VALLEYCARE, LLC

Jessica L. Brim, AGNP

610 S Market St
Salem, VA 24153
Phone: (540) 404-9637
Fax: (540) 404-4146

Welcome to ValleyCare, LLC!

Enclosed is your new patient packet. Please fill out and sign (where indicated) each page. You may mail them to our office prior to your scheduled appointment (as time permits) or bring them with you when you come to our office for your first appointment.

Your first visit will be considered a New Patient-Get Established visit or a New Patient-Problem visit (you are having a pressing/ acute issue you would like for us to address at your first visit). Please see the enclosed handout that states what a New Patient visit entails. Please note that a Wellness Examination will be reserved for your second visit, or when you are due for one based on when your last Wellness Examination was done at your previous provider's office.

Please bring your current insurance card(s), your photo id, and any current medications you are taking with you, to this appointment (bottles are preferred, but a list with names, strengths and directions for use will be fine as well). We ask that you arrive five to ten minutes prior to your appointment time so that we may have time to add the completed information to your account before the provider sees you.

We are located on Market Street across from the school bus lot which is beside GW Carver Elementary School.

If you have any questions prior to your appointment, please do not hesitate to call our office at 540-404-9637.

We look forward to seeing you!

Thank you!

What is New Patient Exam: Overview, Benefits, and Expected Results

Definition and Overview

A new patient exam refers to where a patient undergoes an exam during his first visit to a doctor. It is beneficial for any new patient with health concerns. The purpose of this visit is to address any health problem or determine the causes of symptoms that the patient is experiencing. The exam involves an in-depth check of the patient's medical history, comprehensive exams on specific parts of the body where the symptoms originate from, as well as x-rays and other imaging scans. This exam can help detect any diseases that the patient may have.

Who Should Undergo and Expected Results

A new patient exam is an important step for any patient who is experiencing unexplained symptoms or suffering from undiagnosed health problems, if these are not urgent or life- threatening. The exam is performed by any medical professional, such as a general practitioner, a family doctor, an internist, or even a dentist.

For urgent concerns, the patients first visit should be directly to the emergency room, which is staffed by medical professionals who are trained to handle life-threatening conditions.

The goals of this visit are:

- To assess the patient's current health status
- To detect and diagnose any existing health problems
- To address any symptoms that causes some trouble for the patient
- To develop a treatment plan, if necessary
  The treatment plan will explain the findings of the exam in complete detail, including the doctor's treatment recommendations and the potential consequences of not seeking treatment.

How Does the Procedure Work?

Medical Exam

To achieve the goals of a new patient exam, the visit is consists of:

- Comprehensive review of medical history

- Height and weight measurement
- Blood pressure reading
- Cholesterol and glucose level testing
- Physical examination of the eyes, ears, neck area (for throat and lymph nodes), chest area (for the heart and lungs), and abdominal organs
- Blood work and lab tests (some doctors may be able to perform these tests on their own and in the same clinic, but some may ask the patient to go to a separate laboratory with a request slip)
- X-rays
- Other imaging scans
- Special screenings, such as cardiac or cancer screening, possibly upon the patient's request or based on the doctor's opinion especially when the patient is at risk of certain diseases Depending on their age, symptoms, and risk factors, male patients may require a number of special tests, such as:

- Testicular exam (Labs) for testicular cancer

VALLEYCARE, LLC.

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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (I) treatment, (II) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to

determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because

you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in

writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States

Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions: Phone number: 540-404-9637

Effective Date

The effective date of this revised Notice of Privacy Practices is June 1, 2021.

PATIENT RESPONSIBILITY AGREEMENT

I hereby give permission to ValleyCare, LLC,to examine, diagnose and treat me medically. I accept full responsibility forany charges rendered to me. Payment is due for services when rendered unless other arrangements have been made in advance in writing. I understand that I am responsible for all deductibles, co-payments, and non-covered services that are not reimbursed by my insurance policy.
Cancellations and re-scheduled appointments must be made 24 hours in advance of being charged. Insurance cannot be billed for missed appointments. The broken appointment fee is $50.00. If a patient needs to be seen outside of normal business hours there will be a cash charge of $45.00 for telephone consult. These fees will be collected the next business day via the phone.

