Social Security Number:	to the PATIENT ONLY
	If Employed, Employer:
Last Name: Jr., II,	
irst Name: MI	Work Phone: ()
ickname / Alias:	Address:
ddress:	Zip Code:
ip Code:State:	City/State:
ome Phone: () Cell Phone: ()	If Student
irth Date (mm/dd/yy):	Name of School:
ex: Male Female	Email:
Iarital Status: <u>Married Single</u> se <u>Parated Divorced Widowed</u> Subscriber Information: Please ensure the office has a copy of your r	Pharmacy:
RIMARY INSURANCE COVERAGE - elationship to Patient: Self Parent Spouse sured Name(as on card):	Other: Insured ID #:
sured Social Security Number:	Group/Policy #:
ame of Insurance Company:	Effective Date:
surance Address:	Employer:
p:State:	Address:
surance Phone #: ()	Zip:City:State:
sured Birth Date (mm/dd/yy):	Employer Phone #:
x: Male Female	If Student
arital Status: Married Single seParated Divorced Widowed	Name of School:
sured Address and Phone # if different from patient:	
IN CASE OF EMERGENCY	
Name and Phone number of nearest relative NOT living with you (include	relationship):
Name & Phone number of next of kin.	
AUTHORIZATION TO PAY BENEFITS TO	THE PHYSICIAN
	d. I recognize and accept responsibility for services rendered
I hereby authorize the office of WVVA Health Care Alliance, P.C., to release any medical treatment and permit payment directly to them any benefits due for their services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment,	
treatment and permit payment directly to them any benefits due for their services rendered	uardian, if patient is Minor
treatment and permit payment directly to them any benefits due for their services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, Date Signature of Patient and / or Go MEDICARE AUTHORIZAT	ION
treatment and permit payment directly to them any benefits due for their services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, Date Signature of Patient and / or Go	ION to WVVA Health Care Alliance, P.C., for any services about me to release to the Health Care Financing

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Exhibit B

WVVA Health Care Alliance, PC Acknowledgment of

Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of WVVA Health Care Alliance, PC's (the "Practice") Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA") that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Patient's Name	Patient's Date of Birth
Patient's Signature	
Date	
IF PATIENT REFUSES TO SIGN ACKNOWLEDGE	MENT, COMPLETE THIS SECTION:
Patient refuses to sign Acknowledgement [EMPLOYEE/POSITION] made the following efforts	
Signature of Practice Employee	
Signature of Chief Privacy Official	



A Division of WVVA Health Care Alliance, PC

Consent

By signing this consent form you are agreeing that your provider at Melrose Family Medicine, a division of WVVA Health Care Alliance, PC., may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Melrose Family Medicine, a

	th Care Alliance, PC., to enroll me in this ePr and all of my questions have been answered	
	Print Name	Patient DOB
	Signature of Patient or Guardian	Today's Date
	Relationship to Patient	

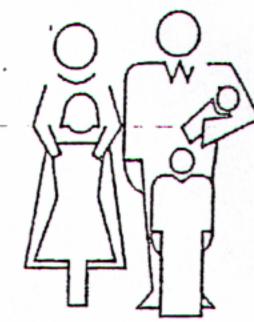


We now have the ability to email and/or text you reminders for your appointments. If you would like to enroll, please read the consent and complete the form below.

