
# Welcome Packet and Consent Forms

# Table of Contents



**For your convenience all documents will be signed electronically at your visit, and a copy will be added to your medical record.**

## Welcome to Arkansas Verdigris Valley Health Centers, Inc.

AVVHC promotes Healthier lifestyles by providing quality, compassionate, affordable healthcare, and health education services for all. We are a private, non-profit community health center serving Coweta, Porter, Muskogee, and surrounding areas. AVVHC accepts a Medicare, Medicaid, private insurances, as well as offering a sliding fee scale for those patients who are under insured. Our sliding fee scale is adjusted periodically based on federal guidelines for family income and size. For those who qualify, a minimum or nominal fee is charged for each service performed (office visit, lab, x-ray, etc.)

AVVHC provides the following services Medical, X-Ray, Behavioral health, Substance Use Treatment, Physicals, 340B Pharmacy, Transportation and Dental. We look forward to becoming your hometown provider.

**LOCATIONS**

| | | |
|---|---|---|
| **Coweta Location** | 607 South Broadway Coweta, Oklahoma 74429 | 877-480-0111 |
| **Porter Location** | 505 South Main Street Porter, Oklahoma 74454 | 877-480-0111 |
| **Muskogee Location West** | 201 N. 32nd Street Muskogee, Oklahoma 74401 | 877-480-0111 |
| **Muskogee Location East** | 110 W. Martin Luther King Muskogee, Oklahoma 74401 | 877-480-0111 |

Hours for each clinic can be accessed via our website at avvhealthcenters.com.

For the safety of our staff and patients, please note that while at any of our locations:

- No smoking is allowed (tobacco and vapor products
- No weapons are allowed while on premises with the exception of law enforcement.

# Notice of Privacy Practices

**Effective Date: 8-8-2011**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIDS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Arkansas Verdigris Valley Health Centers, Inc. ("AVVHC") is committed to protecting your medical information (including dental and behavioral health information). We are required by law to:

- Maintain the privacy of your medical information;
- Give you a notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the notice currently in effect.

**What is this document?**
This Notice of Privacy Practices describes how we may use and disclose your medical information. It also describes your rights to access and control your medical information.

**What does this Notice cover?**
This Notice of Privacy Practices applies to all of your medical information used to make decisions about your care that we generate or maintain, including sensitive information such as mental health, communicable disease and drug and alcohol abuse information. Different privacy practices may apply to your medical information that is created or kept by other people or entities.

Who does this Notice cover? This Notice of Privacy Practices will be followed by all AVWHC employees; any health care professional who provides treatment to you at AVVHC and any member of a volunteer group that provides services at AVVHC.

**What will you do with my medical information?**
The following categories describe the ways that we may use and disclose medical information. Not every use or disclosure in a category will be listed. You will acknowledge receipt of this document by signing the attached Patient Agreement and Acknowledgement.

If you are concerned about the possible use or disclosure of any part of your medical information, you may request a restriction. Your right to request a restriction is described in the Section regarding patient rights below.

Certain regulations are in place related to mental health and substance abuse records and AVVHC complies with those standards.

**Treatment.** We will use your medical information to provide you with medical treatment and Services.

Example: Your medical information may be disclosed to doctors, nurses, technicians, students or other personnel who are involved in taking care of you.

We may disclose your medical information for the treatment activities of any other health care providers.

Examples: (1) We may send a copy of your medical record to a physician who needs to provide subsequent or additional care to you. (2) We may send a copy of your health care instructions to a hospital or nursing home to which you have been admitted or transferred to facilitate coordination of care.

**Payment.** We may use medical information about you for our payment activities. Common payment activities include, but are not limited to:

- Determining eligibility or coverage under a plan; and
- Billing and Collection activities.

Examples: (1) Your medical information may be released to an insurance company to obtain payment for services. (2) We may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We may disclose medical information about you to another health care provider or covered entity for its payment activities.

Example: We may send your health plan coverage information to an outside laboratory or imaging center that needs the information to bill for tests that it provided to you.

