IVPS
INTEGRATED VISITING PHYSICIAN SOLUTIONS

18000 W. 9 Mile Rd. Ste. 525
Southfield MI 48075
Phone: (248) 327-6196
Fax: (877) 311-5596
www. IVPSPC.com

CONSENT FOR TREATMENT

▪ I give my consent and authorize medical treatment as deemed necessary and appropriate by the physicians of INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC, and their employees participating in my care.

▪ I authorize INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC to release pertinent information to my health insurance companies that is required during my examination or treatment. I also give my consent and authorize payment of all insurance benefits, including Medicare and Medicaid payments, be sent directly to INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC. I understand that I am solely responsible for any medical or surgical changes incurred during my treatment that are rejected by my insurance company or are considered co-pays or deductibles as applicable.

▪ I also authorize INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC to contact me via phone or mail, including leaving messages, sending out letters, about my care provided it assists the practice in carrying out necessary treatments for me, or as required to ensure payment or other timely management of health-related benefits for myself.

▪ I consent in being automatically enrolled in the Chronic Care Management Program that will give me 24/7 access to my provider, in return, it will allow my advanced practitioner and their designees to perform a CCM on my behalf. I understand that Integrated Visiting Physician Solutions PC will bill my insurance for this service, and that I am responsible for any copayment or deductible. I understand that I can revoke this permission at any time by notifying Integrated Visiting Physician Solutions PC in writing.

▪ I understand that I may revoke this consent in writing, as permitted by law, except to the extent that the practice has already made disclosures or provided treatment in reliance upon my prior consent. If I refuse to sign this consent, I understand that INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC has the right to decline to provide services and treatment to me

_____
Patient Printed Name

_____
Patient / Representative Signature

_____
DOB

_____ / _____ / _____
Date

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PATIENT TREATMENT CONTRACT

As a participant in treatment for pain management, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree not to sell or give any of my medication to another person. I understand that it is illegal and could result in being discharged.

2. I agree that my prescription can only be given at my regular doctor visits. If I miss a visit/or cancel my appointment I cannot get my medication/prescription until the next doctor visit. (Unless a documented emergency occurs).

3. I understand that narcotic medications will NOT be called in. I understand the DR will NOT refill any narcotic medication without a visit. NO early refills permitted.

4. I agree NOT to get ANY other narcotic pain medicine from another doctor, unless an Emergency. I agree that ONLY the DR will prescribe my pain medicine. If narcotic pain medicine is prescribed in my name (after I sign this agreement) I could be discharged.

5. I agree that any rude, inappropriate or threatening behavior to the doctor, his staff, or the pharmacy may result in being discharged.

6. I agree that the medication I receive is my responsibility. I agree to keep it in a safe, secure place. I agree that medication may not be replaced if lost or stolen.

7. I agree to take my medication as instructed and not to change (increase or decrease) the way I take my medication without first asking my doctor.

8. I agree NOT to take any benzodiazepam medications (Valium, Klonipin, Xanax, etc.) unless authorized/prescribed by the DR or under emergency conditions at a hospital.

9. I understand that medication alone is not sufficient treatment for my condition. Other treatments, including Physical Therapy or even possible intervention/injections, and/or surgery may be recommended as part of my treatment.

10. I agree not to take any other narcotics/*pain medicine, cocaine, or addictive/illegal substance(s).
*Unless a hospital emergency, and then I will notify Traveling Doctor's office with the hospital information.

11. I agree to provide random *urine samples. I understand that Michigan Guidelines for prescribing narcotic pain medicine include urine monitoring. If I refuse to provide urine for this purpose, the DR is NOT required to prescribe my pain medicine AND I may be discharged. *Dialysis patients agree to provide blood samples for monitoring.

12. I agree NOT TO TAKE SOMA; I understand the DR DOES NOT prescribe XANAX, due to its high abuse potential. The DR may prescribe a similar medication (Klonipin, Valium or other safer "cousins" to Xanax) if needed for short term severe anxiety. No cough syrup with Codeine will be prescribed, especially with pain medicine.