Consent to Email and/or Text Message for an Appointment Reminder and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receive appointment reminders and oth communications/information at the email and/or text. Melrose Family Medicine.	
(Patient initials) I consent to receive text receive and any number forwarded or transferred	· · · · · · · · · · · · · · · · · · ·
My cell phone number that I authorize to receive tex reminders, feedback, and general health reminders/	• •
(Cell Carrie	er:
(Patient initials) I consent to emails, to real above.	eceive communications as stated
The email that I authorize to receive email message general health reminders/feedback/information is	s for appointment reminders and
I understand that this request to receive emails and future appointment reminders/feedback/health infinity in writing, to opt out of this service.	
Patient Signature:	Date:
Witness:	Data



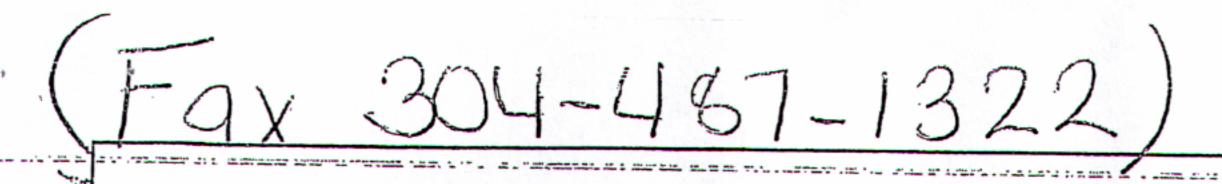
Melrose Family Medicine ___ A Division of WV / VA Health Care Alliance_____

RICHARD SHORTER, D.O.

756 Athens Road • Princeton, WV 24740 (304) 425-0716 Fax (304) 487-1322



I give permission to Melrose Family Medicine to discu with the persons listed below: (PLEASE PRINT EACH I	
	,
	•
I <u>DO NOT</u> give permission to Melrose Family Medicine information with the persons listed below: (PLEASE P	
	4
The following persons have my permission to seek treatabsence, including vaccines deemed necessary by the EACH NAME)	
	•
Signature of Patient and/or Guardian, if patient is a Minor	Date



MELROSE FAMILY MEDICINE

RICHARD SHORTER DO

756 ATHENS ROAD PRINCETON, WV 24740 304-425-0716

WVVA Health Care Alliance, P.C.

PATIENT'S NAME:		DOB:
		DOD
ADDRESS:		
. **		•
OCIAL SECURITY NUMBER:		
hereby Authorize:		
MAN TO SERVE A SERVE OF THE PROPERTY OF THE PR		
•	PHYSICIAN FROM WI	HOM YOU ARE REQUESTING RECORDS
PROVIDE CONFIDENTIAL INFORMAT	TON CONTAINED WITHIN MY MEDICAL R	ECORD TO:
•		
formedian to be miles and alessal	J:II	
formation to be released should		
case check type of information to be rel Complete health record	☐ Office Notes	Discharge automate
History and physical exam	☐ Consultation reports	☐ Discharge summary
Laboratory test results	☐ X-ray reports	Progress notes
Immunization record	☐ Demographic/insurance	☐ X-ray films / images
Immidinzation record	information	☐ Itemized bill
rpose of Request:		
Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
Other, (specify)		
		•
	Le Periods of Health Care: All Dates	of Service
a undersigned have read and outherize	the staff of the disclosion for its	
retand the information disclosed by the	the stair of the disclosing facility named to	disclose information as herein contained. I
stad by the Health Inguing Doutshill	s authorization may be subject to redisclosu	ire by the recipient and will no longer be
cied by the Health Insurance Portabilit	y and Accountability Act of 1998. The faci	lity, its employees, officers and physicians are
by released from any legal responsibility	y or liability for disclosure of the above inf	formation to the extent indicated and authorized
n. I understand that I do not have to sig	in this authorization, and my treatment or pr	ayment for services will not be denied if I do
ign this form unless specified above un	der <u>Purpose of Request</u> . I can inspect or co	by the protected health information to be used
sclosed. Except to the extent that action	has been taken in compliance with this req	uest, this authorization may be revoked by me
•	g to the facility Privacy Officer at	
ss revoked, this authorization will expin	e on the following date or event:	1 .1
		, unless otherwise specified.
		· · · · · · · · · · · · · · · · · · ·
	•	
Signature of Patient / Legal G	uardian	Date '

_ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually

30373-BJW Printing & Office Supplies

Initial _

transmitted disease, Hepatitis B or C, HIV results or AIDS information.