**Operations**

We may use your medical information for operational or administrative purposes. These uses are necessary to run our facility and to make sure patients receive quality care. Common operation activities include, but are not limited to:

- Conducting quality assessment and improvement activities,
- Reviewing the competence of health care professionals;
- Arranging for legal or auditing services;
- Business planning and development; Business management and administrative activities; and
- Communicating with patients about Our Services.

Examples: **(1)** We may use your medical information to conduct internal audits to verify that billing is being conducted properly. (2) We may use your medical information to Contact you for the purposes of conducting patient satisfaction surveys or to follow-up on the services we provided. (3) We might

use a patient list to announce the arrival of a new physician or the purchase of a new piece of equipment or the addition of a new service.

We may disclose medical information about you to another health care provider or covered entity for its operation activities under certain circumstances.

Example: We may disclose your medical information to your health plan for its utilization review analysis.

**Business Associates.** We may disclose your medical information to other entities that provide a service to us or on our behalf that requires the release of patient medical information. However, we only will make these disclosures, if we have received satisfactory assurance that the other entity will properly safeguard your medical information.

Example: We may contract with another entity to provide transcription or billing Services.

**Treatment Alternatives.** We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you individuals involved in Your Care or Payment for Your Care. We may release medical information about you to a friend, family member or legal guardian who is involved in your medical Care.

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for medical treatment or services.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Research.** We may use and disclose medical information about you to researchers. In most circumstances, you must sign a separate form specifically authorizing us to use and/or disclose your medical information for research. However, there are certain exceptions. Your medical information may be disclosed without your authorization for research if the authorization requirement has been waived or altered by a special committee that is charged with ensuring that the disclosure will not pose a great risk to your privacy or that measures are being taken to protect your medical information. Your medical information also may be disclosed to researchers to prepare for research, as long as, certain conditions are met. Medical information regarding people who have died can be released without authorization when ce1tain circumstances. Limited medical information may be released to a researcher who has signed an agreement promising to protect the information released.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Can you ever use and disclose my medical information without my authorization? Yes. The following categories describe the ways that we may be required to use and disclose your medical information without your consent. Not every use or disclosure in a category will be listed.

**Required by Law.** We may disclose your medical information when required to do so by federal, state or local law.
Examples: (1) We may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. (2) We are required by law to report cases of Suspected abuse and neglect. These reports may include your medical information.

**Public Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

**Public Health.** We may disclose medical information about your public health activities intended to:

- Prevent or control disease, injury or disability;
- Report births and deaths; Report abuse, neglect or violence as required by law;
- Report reactions to medications or problems with products, Notify people of recalls of products they may be using;
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Example: Oklahoma law requires us to report, among other things, births, deaths, certain birth defects, Communicable diseases and other health conditions and statistics.

**Food and Drug Administration (FDA).** We may disclose to the FDA and to manufacturers health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing Surveillance information to enable product recalls, repairs or replacements.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a Court or administrative order. In limited circumstances, we may disclose medical information about you in response to a subpoena or discovery request.

**Law Enforcement.** We may release medical information if asked to do so by law enforcement official:

- in response to a court order, warrant, Summons or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;

- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement,
- About a death We believe may be the result of criminal conduct;
- About Criminal conduct at the hospital; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description location of the person who Committed the Crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a Coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**National Security and intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Military/Veterans.** We may disclose your medical information as required by military command authorities, if you are a member of the armed forces.

**Inmates.** If you are an inmate of a correctional facility or under the custody of law enforcement official or agency, we may release your medical information to the correctional facility or law enforcement official or agency. This release may be necessary to: (1) enable the correctional facility to provide you with health care; or (2) protect the health and safety of you and/or other people.

What if you want to use and/or disclose my medical information for a purpose not described in this Notice? We must obtain a separate, specific authorization from you to use and/or disclose your medical information for any purpose not covered by this notice or the laws that apply to us.

We are required to obtain your authorization for the following uses and disclosures.

Psychotherapy Notes: We must obtain authorization to use and disclose psychotherapy notes, which are defined as notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session and that are separated from the rest of a patient's medical records.

**Marketing:** We must obtain authorization to use and disclose your medical information for marketing if the marketing involves direct or indirect financial payment from a third party.

