VALLEYCARE, LLC

Jessica L. Brim, AGNP

Salem, VA 24153
Phone: (540) 243-1417

Email:Valleycaremed@gmail.com

Welcome to ValleyCare, I.LC!

Enclosed is your new patient packet. Please fill-out and sign (where indicated) each page. You may email the forms back prior to your scheduled appointment. Please include your current drivers license

Once your documents have been received and your medical chart has been created, you will receive an appointment. We arc a remote medical service provider; delivering weight-loss shots, vitamin injections, performing IV nutritional hydration, performing, and on-site DOT physicals. Medical cannabis certificates/recertification's are all telehealth along with telehealth for medical consultations; for anyone looking for further or more detailed medical advice.

Concerning payment for services or product we do not accept HSA payments. All weight loss patients are required to send requested lab results before initiating weight loss injections and will be required to send within the year lab results based upon the patients needs regarding the services you are receiving. At the beginning of every year the patient will be required to sign an updated consent form if you are receiving weight loss injections.

If you have any questions prior to your appointment, please do not hesitate to call our office at 540-243-1417.

We look forward to providing the best care possible for you and your family!

VALLEYCARE,LLC-Remote/Telehealth Services

INFORMATION SHEET

Account #:	SSN	Last Name:	First Name:	Middle

Mailing Address:	Email:

City	State:	Zip Code:

Home Phone:	Cell Phone:	Date of Birth:	Gender:

Marital Status:	Employment:		

Employer/ School/College Name:

Address:

City:	State:	Zip Code:	Business Phone:

Name of person filing out form if not the patient & Relationship to patient:

Signature: 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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

☐ **Please mail records.**
☐ **Please fax records.**

Fax: _____ **Phone:** _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

PATIENT RESPONSIBILITY AGREEMENT

I hereby give permission to ValleyCare,LLC to examine, diagnose and treat me medically. I accept full responsibility for any 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 charges.

Cancellations and rescheduled appointments must be made by the patient 24 hours in advance. A broken appointment fee is $50.00. A payment link will be sent to the email on file prior to the appointment for processing of payment.

The responsible party will be liable for all cost of collection including attorney fees (if warranted) equal to 33.3% of the unpaid balance. There is also a 6% percent interest added to the total balance every month after 90 days of unpaid balances. At that time, your account may be reported to a consumer credit reporting agency. At that time, the patient account will be closed and no further appointments will be made until the balance is paid in full.

By signing below I am consenting to all information that is apart of the New Patient Packet.

*Bounced Check Fee:$35

Patient Signature:
Patient Name:
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:____

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/ Medullary Thyroid Cancer
- o Rheumatoid arthritis
- o Osteoarthritis
- o Kidney disease
- o Liver disease/jaundice
- o Irritable bowel disease
- o Depression
- o Anxiety
- o Schizophrenia
- o Bipolar disorder
- 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: Please note if family history of Medullary Thyroid Cancer

Valley Care LLC

Notice of Privacy Practices

This notice describes how protected health.

Information about you may be used and Disclosed and how you can get access to This information.

Please review it carefully and sign the final page

Thank you,

Jessica Brim, NP

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information
This Notice of Privacy Practices will tell you the ways in which VDH will use and disclose protected health information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of protected health information.

For Treatment:
We may use protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, or other healthcare personnel who are involved in your treatment. For example, a clinician treating you for an infection may need to know if you have another condition that could affect your treatment plan and recovery. Different departments of VDH also may share protected health information about you in order to coordinate the different things you need, such as authorization review. We also may disclose protected health information about you to people outside the department who may be involved with your overall health care.

For Payment:
We may use and disclose protected health information about you so that the treatment and services you receive at a local health department may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may use your protected health information from a procedure you received at the clinic so that the department can be reimbursed. We may also use your information to obtain prior approval for a treatment you may receive or to determine whether some other third party will cover the treatment.

For Health Care Operations:
We may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to make sure all patients receive quality care. For example, we may use protected health information to review your treatment and services and to evaluate the performance of the staff caring for you. We may also combine protected health information about many patients to decide what additional services should be covered, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other department personnel for review and learning purposes.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization:

Required By Law:
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Emergencies:
We may use or disclose your protected health information in an **emergency** case or situation where it is impractical to obtain your written authorization. If this happens your physician shall try to obtain

your **oral** authorization for a health care provider or health plan to discuss your health records with a third party specified by you.

Public Health:
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases:
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight:
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect:
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration:
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, biologic product deviations, product defects or problems; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required by law.

Legal Proceedings:
We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, search warrant, discovery request or other lawful process.

Law Enforcement:
We may also disclose protected health information, so long as applicable federal and state legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and purposes otherwise required by law, (2) limited information requests for identification and location purposes, (3) evidence of a crime committed on our premises, and (4) suspicion that death has occurred as a result of criminal conduct.

