telephone number, date of birth, Social Security number, insurance information and/or payment information, and employer when it is necessary.
• Provide us with a copy of your advance directive if you have one and want it to be part of our medical record.
• Abide by all clinic rules and regulations including NO SMOKING and No WEAPONS on the premises policy.
• Be considerate of the rights and comfort of all patients such as noise levels, privacy, and safety.
• Ask questions of your insurance company or our billing departments if there is a financial issue that you do not understand.

Patients have the following Rights:

• Not to be discriminated against because of race, religion, age, national origin, gender, sexual preferences, disability, marital status, or diagnosis.
• To receive treatment that supports and respects the patient's individuality, choices, strengths and abilities
• To personal privacy in treatment and care for personal needs;
• To have a safe and clean environment during your visit
• To review, upon written request, your own medical record per Arizona Revised Statutes 12-2293, 12-2294 and 12-2294.01.
• To know the name and professional status of caregivers providing services to you,
• To have your complaints reviewed and, when possible, resolved
• To receive a referral to another health care institution or provider if the OTC is unable to provide the health care services you need.
• To participate or to refuse care that involves research, experimental treatments, or educational projects
• To participate or have your representative participate in the development of, or decisions about your treatment.
•To receive assistance from a family member, representative or other individual in understanding, protecting or exercising your rights as a patient.

PATIENT / Patient's Representative, or Patient's POA if applicable-RPM:

Print Name (Patient) ______________________________ **DOB:** ______________________

Signature (Patient/Guardian/POA) ______________________________ **Date:** ______________________

CONSENT FOR BEHAVIORAL HEALTH PROGRAM

Treatment Agreement.

I consent to receive mental health services by Active Vital Care, LLC, including any or a combination of the following: evaluation, individual therapy, group therapy, psychological or neuropsychological testing, and medications. It's important that we develop a mutual treatment plan so that both parties know what we are working on and with whom we are working. Usually our first three sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. If necessary we will refer you to our licensed clinical social workers for additional support, internal neuropsychologists for testing, or psychiatrists for medications.

You are expected to take an active role in therapy, which includes regular feedback to your therapist as to your progress, and also some assignments outside of the therapy hour. These might include journaling, thought and behavior tracking logs, practicing stress reduction techniques, practicing assertive communication skills or attending various support groups. The outside assignments are essential aspects of your treatment and failure to follow through may seriously impair my ability to be helpful to you. We will then have to reassess our treatment plan and decide if I can still be helpful to you. If you believe therapy is not working, please inform your personal psychologist and AVC. We will arrange to give you the service that works best for you. You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or terminate therapy at any time. Nevertheless, we recommend you give a two-week notice for termination.

During the course of treatment, you will either be seeing a psychologist, or a psychology doctoral intern. Please note that all interns are supervised by the supervising psychologist, and you may ask to meet the supervising psychologist should any issues arise.

Since openness is vital to successful therapy, we encourage you to discuss these policies with us, prior to or during your treatment. Whenever you have a concern about any aspect of your treatment, please inform your personal psychotherapist and AVC. When you choose to participate in the Vibrant Living Program, various energy psychology modalities are used and will be explained as provided. It is always your right to refuse a modality. Treatment surveys will be provided for feedback.

Confidentiality.

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When we believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires us to inform that person as well as the legal authorities. If we are ordered by a court to release information as part of a legal involvement.
4. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc. In natural disasters whereby protected records may become exposed.
5. As required by the Patriot Act or when otherwise required by law.

When you registered with AVC, you should have signed a Release of Information so that we may speak with other healthcare professionals (such as your primary care physicians) or to family members to discuss your health.

Record Keeping.

A clinical chart is maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Fees & Payments.

When you registered with **AVC**, you should have read and signed a notice of billing and payments to any of your services offered by **AVC**.

Consultations via Telemedicine.

Sometimes, having a face-to-face visit is not always possible. As such, with enough advance notice, we can and will facilitate a counseling session with you via telemedicine technology, equipped with both video and audio. The charge for this is the same as it would be for a House Call or Clinic visit.

PATIENT / Patient's Representative, or Patient's POA if applicable-Behavioral Health Consent:

Print Name (Patient) ____________________ **DOB:** ____________________

Signature (Patient/Guardian/POA) ____________________ **Date:** ____________________

CONSENT FOR PAIN MANAGEMENT

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in AVC not providing ongoing care for me.

