Alexander Valley Healthcare
Feel Good... We Have You Covered

Staff Initials: _____

PATIENT NAME: _____ DOB: _____ DATE: _____

PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Alexander Valley Healthcare. These may include but are not limited to: triage treatment or services, laboratory procedures, medical or surgical treatment or procedures, or anesthesia provided to me under the general and special instructions of my providers.

FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorize my insurance benefits be paid directly to Alexander Valley Healthcare. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically co-payments and charges for services not covered by my insurance.

COPAYMENT POLICY: If applicable, at the time of check-in, I will be required to pay a co-payment. If I do not pay my co-payment, I understand that my visit may be cancelled.

INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

REFERRALS/AUTHORIZATION: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7 - 10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without a prior authorization from my provider, or I elect to use a Point of Service option, or fail to notify Alexander Valley Healthcare if my insurance plan requires specific outside vendors such as laboratories to perform referred services, I may be financially responsible for the services rendered and insurance may not cover the relevant services.

ANCILLARY SERVICES: I understand that depending on my insurance, I may receive a separate bill for laboratory, or other ancillary services.

RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to provide health care, to process my medical claims, and for other purposes relating to the health care operations. Additional information provided in our Notice of Privacy Practices.

FEES FOR PATIENT'S HEALTH INFORMATION: I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

FEES FOR FORMS: I understand if I request to have any forms completed by my provider that are not directly related to patient care I may be required to pay a fee. Examples of those forms include but are not limited to jury duty excuse, Family Leave Act applications, accident reports, etc. There may be other forms with associated fees.

ON TIME ARRIVAL POLICY: I understand that I must arrive at least 15 minutes before the time of my appointment in order to register and complete information prior to the time my provider is scheduled to see me. If I arrive late for my scheduled appointment I understand that it may be necessary to reschedule my appointment. My provider(s) attempt to maintain an “on-time” schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my provider to be late for my appointment.

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NO SHOW POLICY: I understand that if I miss appointments with my provider I may not be able to schedule appointments and will be on a same day appointment only list.

MEDICATION REFILLS: I understand that refills may take 24-48 hours to complete and that the most efficient way to get a refill is to contact my pharmacy directly. In order to ensure timely medication refills, I agree to notify my provider's office regarding my preferred pharmacy.

PATIENT PHOTOGRAPH: I understand that Alexander Valley Healthcare is deeply committed to my safety and identity protection. I agree to have my picture taken at check-in for inclusion in my medical record. I understand that my photograph will be used to protect me from identity theft, to ensure patient safety and to further personalize the services I will receive. My picture helps to confirm that all members at Alexander Valley Healthcare are accessing the correct medical record.

PATIENT INITIALS: _____

ABOUT OUR NOTICE OF PRIVACY PRACTICES

At Alexander Valley Healthcare we are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy States:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACYPRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practice

PATIENT INITIALS: _____

I certify that I have read and fully understand the above. Anything that I did not understand was explained to me. I have no additional questions.

Signature: _____ Date: _____

If a minor, signature, name and date of parent/ guardian:

Signature: _____ Date: _____

Name: _____