Criminal Activity:
Consistent with applicable federal and state laws, we may disclose your protected health information if you have communicated to your provider a specific and immediate threat to cause serious bodily injury or death to an identifiable person or persons, and your provider believes you have the intent and ability to carry out that threat imminently.

Coroners, Funeral Directors, and Organ Donation:
We may disclose protected health information to a coroner or medical examiner for identification purposes, cause of death determinations or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law, in order to carry out funeral-related duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research:
We may disclose your protected health information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

Military Activity and National Security:
We may use or disclose protected health information as required or authorized by law of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of the foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation:
We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs that provides benefits for work-related injuries or illnesses.

Inmates:
We may disclose your protected health information to a correctional institution or in other law enforcement custodial situations if it is necessary for your care, or if the disclosure is required by state or federal law.

Immunization Registry:
We may disclose your immunization history with the Virginia Immunization Information System to help prevent you from receiving unnecessary vaccinations. The Virginia Immunization Information System may disclosure child immunization proof to schools.

Business Associates:
Some of our services are provided through contracts or agreement with other public and private entities and some of these contracts or agreements requires that health information be disclosed to the contractor. These contractors are known as "business associates." Examples include physician consultants, laboratories, dentists and lawyers from the Office of the Attorney General. We may disclose your health information to these people so they can perform the job we have asked them to do.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Someone Authorized to Make Decisions on Your Behalf:
We may disclose information to those authorized to make decisions on your behalf, such as a power of attorney or a guardian.

2. OTHER USES OF PROTECTED HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. Your health information will not be used and disclosed for marketing purposes or sale without your *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. Also, we are required to retain our records of the care we provided to you.

3. YOUR RIGHTS

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy:
You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes.

To inspect and copy your protected health information, you must submit your request in writing to the Health Department or to the HIPAA Privacy Officer at the **address on the top of this Notice**. If you request a copy of information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information; you may request the denial be reviewed. For more information call **(804) 864-7661.**

Right to Amend:
If you feel that protected health information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for VDH. To request an amendment, your request must be made in writing and submitted to the Richmond City Health District, 400 E. Cary Street Richmond Virginia 23219 (804) 205-3917. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for VDH;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures:
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you. The accounting will not include disclosures: (1) for purposes of treatment, payment, or health care operations; (2) made to you; (3) made pursuant to your authorization; (4) made to friends of family in your presence or because of an emergency or disaster; (5) for national security or intelligence purposes; (6) to correctional institutions or law enforcement; (7) as part of a limited data set; or (8) incident to otherwise permissible disclosures. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically).

Right to Request Restrictions:
You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. **We are required to agree to your request** if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you must make your request in writing to the Richmond City Health District 400 E. Cary Street, Richmond, Virginia 23219. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications:
You have the right to request that we communicate with you about protected health matters in a certain way or at a certain location. VDH reminds you of upcoming appointments and missed appointments. You can ask that we do not contact you that we send this correspondence to an address other than your home, or you can ask that we only contact you by phone.

To request confidential communications, you must make your request in writing to the Richmond City Health District. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach:
You have the right to be notified in the event that we (or a Business Associate of ours) discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, call **(804) 864-7661** during regular working hours.

4. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Virginia Department of Health, Privacy Officer, 109 Governor Street, Suite 452A, Richmond, VA 23219 or with the Secretary of the U.S. Department of Health and Human Services, Regional Manager, Office for Civil Rights, 150 S. Independence Mall West, Suite 372, Philadelphia, PA 19106-3499.

To file a complaint with VDH, you may contact our Privacy Officer at (804) 864-7661 Monday through Friday from 8:30 AM. to 4:30 PM, except State holidays or by email to kim.barnes@vdh.virginia.gov. *You will not be penalized for filing a complaint.*

This notice was published and becomes effective on September 23, 2013

Print _____ Date _____

Sign _____ Date _____

COMMONWEALTH of VIRGINIA
Virginia Department of Health

Cynthia C. Romero, M.D., F.A.A.F.P.
STATE HEALTH COMMISSIONER

Notice of Privacy Practices

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact:
VDH Privacy Officer at (804) 864-7661
109 Governor Street, Suite 452A
Richmond, VA 23219

It is the policy of the Virginia Department of Health (VDH), Commonwealth of Virginia, to provide you with a privacy notice that explains how your healthcare information is being used or disclosed. VDH is required by law to maintain the privacy of your protected health information and provide a notice of its legal duties and privacy practices with respect to protected health information.

This Notice of Privacy Practices describes how VDH may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by state or federal law. It also describes your rights to access and control your protected health information. "Protected health information" is information related to your past, present or future physical or mental health or condition and related health care services, including demographics that may identify you.

VDH is required to abide by the terms of this Notice of Privacy Practices currently in effect. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time and will be posted at the VDH office. Upon your request, we will provide you with a revised Notice of Privacy Practices. You may request a revised Notice of Privacy Practices by calling VDH at **(804) 864-7661** and requesting that a revised copy be sent to you in the mail. We retain prior versions of the Notice of Privacy Practices for six (6) years from the revision date.