I, (Print Name/Date of Birth) ____, agree to undergo pain management treatment provided by a provider of AC.

My diagnosis is____

I agree to the following statements and Plan of Care:

- I will not accept any narcotic prescriptions from another doctor.
- **I understand that medications will not be refilled early.** I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications, thus, I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.
- **I agree that medications must be taken as prescribed at the correct dosage and frequency. Not adhering to medication instructions and requesting medications early is a breach of the narcotic contract.**
- I agree that refills of my prescription for pain will only be made at the time of my visit. No routine refills will be made available during the evening, after 4 pm, on weekends, holidays, or through the emergency room.
- Medications will not be mailed or refilled without me being seen monthly, thus, I will keep my scheduled appointments with AVC unless I give notice of cancellation 24 hours in advance.
- I will attend all appointments, treatments and consultations as requested by my provider. I will attend all appointments and follow pain management recommendations.
- I understand that failure to keep appointments may lead to discontinuation of treatment.
- I understand that I must keep my medications in a safe place.
- I understand that AVC may not supply additional refills for the prescriptions of medications that I have lost. If my medications are stolen, AVC will refill the prescription **one time only** if a copy of the police report of the theft is submitted to AVC.
- I will only use one pharmacy listed here: ___________________________
- If I change my pharmacy I will notify AVC immediately.
- I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by a AVC provider, however, I agree I will not abuse alcohol.
- I understand the goals of treatment are not to completely eliminate pain but to control my pain in order **to improve my quality of life and ability to function**. Chronic Opioid therapy is only ONE part of my overall pain management plan.
- The risk and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgements and affect reflexes and motor skills. I will not participate in activities that would endanger myself or others while using these medications
- **I agree I will not share, sell or trade my medication with anyone. State and federal law prohibit sharing, selling, or trading medication. If my provider becomes aware that I am illegally misusing or selling my medication, I understand that AVC will fully cooperate with legal authorities in any official investigations that may occur.**
- I authorize AVC to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- **I understand that narcotic medications with long term use will cause some level of dependence on the medication. AVC is not in any way responsible for causing this dependence, this is a side effect of any and all narcotic medications.**
- **If it appears that I am becoming addicted to medication, my provider has the right and obligation to explain the concerns of addiction to me, and begin to taper the medication to keep me safe. I understand that my safety and well-being is the primary concern to AVC providers.**
- If it appears to the clinician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medications as directed by the prescribing physician.
- I understand that if **I am verbally or physically abusive to any staff member** or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police department, Drug Enforcement Agency, etc. As deemed appropriate for the situation.
- I will consent to urine/blood/saliva toxicology testing as determined by AVC to ensure that I am compliant with my treatment and this contract.
- I will not break the urine cup or saliva seal once performed.

- I understand that if I violate any of the above conditions, my provider may choose to stop writing opioids prescriptions for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.

Documentation:

Original Copy of this Agreement to be given to the patient or Power of Attorney.

Electronically scanned/photocopy of Pain Management Agreement to be scanned into the patient's chart under the **"Consent"** folder.

Medication Refill Information:

1. Advance notice of 5-7 business days is required for all refills of the prescriptions
2. Requests for scheduled refills must be telephoned to the pharmacy only during regular office hours Monday-Friday (7:30 am – 4::30 pm). Refills will not be made at night, on holidays, or on weekends.
3. NO controlled substances will be telephoned into the pharmacy.
4. I will be given a (30) thirty day supply each month.
5. All hard copies of the opioids prescriptions must be hand delivered to the pharmacy by myself.

I understand that AVC believes in the following **"Pain Patients' Bill of Rights**.":
You have the right to:

- Have your pain treated as safely as medically possible.
- **Know and understand all reasons why any medications may be stopped or tapered**
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Include your family in decision-making
- Refuse treatment without prejudice from your physician. .

My treatment plan may change based on the outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.

My AVC treatment plan includes:

Medications ______________________________

Physical therapy/exercise ______________________________

Relaxation techniques______________________________

Psychological counseling ______________________________

By Signing below, I agree to enter into a contract with AVC to manage my Pain and agree that I will abide by the terms of this contract or I shall be discharged from the practice.

PATIENT / Patient's Representative, or Patient's POA if applicable-Pain Management:

Print Name (Patient) ______________________________ **DOB:** ____________________

Signature (Patient/Guardian/POA) ______________________________ **Date:** ____________________

Provider Name: ____________________ Provider Signature: ____________________ Date: ______________