WVVA Health Care Alliance, P.C.

Patient Information: This section refers to the PATIENT ONLY

Social Security Number:_____ If Employed, Employer: _____

Last Name:_____ Jr., II, _____ _____

First Name:_____ MI_____ Work Phone: (_____)_____

Nickname / Alias:_____ Address: _____

Address:_____ Zip Code:_____

Zip Code:_____ City:_____State: _____ City/State:_____

Home Phone: (___) _____ Cell Phone: (___) _____ If Student ☐ Full-Time ☐ Part-Time

Birth Date (mm/dd/yy):_____ Name of School:_____

Sex: ☐ Male ☐ Female Email:_____

Marital Status: Married Single seParated Divorced Widowed Pharmacy:_____

Subscriber Information: Please ensure the office has a copy of your most recent Insurance Crd(s) and Drivers License

PRIMARY INSURANCE COVERAGE -

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other:_____

Insured Name(as on card):_____ Insured ID #:_____

Insured Social Security Number:_____ Group/Policy #:_____

Name of Insurance Company: _____ Effective Date:_____

Insurance Address:_____ Employer:_____

Zip:_____ City:_____State:_____ Address:_____

Insurance Phone #: (_____) _____ Zip:_____City:_____State:_____

Insured Birth Date (mm/dd/yy):_____ Employer Phone #:_____

Sex: ☐ Male ☐ Female If Student ☐ Full-Time ☐ Part-Time

Marital Status: Married Single seParated Divorced Widowed Name of School:_____

Insured 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 . . . .

I hereby authorize the office of WVVA Health Care Alliance, P.C., to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

_____ _____

Date Signature of Patient and / or Guardian, if patient is Minor

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to WVVA Health Care Alliance, P.C., for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Date Signature of Patient and / or Guardian, if patient is Minor

How were you referred to the practice . . .

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 ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

____Patient refuses to sign Acknowledgement. _____WVVA Health Care Alliance [EMPLOYEE/POSITION] made the following efforts to attempt to obtain a signature from the patient:

_____

_____

_____

_____

Signature of Practice Employee

_____

Signature of Chief Privacy Official

Melrose Family Medicine

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 division of **WVVA** Health Care Alliance, PC., to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Name _____Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient

Richard Shorter, D.O. :: Leah Petrunger, PA-C
Phone:(304) 425-0716
756 Athens Road
Princeton, WV 24740
Fax:(304) 487-1322

WVA

HealthCare Alliance PC

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 other healthcare communications/information at the email and/or text listed below from Melrose Family Medicine.

_____ **(Patient initials)** I consent to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number.

My cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(_____) _____-_____ Cell Carrier: _____

_____ **(Patient initials) I consent to emails, to receive communications as stated above.**

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is

_____

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing, to opt out of this service.

Patient Signature: _____ **Date:**_____

Witness: _____ **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

I give permission to Melrose Family Medicine to discuss my medical information with the persons listed below: ***(PLEASE PRINT EACH NAME)***

_____

_____

_____

_____

_____

I ***DO NOT*** give permission to Melrose Family Medicine to discuss my medical information with the persons listed below: ***(PLEASE PRINT EACH NAME)***

_____

_____

_____

_____

_____

The following persons have my permission to seek treatment for my child in my absence, including vaccines deemed necessary by the provider: ***(PLEASE PRINT EACH NAME)***

_____

_____

_____

_____

_____

_____ _____

Signature of Patient and/or Guardian, if patient is a Minor

Date

(Fax 304-467-1322)

MELROSE FAMILY MEDICINE
RICHARD SHORTER DO
756 ATHENS ROAD
PRINCETON, WV 24740
304-425-0716

WVVA Health Care Alliance, P.C.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ DOB: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

I hereby Authorize: _____

PHYSICIAN FROM WHOM YOU ARE REQUESTING RECORDS

TO PROVIDE CONFIDENTIAL INFORMATION CONTAINED WITHIN MY MEDICAL RECORD TO: _____

Information to be released should include: ☐ Other _____

Please check type of information to be released:

☐ **Complete health record**	☐ Office Notes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Immunization record	☐ Demographic/insurance information	☐ Itemized bill

Purpose of Request:

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other, (specify)

_____

Information To Be Released - Covering the Periods of Health Care: ☐ All Dates of Service

From (date) _____ to (date) _____

I, the undersigned, have read and authorize the staff of the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1998. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has been taken in compliance with this request, this authorization may be revoked by me at any time, by submitting a notice in writing to the facility Privacy Officer at _____.
Unless revoked, this authorization will expire on the following date or event: _____
_____, unless otherwise specified.

_____ _____

Signature of Patient / Legal Guardian Date

Initial _____ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually transmitted disease, Hepatitis B or C, HIV results or AIDS information.

30373-BJW Printing & Office Supplies

WVVA
HEALTH CARE ALLIANCE, PC

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: ○ Insurance (present card at check-in) ○ Self-pay (payment due at time of service)
○ On-the-job injury ○ Other: _____

Patient Name:		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: ○ M ○ F
Marital Status: ○ Single ○ Married ○ Divorced ○ Separated	Email Address:	
Street Address:		City, State, ZIP
Home Phone: ○ Preferred	Cell Phone: ○ Preferred	Work Phone: ○ Preferred
May we leave a message regarding your care (x-ray, lab results) on your preferred phone? ○ Y ○ N	Ethnicity: ○ Hispanic ○ Non-Hispanic	Race:

If patient is a minor, are there any custody issues we need to be aware of: ○ Y ○ N

Please state your reason for today's visit:

Are you experiencing any of the following? Please stop and notify attendant immediately.

- ○ SEVERE chest pains
- ○ SEVERE shortness of breath
- ○ Uncontrolled bleeding
- ○ Allergic reaction
- ○ Any other life-threatening condition

PRIMARY Insurance Information: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other

Subscriber Date of Birth (if other than patient):

Secondary Insurance Information: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other

Primary Care Physician:
Should we fax or mail a copy of your chart? ○ Y ○ N

Name:	Phone:	Fax:

WVVA

HEALTH CARE ALLIANCE, PC

Emergency Contact :		
Name:	Phone:	Relation:
Parent or Guarantor's Name: ***Complete with name of insured if the patient is not responsible for his or her charges today.***		
Last:	First:	Middle:
Date of Birth:	Social Security Number:	Sex: ○ M ○ F
Street Address:		City, State, ZIP
Home Phone:	Work Phone:	Employer:

Is this an on-the-job or other work-related injury? ○ Y ○ N *If so, please complete the following:*		
Employer Name:	Employer Phone #:	Supervisor:
Employer Street Address:		City, State, ZIP
Description of Injury or Symptoms:		Date of Injury:

Authorization and Release

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to this clinic for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize this clinic to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this clinic.

In order for us to service your account or to collect any amounts you may owe us, you authorize us and our affiliated physicians, as well as their affiliates which include debt collectors, to contact you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact include but are not limited to the use of pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and facsimile as applicable.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE _____ DATE _____/_____/_____

RESPONSIBLE PARTY _____ DATE _____/_____/_____

REVIEWED BY _____ DATE _____/_____/_____

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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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Fax (304) 487-1322

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 ***all*** 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