I hereby authorize ValleyCare, LLC to release any information regarding services and allow a photocopy or scannedcopy of my signature to be used to file insurance. I also authorize payment of medical benefits to ValleyCare, LLC. I understand that ValleyCare, LLC will file my primary insurance for me, but I am responsible for staying in contact with my insurance company to see that it makes payment in a timely manner. I understand that ValleyCare, LLC will file my secondary insurance as a courtesy to me; however, I will be responsible for any balance that my secondary insurance does not pay. I have notified ValleyCare, LLC of all current existing health care insurance policies in the **correct** order. I take responsibility upon myself to file any other insurance claims with any company that I have not listed previously. In the event that my insurance company pays none or only a portion of ValleyCare LLC's bill, I will be responsible for the remaining balance. Any balances that are unpaid after 90 days from the date of service will be considered delinquent. At that time there will be a 6% interest added to the total balance every month after 90 days. The responsible party will be liable for all costs of collection including attorney fees equal to 33.3% of the unpaid balance. At that time, your account may be reported to a consumer credit reporting agency. If patient has went past 90 days on due balances, the patients account will be closed and will not be able to be seen until balance is paid in full.

*Bounced Check Fee:$35
*Disability/FMLA, misc Forms: $25

*Copay is collected at beginning of appt

Patient Signature:
Patient Name:
Date:

VALLEYCARE, LLC

610 S MARKET STREET SALEM VA 24153 540-404-9637

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND PHOTO IDENTIFICATION

PATIENT INFORMATION SHEET

ACCOUNT#	SSN	LAST NAME	FIRST NAME	MIDDLE NAME

MAILING ADDRESS	EMAIL:

CITY	STATE	ZIP CODE

HOME PHONE	CELLPHONE	DATE OF BIRTH	GENDER

MARITAL STATUS	EMPLOYMENT	STUDENT	RELATIONSHIP TO INSURED
_MARRIED _WIDOWED _SINGLE _DIVORCED _SEPARATED	_RETIRED _FULL TIME _PART TIME _UNEMPLOYED	_FULLTIME _PARTTIME _NOT A STUDENT	_SELF _SPOUSE _CHILD _OTHER

EMPLOYER/ SCHOOL NAME

STREET ADDRESS

CITY	STATE	ZIP CODE	BUSINESS PHONE

HEALTH INSURANCE SUBSCRIBER INFORMATION IF OTHER THAN PATIENT

DATE OF BIRTH	SSN	LAST NAME	FIRST NAME	MIDDLE NAME

HOW DID YOU HEAR ABOUT OUR OFFICE?

_FRIEND /RELATIVE _NEWSPAPER _HOSPITAL

ANOTHER MD/PROVIDER OTHER

DOYOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

_LIVING WILL _MEDICAL DIRECTIVE _POWER OFATTORNEY

PLEASE PROVIDE A COPY OF THE CHECKED DOCUMENTS FOR YOUR MEDICAL RECORD

ANY NUMBERS PROVIDED ON THIS FORM WILL BE USED TO COMMUNICATE WITH YOU. IF YOU HAVE AN ANSWERING MACHINE, VOICE MAIL, ETC., WE WILL LEAVE APPROPRIATE MESSAGES IN ORDER TO COMMUNICATE WITH YOU. IF YOU DO NOT WISH TO HAVE THESE NUMBERS UTILIZED AS LISTED ABOVE, PLEASE DO NOT PROVIDE ANY PHONE NUMBERS ON THIS FORM. IN THIS CASE, YOU WILL BE RESPONSIBLE FOR COMMUNICATING WITH OUR OFFICE REGARDING TEST RESULTS, APPOINTMENTS OR ANY OTHER PATIENT CARE MATTERS. OUR CORRESPONDENCE WITH YOU WILL BE BY OFFICE VISIT OR MAIL ONLY.

IF YOU HAVE CHOSEN NOT TO PROVIDE PHONE NUMBERS TO OUR OFFICE AND YOU DO CALL OUR OFFICE FOR ANY REASON, YOU WILL BE RESPONSIBLE FOR PROVIDING A CONTACT NUMBER FOR THAT SPECIFIC RETURN CALL. YOU MUST BE AVAILABLE TO RECEIVED THE RETURN CALL AT THE NUMBER YOU PROVIDE. THE NUMBER WILL NOT BE RETAINED FOR FUTURE CALLS.

IF ANY OF THE NUMBERS YOU HAVE PROVIDED ARE CELL PHONE NUMBERS, PLEASE BE AWARE THESE NUMBERS ARE NOT SECURE LINES AND YOUR MEDICAL INFORMATION MAY NOT BE PROTECTED.

REMEMBER, OUR RELATIONSHIP IS WITH YOU, THE PATIENT. CORRESPONDENCE WITH OTHER PERSONS WILL ONLY OCCUR AT YOUR REQUEST, AND/OR IN COMPLIANCE WITH FEDERAL AND STATE GUIDELINES.