Patient Intake Form

Please present your insurance card at time of check-in. Settlement of patient financial responsibility is expected at time of service.			
TYPE OF VISIT: O Insurance (present card at check-in) O Self-pay (payment due at time of service) O On-the-job injury O Other:			
Patient Name:			
Last:	First:	Middle:	
Date of Birth:	Social Security Number:	Sex: O M O F	
Marital Status: OSingle O Married	Email Address:		
O Divorced O Separated			
Street Address:		City, State, ZIP	
Home Phone: O Preferred	Cell Phone: O Preferred	Work Phone: O Preferred	
May we leave a message regarding	Ethnicity:	Race:	
your care (x-ray, lab results) on your preferred phone? OYON	OHispanic		
,	ONon-Hispanic		
If patient is a minor, are there any custody issues we need to be aware of: O Y O N			
Please state your reason for too	day's visit:		
Are you experiencing any of the	following? Places stop and no	tify attandant immediately	
Are you experiencing any of the following? Please stop and notify attendant immediately. O SEVERE chest pains O Allergic reaction			
O SEVERE chest pains O Allergic reaction O SEVERE shortness of breath O Any other life-threatening condition			
O Uncontrolled bleeding			
PRIMARY Insurance Information: Medicare Medicaid Commercial Other			
Subscriber Date of Birth (if other than patient):			
Secondary Insurance Information	on: Medicare Medicaid Comme	ercial Other	
Primary Care Physician:			
Should we fax or mail a copy of your chart? O Y O N			
Name:	Phone:	Fax:	

' WYYA

HEALTH CARE ALLIANCE, PC

Emergency Contact :					
Name:	Phone:	Relat	ion:		
	T HOHO.	IXelat	1011.		
Parent or Guarantor's Na	me:				
Complete with name of in	sured if the patient is not respor	nsible for hi	s or her charges to	dav.	
Last:	First:	Midd			
Date of Birth:	Social Security Number:	Sex:	ОмОг		
Street Address:		City,	City, State, ZIP		
Home Phone:	Work Phone:	Empl	loyer:		
Is this an on-the-iob or ot	her work-related injury? O Y	O N			
If so, please complete the		.			
Employer Name:	Employer Phone #:	Supe	rvisor:		
Employer Street Address:		City	City, State, ZIP		
		J.,	J. L.		
Description of Injury or Sympto	oms:	Date	of Injury:		
Authorization and Release					
	oluntarily consent to the administratio	n and cost of	medical and surgical		
procedures, x-ray, and medicati	on for myself and my dependents.				
Assignment of Insurance Benef payable to me.	its: I authorize payment directly to this	clinic for all b	enefits otherwise		
Guarantee of Payment: I unders	stand that I am financially responsible a	and agree to r	oav all of the charges th	at are	
not paid or billed to insurance o	or any other third party payer. I understa	and that I mus	st pay in full today for a	II	
	surance is accepted. I also understand bays, coinsurances, and deductibles to	•	•	ıust	
insurance at time of service, I w		day. II you ar	e unable to verify my		
	this clinic to release (verbal or in writing my insurance carrier, employer if trea				
	perations which may be liable to me or				
	anagement, utilization review, transfer,		` '		
Receipt of Privacy Practices: 1 a clinic.	acknowledge that I have received and re	ead the Notice	e of Privacy Practices o	f this	
In order for us to service your a	ccount or to collect any amounts you n	nav owe us. v	ou authorize us and ou	r	
	their affiliates which include debt colle				
	count, including wireless telephone nu		•		
•	but are not limited to the use of pre-re telephone dialing systems, predictive t		• •		
SMS text message reminders, and		leiephone dia	ing systems, automate	u	
I understand that a copy of this	agreement may be used with the same	effectiveness	as the original.		
PATIENT SIGNATURE	Γ	DATE	/ /		
RESPONSIBLE PARTY		DATE	/		
REVIEWED BY		DATE	//		



Melrose Family Medicine A Division of WV / VA Health Care Alliance

RICHARD SHORTER, D.O.