13. I agree if I use marijuana, IVPS is not responsible for any interaction with my other medications.

14. I understand if I make suicidal statements, IVPS is legally bound to call 911.

15. I understand that violations of the above may be grounds for termination of treatment.

_____ _____

Patient / Representative Printed Name Patient / Representative Signature

Date: _____ / _____ / _____

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MEDICAL INFORMATION DISCLOSURE

A. USES AND DISCLOSURES

1. **Treatment**: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
2. **Payment**: Your health information may be used to seek payment from you health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may used to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
3. **Health care operations**: Your health information may be used as necessary to support the day-to-day activities and management of **Integrated Visiting Physician Solutions, PC**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
4. **Law Enforcement**: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
5. **Public health reporting**: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to Michigan's public health department.
6. **Other uses and disclosures require your authorization**: Disclosures of your health information or its used for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure that occurred before you notified us of your decision.

B. ADDITIONAL USES OF INFORMATION

Appointment Reminders: your health information will be used by our staff to make appointment reminders.
Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may interest you.

C. INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice.

INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice. We have detailed policies and procedures that we follow to further assure the privacy rule is followed. RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Whatever the reason for these revisions, we will provide you with a revised notice in your next visit by giving you a copy or mailing you the new law. The revised policies and practices will be applied to all protected health information that we maintain.

D. REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC.
18000 W. 9 Mile Rd STE 525
Southfield MI 48075

E. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

INTEGRATED VISITING PHYSICIAN SOLUTIONS, PC reserves the right to modify the privacy practices outlined in the notice.

AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL INFORMATION

Name_____ Phone: _____

Street Address: _____

INFORMATION MAY BE DISCLOSED TO AND OBTAINED FROM:

NAME: _____

ADDRESS: _____ PHONE: _____

CITY: _____ FAX: _____

STATE: _____

ZIP: _____

I authorize Integrated Visiting Physician Solutions PC to RELEASE AND OBTAIN information regarding my medical treatment contained in my patient records including:
Information about communicable diseases and infections, as defined by statute and the Michigan Department of Public Health Rules. Alcohol and Drug Abuse Treatment information protected under the regulations in 42 Code of Federal Regulations (CFR), Part 2. Mental Health treatment records, psychological services, and social services information, including communications made by social workers, psychologists or similar mental health professionals.

INFORMATION REQUESTED: Dates of treatment, and diagnosis _____Labs ( )yr: _____

Progress Notes ( ) yr: _____ Operative/Procedure Report ( )yr: _____

NOTES: _____

Continuity of Care Attorney/Legal Insurance Other:

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment and records under 42 CFR Part 2, and I understand those rights. This release is valid for 1 year, and may be revoked in writing at any time, but may not affect retroactive exchange of information. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore lose the legal privacy protection,

_____ _____

Patient / Representative Printed Name Patient/ Representative Signature

_____ / _____ / _____

Date

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AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL INFORMATION

Name:_____ DOB: _____ / _____ / _____

Address (Street, City, Zip): _____

INFORMATION MAY BE DISCLOSED TO AND OBTAINED FROM:

Name of Person/Business: _____

Address (Street. City, Zip): _____

Phone: _____ / _____ / _____ Fax: _____ / _____ / _____

I authorize Integrated Visiting Physician Solutions PC to RELEASE AND OBTAIN information regarding my medical treatment contained in my patient records including: Information about communicable diseases and infections, as defined by statute and the Michigan Department of Public Health Rules. Alcohol and Drug Abuse Treatment information protected under the regulations in 42 Code of Federal Regulations (CFR), Part 2. Mental Health treatment records, psychological services, and social services information, including communications made by social workers, psychologists or similar mental health professionals.

INFORMATION REQUESTED: Dates of treatment, and diagnosis _____Labs ( )yr: _____ Progress Notes

( ) yr: _____ Operative/Procedure Report ( )yr: _____ NOTES:

_____

Continuity of Care Attorney/Legal Insurance Other:

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Patient / Representative Printed Name

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PATIENT ACKNOWLEDGMENT

I hereby affirm that I have not received, nor have I been promised to receive, any payment, cash, money, gift, kickback, or other consideration, directly or indirectly, from any person or company (including any home care company) in return for my requesting any item, good, or service for my medical treatment either by (1) Integrated Visiting Physicians Solutions, PC, or by (2) any other healthcare provider, for which payment may be received in whole or in part under a Federal health care program.

I acknowledge that:

- I have read the above paragraph,
- I have had an opportunity to ask any questions, and I have had my questions satisfactorily answered, and
- I understand the above paragraph.

_____
Patient / Representative Printed Name

_____
Patient / Representative Signature

_____ / _____ / _____
Date