**Sale of Medical information:** We must obtain an authorization for any disclosure of your medical information for which We receive payment, unless otherwise permitted by law.

If you provide us with authorization to use or disclose your medical information, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your authorization. However, your revocation will not apply to disclosures already made by us in reliance on your authorization.

**What are my rights regarding my medical information?** You have the rights described below regarding the medical information that we maintain about you. You are required to submit a written request to exercise any of these rights. You may contact our Privacy Official to obtain a form that you can use to exercise any of the rights listed below.

**Right to inspect and Copy.** You have the right to inspect and copy medical information used to make decisions about your care. if you want a copy of your medical information, we may charge a fee of $1.00 for the first page and .50 cents for each subsequent page. We may deny your request to inspect and/or copy your medical information in certain circumstances. If you are denied access, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information that We Created is incorrect Or incomplete, you may submit a request for an amendment for as long as we maintain the information. You must provide a reason that supports your amendment 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 to amend information that:

- We did not create, unless the person or entity that created the information is not available to make the amendment;
- is not part of the medical information that we maintain;
- ls not part of the information that 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 one free "accounting of disclosures" every 12 months. This is a list of Certain disclosures we made of your medical information. There are Several categories of disclosures that we are not required to list in the accounting. For example, we do not have to keep track of disclosures that are authorized. Your request must state a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.

If you request more than one accounting in a 12-month period, We may charge you for the costs of providing the list. We will notify you of the cost involved and you

may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you unless our use and/or disclosure is required by law. You also have the right to request a limit on the medical 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.

We are not required to agree to your request unless you are requesting a restriction on the disclosure of information to your health plan and you are willing to pay out of pocket for the medical treatment provided. If we agree to other requested restrictions, We will comply with your request unless the information is needed to provide emergency treatment to you.

in your request, you must indicate:

- The type of restriction you want and the information you want restricted; and
- To whom you want the limits to apply, for example, your Spouse.

**Right to Request Confidential Communications.** You have the right to request that we Communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice always will be available in our medical record department.

Can you change this notice? We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Copies of the current notice will be posted at all AVVHC facilities and will be available for you to pick up on each visit to AVVHC.

What if I have questions or need to report a problem? If you believe your privacy rights have been violated, you may file a complaint with us or with the Office of Civil Rights of the Department of Health and Human Services. To file a complaint with us, or if you would like more information about our privacy practices, contact our Privacy Official at 918-483-0111. The Privacy Official's mailing address is P.O. Box 334,

**Arkansas Verdigris Valley Health Centers, Inc.**

**CONSENT TO TELEMEDICINE**

**CONSENT TO PARTICIPATE:**

I give my consent to participate as a patient using the Arkansas Verdigris Valley Health Centers, Inc. (AVVHC) telemedicine network. I will be receiving health care services through interactive video and/or camera equipment.

I understand the use of video/camera equipment is a new method of health care delivery. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand the equipment will be shown to me and I will get to see how it works before I receive any services.

I understand my participation in this is totally voluntary and I may decide to quit at anytime. My privacy and confidentiality will be protected at all times. When I receive services using video, I will be able to see everyone in the telemedicine room at the other site. During times of emergency and when allowed by law, I consent to receiving health care services through telephonic method when a video connection is not able to be established.

I give my consent to receive services over the videoconferencing and/or camera equipment.

I understand the services I receive will become part of my treatment record.

I understand the health care providers at both sites will have access to any relevant medical information about me including any mental health records, psychiatric and/or psychological information, alcohol and/or drug abuse, communicable or venereal disease, and other sensitive information.

I have read this document and I hereby consent to participate in the AVVHC telemedicine network under the terms described above. I understand this document will become a part of my medical record.

Reviewed 3/21/2020

**Arkansas Verdigris Valley Health Centers, Inc.**

**AUTHORIZATION TO RELEASE BILLING INFORMATION**

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals and entities authorized by me or their contracted entities. [If the patient is a minor, the parent or legal guardian must sign].

Please note that the use of all daily authorized and released records are not under **Arkansas Verdigris Valley Health Centers** control.