756 Athens Road • Princeton, WV 24740 (304) 425-0716 Fax (304) 487-1322



Cancellation/No Show Policy

Cancellation of appointments must be made 24 hours in advance. Failure to provide 24 hours advanced notice on 3 occasions within a 12 month period will result in dismissal from the practice.

We can only see a finite number of patients per day and failure to provide adequate notice of intent to miss an appointment deprives other patients of needed care.

Thank you for your consideration in this matter,

Richard A. Shorter, D. O. Tara Mitchell, D. O. Elizabeth Johnson, PA-C Sheila Snidow, FNP-BC

Attention New and Established Patients

Effective 1/1/2021 Melrose Family Medicine charges a "no-show" fee of \$40.00

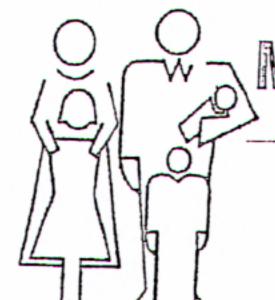
This applies to new and established patients and will be charged directly to the patient/guarantor, NOT the patient's insurance.

All no show fees MUST be paid prior to the next appointment in order to be seen.

Melrose Family Medicine reserves the right to terminate the doctor-patient relationship of established patients due to no-shows.

New patients who no-show for their appointment will NO longer be able to schedule with our providers and WILL be billed the no-show fee.

Thank you!

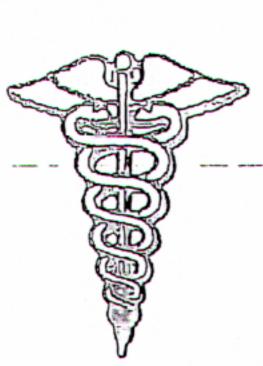


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Thank you for placing your trust in us for providing medical care for you and your family. We will try to provide competent, compassionate care in a timely manner for your medical needs. In order to achieve this goal we have provided the information below to assist you in getting the most satisfactory experience here.

Office Hours: Monday-Friday—8:00AM-6:00PM

Appointments: We see patients even for urgent sick visits primarily by appointment. Appointments should be made for <u>all</u> visits. If you or your child is sick, please call the office so that you can be fit in among those that already have appointments that day. If you are very sick, you will be seen in priority ahead of others. Walk-ins will be seen if there is time left in between the above patients. Allergy shots and other regular injections or lab work will be seen in priority as well, as long as a detailed visit with the provider is not required.

How to Get the Best Care: To properly examine a child for a regular check-up, it is best that they are undressed down to the diaper or underwear. This way skin cancer and other important disorders will not be missed. It is helpful to bring an extra diaper and a blanket so small children will not be uncomfortable while waiting.

What to Do When You Need to Reach Me: During office hours, it is important to ask for a nurse. They have been trained to take your calls. Tell them the problem and they will get the message to the appropriate provider. They will give you appropriate instructions after talking to the provider. If there is an urgent problem, the provider will call you back as soon as is possible. Otherwise, the provider will call back at the end of the day if necessary. We find this is the best method for you to get an answer to your problem quickly. After hours, if there is an emergency, you can reach Dr. Shorter by calling Princeton Community Hospital at 304-487-7000. You should also know that we generally do not prescribe antibiotics over the phone. If you are sick enough to require antibiotics, you should be seen. If you or your child is admitted to the hospital, please have a family member inform the office. Always ask the physician who is taking care of you in the hospital to send us a summary of your discharge. This is very helpful for your follow-up care.

We are concerned about your waiting time. With your cooperation, we are hoping this will make your visit less troublesome.

The Providers and Staff of Melrose Family Medicine