



VIRTUAL MEDICAL PRACTICE, LLC

expanding genetic horizons.....

PATIENT CONSENT FORM – FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As our patient, VMP (Virtual Medical Practice, LLC) respects the privacy of your personal medical records and follows HIPAA guidelines to protect this information. Please understand that managing patients and their medical information is a complex process. We strive to provide the minimum necessary information to only those we feel are in need of your TPO (treatment, payment, healthcare operations).

Following are the types of disclosure and means of communication that we utilize (including but not limited to):

Disclosures:

- Hospitals involved in your care
- Referring physician(s) and primary care providers
- Other physician groups (surgeons, consultants)
- Laboratories that will be involved in testing
- Business related activities (quality assurance, information technology)
- Insurance Companies, as provided by you or referring physician
- Other 3rd party billing entities

Communication: Consults, reports, clinical and laboratory results, and general communication may be communicated to you (or other's specified by you), to your physician(s), to your insurance company, and to other health care professionals involved in your care that assist VMP in carrying out TPO by:

- VoIP (*Voice over Internet Protocol*)
- Telephone (*verbal and voice message*)
- Facsimile
- Email, encrypted and/or unencrypted
- Website
- Internet
- Skype
- Webcam

TESTING

We have no laboratory affiliation or financial incentive in the tests we order. Testing will be performed at outside, independent 3rd party laboratories. Accurate interpretation of test results requires that an accurate and thorough report of the patient & family medical history has been provided, and that the reported family relationships are the true biological relationships. You agree that it is your responsibility to seek explanation from your referring physician or the laboratory of any recommended or ordered testing.... or **you will ask** for explanation of the following from a VMP physician during your appointment with them:

- a) The purpose and description of the recommended testing;
- b) Reliability of positive or negative test results and the degree of certainty of a given test;
- c) The availability and importance of further testing, physician consultation and genetic counseling;
- d) A general description of each specific disease or condition tested for;
- e) The person or persons to whom the test results may be disclosed.

REPORTING RESULTS AND IMPLICATIONS OF RESULTS

Any testing results ordered and reviewed by VMP will be relayed directly to you so that any questions and concerns can be appropriately addressed. You will receive a brief summary of testing results after all testing is completed. A VMP physician will be available by appointment to further discuss the testing results as needed. Upon your request, detailed testing results will be sent to you.

CARE ASSISTANCE

Due to the limitations in the number of physicians that understand these disorders, we can be available to you or your physicians concerning various issues through our *Care Assistance* program. You must be an active patient with VMP to participate in this program. Please see our CARE ASSISTANCE services for details.

PAYMENT OF SERVICES & INSURANCE MATTERS

You agree to be held solely responsible for any & all charges from VMP. VMP requests deposits and requires that balances be paid prior to or at your appointment. It is your responsibility to fully understand your particular

Initial & return with next sheet



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insurance coverage and to obtain any required referral from your primary care physician. VMP does not bill most insurance companies, nor Medicaid, nor Medicare. Any testing will be billed through the laboratory used.

By signing this consent form, you signify that you understand and agree to the above and:

- 1) Understand and agree to VMP’s Patient Privacy Notice (see separate Patient Privacy Notice),
- 2) Understand and agree to the types of uses and disclosures of your personal health information, as well as the means of communication that VMP will use,
- 3) Understand and agree that any internet enabled or traditional communications with VMP teleports you by its use to VMP’s offices in the State of Georgia and that by doing so you agree & consent that exclusive jurisdiction for any dispute with VMP, its licensors, officers, members, employees, agents, and suppliers, resides in the courts of the State of Georgia. You expressly consent to the exercise of personal jurisdiction in the courts of the State of Georgia in connection with any such dispute.
- 4) Have the right to request, *in writing*, that VMP restrict how it uses or discloses your personal health information. However, VMP is not required to agree to these restrictions, but if it does, it is bound by this agreement,
- 5) Have the right to revoke consent, at any time, *in writing*, except to the extent that VMP has already made disclosures in reliance upon your prior consent,
- 6) Understand and agree if you do not sign this consent, or later revoke it, VMP may decline to provide services to you,
- 7) Understand and agree that genetic information may be obtained during the course of your evaluation,
- 8) Understand and agree that you may make inquiries during your VMP appointment concerning any ordered testing,
- 9) Understand and agree to the implications to you for any ordered testing,
- 10) Understand and agree that VMP is not but you will be solely responsible for working directly with your insurance company to obtain any insurance benefit and to gain approvals as may be required for reimbursement,
- 11) Agree that account balances owed to VMP will be paid in full prior to or at the appointment, unless special arrangements have been made,
- 12) Agree to pay a \$30 Returned Check Fee for the first check not honored by your bank for any reason. A second returned check will additionally be assessed a returned check fee of 5% of the face value of the check or \$30, whichever is greater as allowed by Georgia state law.
- 13) Agree that cancellation notification; including the patient’s name and date/time of appointment; will be accepted by VMP only in fax or email form,
 - Cancellation Notification made more than 7 days prior to an appointment:
 - will be charged a \$50 cancellation fee that may be deducted from any deposits,
 - that has already been **rescheduled** at least once before will be charged a \$150 cancellation fee which may be deducted from any deposits,
 - Cancellation Notification made **within** 7 days of the appointment or on “**no shows**” will be charged \$300-\$450,
 - Exceptions may be made under the sole discretion of VMP if unusual circumstances apply.

I have read the contents of this Consent, and I fully understand and accept all terms by signing below. My consent to the above and any or all associated assignments remains effective until I revoke it in writing.

Please sign and date on the lines below and return to our office by mail/email/fax prior to your appointment. We cannot provide notes, claim forms, orders, or prescriptions unless we have this signed form on file.

 PLEASE PRINT - PATIENT NAME

 DATE OF BIRTH

 PLEASE PRINT –NAME OF PARENT/GUARDIAN OF PATIENT AND THE RELATIONSHIP TO PATIENT if so signing

 SIGNATURE – PATIENT OR PARENT/GUARDIAN

 DATE SIGNED