AUTHORIZATION FOR PATIENT PICTURE: I hereby authorize **Arkansas Verdigris Valley Health Centers** to take a picture for my electronic medical records if I do not produce a current Photo ID.

**Arkansas Verdigris Valley Health Centers**

**ASSIGNMENT OF BENEFITS**

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by:

> **Arkansas Verdigris Valley Health Centers** and the medical professionals caring for me during my treatment in this office to be paid directly to **Arkansas Verdigris Valley Health Centers,** or other associated providers as appropriate.

I understand that I am responsible for all charges not paid by insurance. This will remain in effect until revoked in writing by me.

**Arkansas Verdigris Valley Health Centers**

**PATIENT AGREEMENT**

**Authorization for Release of Information**

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information released. I also understand that I or my legally authorized representative may revoke this consent in writing at any time unless action has already been taken based upon it. I can do this by submitting a written request to the Medical Records Department. I freely and voluntarily give this consent.

I understand that the records requested may be protected under 42 C.F.R.,Part 2, governing Alcohol and Drug Abuse patient records the Health Insurance Portability and Accountability Act of 1996 (HIPAA ), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

I **ACKNOWLEDGE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.**

I UNDERSTAND THAT I AM UNDER NO OBLIGATION TO SIGN THIS FORM AND MY REFUSAL TO SIGN WILL NOT AFFECT THE ABILITY TO OBTAIN TREATMENT.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME PRIOR TO THE RELEASE OF THE INFORMATION SPECIFIED ABOVE. IF USED FOR ONGOING COMMUNICATION, THIS AUTHORIZATION EXPIRES IN TWELVE (12) MONTHS. DISCLOSURES MADE IN GOOD FAITH PRIOR TO REVOCATION DOES NOT CONSTITUTE A BREACH OF CONFICENTIALITY.

If the patient is a legally competent adult, he/she must sign this form. If he/she is a legally incompetent adult, it must be signed by the personal guardian (accompanied by proof of guardianship). If the patient is under the age of 18 years, the patient's parent or legal guardian must sign. (Signatures must be witnessed by at least one person.) If the patient is incompetent, and unable to sign, his/her mark or consent must be witnessed by at least two persons.

NOTICE TO RECIPIENTS OF INFORMATION: Any information disclosed to you pertaining to drug and/ or alcohol treatment was taken from records of which confidentiality is protected by State and/or Federal Law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure ofit without the specific, written consent ofthe person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release ofmedical or other information is not sufficient for this purpose. ALL BLANKS MUST BE COMPLETED TO BE VALID.

**Arkansas Verdigris Valley Health Centers**

**CONSENT FOR SERVICES**

I, the undersigned, give my consent for the services that I am requesting from the Arkansas Verdigris Valley Health Centers (AVVHC), Inc. d/b/a Porter Health Center. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

I also understand that the information regarding myself and the services I receive will be entered into AVVHC management information systems and may be used for program evaluation, management and billing purposes. However, my name will not be released without my written permission.

**Receipt of AVVHC Notice of Privacy Practices**

I acknowledge that I have received a copy of the AVVHC Notice of Privacy Practices as required by the Health Insurance P01iability and Accountability Act.

**Receipt of Patient Rights and Responsibilities**

I acknowledge that I have received a copy of the AVVHC Patients Rights and Responsibilities.

**Medication History Download**

I understand and I give my consent to retrieve and review my medication history. I understand that this will become part of my medical record. A medication history is a list of medicines that these providers and other healthcare providers have recently prescribed for a patient. It is collected from a variety of sources, including, a patient's pharmacy, health plans, and other healthcare providers.

**Consent to Call**

Entry of any telephone number constitutes written consent for Practice Entities to send automated, prerecorded, and artificial voice telephone calls to that telephone number. To alter or revoke this consent, visit the Patient Portal "Contact Preferences" page.

**Arkansas Verdigris Valley Health Centers**

**PATIENT-PROVIDER AGREEMENT FOR CONTROLLED SUBSTANCES**

The purpose of this agreement is to give you information for your personal safety about the medications you will be taking for pain management and to assure that you and AVVHC comply with all state and federal regulations, including the Drug Enforcement Administration standards, concerning the prescribing of controlled substances. An opioid therapy treatment plan can be considered to treat moderate to severe pain. We intend that the opioid therapy treatment plan will reduce your pain and increase your ability to function in your daily life.