PLEASE READ THE PRIVACY POLICY PROVIDED TO YOU BY OUR PRATICE. LIST ANY OTHER AUTHORIZED PERSON(S) ON OUR AUTHORIZATION FORM.

THE PERSON(S) NOTED ON YOUR HIPAA FORM WILL BE USED FOR NOTIFICATION IN CASE OF AN EMERGENCY.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE: _____

ValleyCare, LLC.
610 S Market Street
Salem, VA 24153
540-404-9637

TO OUR PATIENTS: **PORTAL INFORMATION** **CODE:**

PT NAME/ACCT#:_ _____

Effective June 30, 2021, our office will be sending our patients an invitation to register for our practice's web Portal. The information will come through your EMAIL. We will be asking patients who would like to utilize this feature to give the front desk, EMAIL address when checking out at the front desk following their doctor appointment.

The PORTAL is a secure site that allows the patient to review certain information that is maintained in their Electronic Medical Record. The patient will create a User Name and Password during the registration process.

When receiving the invitation, you will be prompted with the steps needed to complete your registration. There is a short video to view which explains how the PORTAL can be used.

Certain documents can be printed from your medical record, such as: lab results, radiology results, demographic information, etc. These documents can be given to other doctors/facilities that might need your information. Review your files to determine if personal information is current. Current medications can be viewed along with allergies, etc. Notices of upcoming appointments with your doctor will be provided through the Portal. LAB, SKIN CARE AND BONE DENSITY APPOINTMENTS WILL NOT BE PROVIDED THROUGH THE PORTAL. PLEASE REFER TO YOUR APPOINTMENT CARDS FOR THESE TYPES OF APPOINTMENTS.

The patient will also be able to send our office messages through PORTAL. Office staff will respond to those messages within 24 hours, Monday through Friday. Weekend and Holiday messages WILL NOT be reviewed until the following. business day.

REMINDER: if a medication needs to be refilled, please call our office, since we do not normally refill medications outside of an office visit. Please call your pharmacy for medication refills. Please allow 72 hours for regular medication refills.If an emergency appointment is needed, or you want a same day appointment, call the office as a response to your message may take up to 24 hours.

When the office is closed, our office answering service will continue to function as always.

When reviewing your medical record, if you believe there is a discrepancy, please discuss at the time of your next office visit.

THANKYOU!

VALLEYCARE, LLC

VALLEYCARE, LLC

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Info). I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.
2. Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

NAME	RELATIONSHIP, IF ANY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.
4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Office to any office where I am treated by Provider.
5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.
6. Redisclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.
7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

If a Representative Signs, state the Representative's Authority:

_____

Acknowledgement of Recipient of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

Patient Signature
Or Personal Representative

Date

VALLEYCARE, LLC

PATIENT NAME: (LAST, FIRST, MI)_____

SSN:_____ ACCT#:_____DATE:_____

I. NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING:

Should an employee be exposed to my blood/body fluid *in* a way that might allow transmission due to blood borne disease (i.e. HIV, Hepatitis B, etc.) or other communicable diseases, then I understand that ACCORDING TO VA STATE LAW, for the safety, health and possible treatment of the employees, samples of my blood or body fluid may be tested for evidence of infection.

I also understand that VALLEYCARE, LLC employees and their physiciansare obligated to submit to blood tests for certain infectious diseases, as listed above, if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the office or hospital.

II. LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE PATIENTS AND RELEASE AUTHORIZATION FOR PRIVATE INSURANCE AND/OR PHYSICIAN REFERRALS:

_____ _____

PATIENT NAME (LAST, FIRST, MI) MEDICARE ID # IF APPLICABLE

"I request at payment of authorized Medicare benefits and any other carrier be made either to me or, on my behalf, to VALLEYCARE, LLC, for services furnished me by the physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and any other carrier and its agents any information needed to determine these benefits payable for related services.))

_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

III. RELEASE OF MEDICAL INFORMATION OR RELATED DATA:

"I hereby authorize VALLEYCARE, LLC to release or release from any physician/provider, his/her office, or any other medical facility, information necessary for referral purposes."This authorization shall remain in until written notice is given from the patient or patient representative.

IV. GENERAL CONSENT FOR TREATMENT

"I hereby authorize the physician(s) of VALLEYCARE, LLC, and his/her staff to perform medical treatment, and do consent to such treatment that he/ she feels necessary, includingdiagnostic procedures, medical examinations, and treatment as may, in his/her opinion, be medically necessary, I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment or examination."

