Dysautonomia-MVP Center
2470 Rocky Ridge Road, Ste 200
Birmingham, AL 35243

NEW PATIENT INSTRUCTIONS

On the day of your first appointment, plan to be at the Dysautonomia-MVP Center for 2 to 4 hrs. for education, testing, and evaluation. Your follow-up visits will not take as long. To make your first visit run as smoothly as possible, read the following carefully:

1. **COMPLETE AND BRING** all enclosed forms with you.

2. **COMPLETE AND BRING** the medical questionnaire (enclosed) with you.

3. Bring your insurance card with you. **WE CANNOT SEE YOU WITHOUT IT.**

4. Bring your driver's license or picture I.D.

5. ***FAILURE TO CANCEL A NEW PATIENT APPOINTMENT WITHOUT A MINIMUM OF 24 HOURS NOTICE OR ONE BUSINESS DAY MAY RESULT IN A $100.00 ADMINISTRATIVE FEE.***

6. It is preferable that a parent or guardian accompany patients under the age of 16.

7. **If you had a cardiac stress test, echocardiogram, EKG, or lab tests within the previous 12 months, complete and sign the RELEASE OF INFORMATION FORM. Submit this form to your physician to obtain a copy of these tests. Your physician may mail or fax the results to us, or you may bring them to the center yourself.**

8. **If your insurance requires a referral from your primary care physician, YOU MUST OBTAIN IT BEFORE YOUR VISIT. THIS IS NOT THE RESPONSIBILITY OF THE CENTER. WE CANNOT SEE YOU WITHOUT YOUR REFERRAL. PLEASE CONFIRM THAT WE HAVE THE REFERRAL 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT BY CALLING THE CENTER.**

9. If your insurance requires a CO-PAY, be prepared to pay by cash, check, or credit card (Visa, Mastercard) at the time of this and all visits.

10. Please understand that our physician is only treating you for Mitral Valve Prolapse or Dysautonomia. **PLEASE HAVE A PRIMARY CARE PHYSICIAN FOR ALL OTHER HEALTH PROBLEMS.** We will be glad to send him/her a report of your evaluation.

11. Only the patient is allowed in the testing area. Please provide supervision for your children.

We look forward to seeing you. Please call us if you have any further questions. (205) 286-3200 / (205) 286-3201 Fax.

VISIT OUR WEBSITE AT WWW/MVPCTR.COM

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2470 Rocky Ridge Road, Ste 200
Birmingham, AL 35243
staff@mvpctr.com

☐ Paula D. Moore, M.D.
☐ Susan J. Phillips, M.D.
☐ _____, M.D.

Date: ____/____/____
Age: _____

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

Sex: _____ Race: _____ Marital Status: _____ Birthdate: _____

Retired _____ if yes, date retired _____ Employed _____ Full time student _____ Part time student _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____

Person responsible for account: _____ Relationship _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____ State: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Person to notify in case of emergency: _____ Phone: _____
(Outside Your Home) (Other Than Your Number)

Relatives or friends that are patients: _____

Drug Allergies: _____

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____

Policy holder's name: _____ Birthdate: _____

Employer: _____

Contract Number: _____ Group Number: _____

Relationship of patient to policy holder _____

Insurance Company (Secondary) _____

Policy holder's name: _____ Birthdate: _____

Employer: _____

Contract Number: _____ Group Number: _____

Relationship of patient to policy holder: _____

Referring M.D. and address: _____

PRIMARY MD / ADDRESS: _____

CONSENT FOR TREATMENT — I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION — I authorize Dysautonomia-MVP Center to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS — I hereby authorize payment directly Dysautonomia-MVP Center of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Dysautonomia-MVP Center charges for these services. I understand that I am financially responsible to Dysautonomia-MVP Center charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT — For services furnished by Dysautonomia-MVP Center I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: _____ DATE: _____

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INSTRUCTIONS FOR EXERCISE TESTING

Wear or bring comfortable clothing,
(shorts or pants and top)
Wear or bring comfortable walking shoes –
no strapless heels or sandals.

Eat a light meal prior to appointment time.
A small snack is fine.
Drink adequate fluids on the day of your tests.

NO CAFFEINE, OR ALCOHOL 24 HOURS PRIOR TO THE APPOINTMENT.

NO SMOKING TWO (2) HOURS PRIOR TO TESTING.

<u>Do not exercise the day of your appointment.</u>

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Phone 205-286-3200 Fax 205-286-3201
staff@mvpctr.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ _____ hereby authorize the use or
(Name of Patient) (Date of Birth)
disclosure of protected health information about me as described below.

The protected health information may be authorized from: _____
(Name and Address)

_____

_____/_____
(Phone Number) (Fax Number)

The protected health information may be disclosed to: Dr. _____
Dysautonomia-MVP Center
2470 Rocky Ridge Road, Ste 200
Birmingham, AL 35243
Phone 205-286-3200 Fax 205-286-3201

INFORMATION TO BE DISCLOSED:
- ❑ Echocardiogram
- ❑ GXT (Stress Test)
- ❑ Lab
- ❑ Autonomic Function Test (Tilt Table)
- ❑ X-Ray
- ❑ History & Physical
- ❑ Office Notes
- ❑ Other (Specify) _____

PURPOSE OF DISCLOSURE:
- ❑ Personal Record
- ❑ Follow up Health Care
- ❑ Insurance Purposes
- ❑ Other (Specify)_____

Please **FAX** the requested information to **(205) 286-3201**

This authorization shall be in force and effective for one hundred eighty (180) days, from the date of signature. I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to Michael Ingram, HIPAA compliance officer.

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. The Dysautonomia-MVP Center is not responsible for any information re-disclosed by the third party that information is furnished under valid authorization.

Printed Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____ Date _____

Description of Personal Representative's authority _____

Witness _____ Date _____

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ACKNOWLEDGMENT

I HAVE READ AND UNDERSTAND THE CONTENTS OF THE INFORMATION IN THIS PACKET.

_____
PLEASE PRINT NAME OF PATIENT

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS A MINOR DATE

Dysautonomia-MVP Center

PATIENT CONTACT INFORMATION SHEET

Patient Legal Name:_____

DOB_____

Any physician, staff, employee or representative of **Dysautonomia-MVP Center** has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENTS SIGNATURE: _____

All patients 14 years and older are required to sign. Parent/guardian may sign for patients 13 years or younger.

DATE:_____

OR

I do not want anyone to have access to my protected health information unless I provide explicit authorization.

PATIENTS SIGNATURE: _____ DATE: _____

****If any of this information changes, please let us know so we can update this form.****

HIPAA Notice of Privacy Practices

Dysautonomia-MVP Center
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(205)-286-3200

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PH1) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as By Law, Public Health issues as required by law, Communicable situations include: as Required Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14. 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Effective January 1, 2012, the Dysautonomia-MVP Center will have a charge for a patient who cancels or does not show for their appointment.

NEW PATIENTS - $100.00 Charge for failure to cancel within a 48 hour notice.

RETURN PATIENTS - $25.00 Charge for cancellation for same day or no show appointment.

This fee is NOT covered by insurance.

Patient Name: _____

Patient Signature: _____