Side effects of opioid therapy may include; skin rash; allergic reactions; constipation; nausea; vomiting; sexual dysfunction; sleeping abnormalities; aggravation; depression; confusion; impaired coordination, balance, and motor ability; difficulty driving and operating machinery; drowsiness; and breathing too slowly.

AVVHC requires each patient receiving long-term treatment with controlled substances to read and agree to the following:

- All controlled substances must come only from the physician/provider in this office or during his/her absence, by the covering medical provider unless patient notifies clinic staff otherwise.
- Patient will inform medical staff of any current or past substance abuse.
- Patient will obtain controlled medications from only one pharmacy, disclosed at the end of this agreement, and will notify AVVHC staff if a change needs to be made.
- Patient will not request controlled substances from other providers and will inform AVVHC of all medications being taken. Patient will also notify clinic staff of any adverse side effects to previously prescribed medications.
- Patient will protect and secure medications and will not allow anyone else to use, buy/sell or otherwise access these. This is the sole responsibility of the patient or their caregivers and lost or stolen medications will not be replaced. If patient's medication is changed or discontinued, patient agrees to safely dispose of the medication.

- Patient will take their medications as prescribed and not exceed the maximum prescribed dose. AVVHC providers will perform random pill counts to ensure the adherence to the above-mentioned safety and intended use of any controlled substance. Any discrepancy found could result in dismissal from the controlled substance program, which may include safely discontinuing the patient's opioid medication or terminating the provider-patient relationship. Additional options for treatment will be discussed with patient.
- Medication refills of controlled substances will require monthly appointments during regular business hours and exceptions will only be made at the discretion of the medical provider. No refills will be given at night or on weekends.
- Continued prescription of controlled substances is at the discretion of the medical provider and there is no guarantee that these medications will be prescribed indefinitely.
- Patient will actively participate in programs designed to improve physical and mental health as recommended by medical providers.
- AVVHC participates in the prescription monitoring program through the Oklahoma Bureau of Narcotics. Each patient is followed for appropriate and timely refill intervals and whether options have been obtained from other providers besides AVVHC or from multiple pharmacies.
- If requested by law enforcement authorities, AVVHC will automatically comply with requests for medical records and prescribing practices.
- Random urine drug screens and random pill counts may be requested at the discretion of the medical provider; urine drug screens are at the expense of the patient and will be performed at a minimum quarterly, as often as monthly.
- If the patient is requested to complete a urine drug screening and unable to urinate within 30 minutes of their scheduled appointment time, they will be asked to reschedule their visit to a later date.
- Provided urine specimen must fall within the required concentration and temperature range as outlined by the manufacturer of the urine drug screening kits. Specimens out of range for either temperature or concentration will be reason for dismissal from AVVHC's controlled substance program.

- If the test returns negative for the scheduled medication that AVVHC has been prescribing, this indicates possible misuse of medication and will be reason for the patient's dismissal from AVVHC's controlled substance program.
- If the urine drug test returns positive for illicit drug use, this will be reason for the patient's dismissal from AVVHC's controlled substance program. A confirmation of a positive result can be requested to be sent to the lab prior to the patient being dismissed from AVVHC controlled substance program. This will be at the patient's expense if not covered by insurance. The patient may also request to repeat the urine drug screen one week from the time of the positive result. This test must be performed at AVVHC-Muskogee West and will again be at the patient's expense.
- Patient education resources will be available to help deal with opioid dependence and prevent opioid abuse. Suboxone therapy is an option through Green Country Behavioral Health for patients who wish to pursue treatment in their program.
- The patient understands that there is a risk of development of physical dependence. If the opioid medication is suddenly stopped or is not taken as directed, then withdrawal symptoms, such as sweating, abdominal cramps, diarrhea, goosebumps, difficulty sleeping, and mood changes may occur.
- The understands that there is a risk of psychological dependence. The patient understands that when the treatment is ceased, the opioid medication may be missed or craved.
- The patient understands the risks of addiction and overdose, where the patient may experience loss of control over the opioid drug use, compulsive use, and/or continued use despite harm to self or others. The patient also understands the dangers of taking opioids with alcohol, benzodiazepines and other CNS depressants, such as fatal respiratory depression, brain injury from lack of oxygen, a coma or death. AVVHC will work with the patient to prevent the possible development of addiction.
- By signing this agreement, the patient and physician/provider are stating they have an understanding of the pain-management plan or a question arises, the patient at any time, does not understand the pain-management plan or a question arises, the patient will contact the clinic immediately and seek further guidance.
- The patient's controlled substance plan will include identification of specific medications and all other modes of treatment, including, but not limited to physical therapy or exercise and/or