V. I do understand I am responsible for payment of any outstanding balance; including non-covered services, deductibles, co-pays, etc. Also, I agree to abide by the Office and Billing Policies for VALLEYCARE, LLC.

VI. I acknowledge receipt of the practice's Privacy Policy and Procedures.

I HEREBY ACKNOWLEDGE THAT I HAVE READ OR BEEN EXPLAINED SECTIONS I THROUGH VI LISTED ABOVE AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

_____ _____

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE SIGNATURE OF VC,LLC EMPLOYEE WITNESS

VALLEYCARE, LLC

Jessica L. Brim, AGNP

610 S Market Street
Salem, VA 24153
Phone: 540-404-9637
Fax: (540) 404-4146

Authorization to Release Medical Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Iuformation to be Requested By:
Name:

Address: _____

Information to be Released to:
Name: _____

Address: _____

Purpose of Release:

Transfer of Care

Doctor's Request

Referral to Specialist

Other: _____

Information Release

Clinical

Progress Notes Laboratory
Reports
Radiology Reports (X-Ray, CT, US, etc.)
EKG/Cardiac Testing Reports
Hospitalizations
Other: _____

I understand that the information released may include records of drug abuse, alcohol abuse, psychological or psychiatric impairments,HIV and/or AIDS or other physical conditions. If this type of information has been disclosed, it has been done so from records protected by Federal confidentiality rules (45 CPR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further information is expressly permitted by 42 CPR Part 2. A general authorization for the release of medical or hereto information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy may be accepted by the health care facility in lieu of the original.

I understand I may revoke this authorization at any time by notifying Jessica Brim, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from date of signature.

Signature of Patient _____ Date _____

Signature of Authorized Representative | Relationship to Patient | Date

ValleyCare, LLC

New Patient Medical History

Name:_____ Date of Birth:____ _

Today's date:_____

Reason for today's visit:

_____

Medication Allergies Name	Reaction Experienced

Surgical History- check all that apply

- o Gallbladder
- o Hysterectomy-circle: partial or total
- o Appendectomy
- o Heart Bypass (CABG)
- o Heart Valve
- o Carotid artery
- o Vein stripping
- o C-Section
- o Carpal tunnel
- o Other:._____
- o D & C (dilatation & curettage)
- o Cataract
- o Total hip replacement
- o Total knee replacement
- o Arthroscopic knee surgery
- o Shoulder surgery
- o Carpal Tunnel
- o Prostate Surgery
- o Breast surgery
- o Vascular surgery on legs

Current Medications: include over the counter vitamins and supplements, eye drops, birth control

Medication Name	Dose	Frequency taken

Immunizations

Flu vaccine	Date:
Pneumonia (Pneumococcal 23)	Dc;1te:
Pneumonia (Prevnar 13)	Date:
Shingles (Shingrix)	First dose: -Second dose:
Shingles (Zostavax)	Date:
Tetanus	Date
Hepatitis	First: Second: Third:
Other (PPD, COVID, ETC:	Date:

Screening Tests

Colonoscopy	Date:
Mammogram	Date:
Dental Exam:	
Eye Exam:	

Prostate cancer screening test (PSA)	Date:
Bone Density	Date
Pap smear	Date:
Last complete physical/annual exam	Date:

Social History-Check all that apply

- o Cigarette smoking # per day:.___ #years:___ year quit:___
- o Smokeless tobacco # per day:___ #years: ___ year quit:___

- o Alcohol #perday:___ type:_____#years:____

o Other drug use history that may be important for your provider to know:

_____

Medical History- Check all that apply

- o Heart attack
- o Heart failure
- o Heart valve disease
- o Diabetes
- o Thyroid disease
- o Rheumatoid arthritis
- o Osteoarthritis
- o Kidney disease
- o Liver disease/jaundice
- o Irritable bowel disease
- o Depression
- o Anxiety
- o Bipolar disorder
- o Schizophrenia
- o Asthma
- o Emphysema (COPD)
- o Chronic bronchitis
- o Allergies
- o Sinus disease

- o Cancer Type:___ _

- o Chronic pain
  Location:- _ _ _ _ _ _ _ _
- o Substance Abuse
- o Osteoporosis
- o Colon polyps
- o Migraines
- o Seizures
- o Parkinson Disease
- o Alzheimer Disease
- o Multiple Sclerosis
- o Tremors

- o Please note any family history:

_____

_____