relaxation or psychological counseling. Patient understands that a consistent failure to keep these appointments or participate in these therapies may result in the physician/provider safely discontinuing patient's medication.

- The patient understand and agrees the provider shall be held harmless from civil litigation for the failure to treat pain if the event occurs because of nonadhearance by the patient with any of the provisions of the patien-provider agreement.
- Patient must understand that failure to adhere to these policies will result in being dismissed from AVVHC controlled substance programs and no further scheduled or controlled medications will be prescribed. By signing below, I have read and accept these terms.

I have read the information set forth above regarding my proposed opioid therapy treatment. I have had the opportunity to ask questions for further understanding.

I understand all of the risks, warnings, responsibilities, and the plan for physician oversight.

I understand that the success of my opioid therapy treatment depends on mutual trust, honesty, and communication in the patient-provider relationship in addition toa full understanding and agreement on the risks, benefits, and alternatives to using opioid medication to treat pain. I accept the uncertainties, risks, and limitations of this treatment.

I consent to the treatment as well as any related treatments that my provider considers necessary and appropriate in connection with my treatment plan. I also understand that before my provider prescribe any opioid medication, AVVHC requires that a urine drug screen be performed.

**Arkansas Verdigris Valley Health Centers**

**PATIENT / PROVIDER**
**MEDICAL HOME AGREEMENT**

Good communication between patients and physicians is the key to better outcomes. It is important that you establish a primary care provider and that you see the same provider for each visit, when possible. AVVHC will strive to provide the same provider for each visit along with the same patient care team. Continuity of care results in a better standard of care, as well as a higher level of satisfaction and more effective medical visit for both you and the provider. Our staff is committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

**As your Medical Home Primary Care Provider (PCP), we agree to:**

- Honor your rights as a patient, and treat you with dignity and respect.
- We will focus on listening to your concerns, educating you on your health care needs and preventiveservices.
- Focus on treating you as a whole person: physically, mentally and emotionally.
- Focus on providing you with ***ongoing, high quality*** and ***safe*** medical care, including prevention of future health complications.
- Work to schedule timely office appointments for your chronic and urgent healthcare needs.
- Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
- Provide you with other healthcare resources when we are absent or unavailable.
- Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
- Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

**As a Medical Home Patient, your responsibility is the following:**

- Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
- Communicate with us about all your healthcare concerns and goals.
- Report any changes related to your health, treatments, medications, etc. This includes use of all medications - prescription, over-the-counter, herbal and street drugs.
- This also includes any medical equipment being used or that has been ordered or recommended for use.
- Call us ***before*** going to the Emergency Room, unless it is life threatening.
- Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
- Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
- Keep appointments as scheduled with us and any appointments scheduled with a specialist.
- If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
- You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

**Your Healthcare is a TEAM Approach involving BOTH YOU and \'OUR PROVIDER.**

**Arkansas Verdigris Valley Health Centers**

**HIPAA PRIVACY AUTHORIZATION**

I understand that Arkansas Verdigris Valley Health Centers, Inc. may still use and disclose protected health information as indicated in the Notice of Privacy Practices. Would you like to give someone else access to your medical records?

***Yes, I would like to give access to the following friends, family members, or caregivers:***

| Full Name (First and Last) or Entity | Relationship | Phone |
|---|---|---|

This Authorization is being granted at the request of the individual.

This Authorization will remain in effect until written notice to revoke or a new form is presented to the clinic.

I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.