VMP, llc
Expanding Genetic Horizons

Voice: 404.793.7800
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www.vmpgenetics.com

PATIENT CONSENT FORM

1905

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: Referring physician(s), hospitals involved in your care, primary care providers, laboratories that will be involved in testing, other physician groups (surgeons, consultants), other 3rd party billing entities, business related activities (quality assurance, information technology), or insurance companies as examples.

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),* Website, Internet, Skype and/or Webcam, Telephone *(verbal and voice message),* Facsimile *(secure or none secure),* Email *(encrypted or unencrypted), or* Patient/Customer Portals.

Per the HIPAA Omnibus Rule, VMP uses e-mail, voice, & fax systems which are HIPAA compliant but there may be a lack of security on your end, especially if you are using VoIP telephone service, wireless phone providers or a Gmail, Yahoo! Mail, Hotmail (or similar) account. By your signature on page 3 of this form you acknowledge the HIPAA security risks of the systems YOU use for email, voice, or fax and you still provide VMP the authority to send your private information to these potentially unsecure services used by YOU. Initial only if you wish to opt out of this paragraph and restrict to our portal any HIPAA communication with you:________

APPOINTMENT RESCHEDULING AND CANCELLATIONS

Rescheduling or cancellations have a much more significant impact on us than many other medical practices which is why we send out appointment reminders weeks before the appointment. We ask that patients make every attempt to attend their scheduled appointment on time so that as many people can be helped while avoiding those people who are waiting for their appointments to wait unnecessarily. If one is necessary Rescheduling / Cancellation notification will be accepted only by fax, email, or our portal. Phone call messages are not considered notification. Exceptions may be made under the sole discretion of VMP. **No shows to an appointment without the courtesy of a notification made by them will be charged the full amount for their appointment.**

Rescheduling/Cancellation notification:

- made 15 to 21 days prior to an appointment will incur a $15 fee,
- made 8 to 14 days prior to an appointment will incur a $75 fee,
- made 3 to 7 days prior to an appointment will incur a $150 fee,
- made 1 to 2 days prior to an appointment will incur a $300 fee,
- made the day of the appointment or a No Show will be charged for the appointment.

REMAINING A PATIENT AND THE NEED FOR FOLLOW-UP APPOINTMENTS

Conditions and status can change rapidly for a patient. If not specifically noted by the physician, a patient must have an appointment at least once every 12 months to allow our physician to continue to participate in their care beyond 12 months. A person will be considered a new patient if they have not had an appointment in the past 3 years.

DIRECT TO CONSUMER TESTING

Do not send us DTC (direct to consumer) testing results or interpretations derived from DTC results as it is not diagnostic and will not be reviewed, interpreted, or stored by VMP. Please see Dr Kendall's podcast on the subject of DTC testing at mitoaction.org and on our website.

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TESTING

We have no laboratory affiliation or financial incentive in the tests we order. Any testing will be billed through the laboratory used. You acknowledge that the sensitivity of genetic tests is not 100% and that the cause of the disease in me/my family may not be identified by evaluation, analysis, or testing. Testing will be performed at outside, independent 3rd party laboratories and they will bill your insurance and discuss billing issues with you. During your appointment it is your responsibility to seek explanation from a VMP physician of any ordered testing.

INSURANCE PRIOR APPROVALS AND LETTERS OF MEDICAL NECESSITY

Insurance many demand a PA (Prior Approval) or LOMN (Letter of Medical Necessity) rather than out-right stating the test or prescription is denied. This tactic by insurance has increased from a few per year to now hundreds of demands per year. Typically the lab will work to obtain insurance approval as they are the ones billing insurance for their work. Some insurance companies have now refused to allow the lab to work on your behalf to obtain approval and are forcing the provider to become directly involved. This tactic is done by insurance without compensating the provider for the considerable time and resources their demand has inflicted upon the provider. Rather than raise our fees for everyone to cover such unreimbursed work, we are trying to keep our fee as low as possible. Please be aware that even with our best efforts to obtain approval, your insurance company may still deny approval.

- Without a fee, we will provide the laboratory or pharmacy with the information that they may need to secure any insurance approvals.
- There is an additional fee ($150) if a VMP provider is forced by your insurance company to work directly to obtain an approval.

REPORTING RESULTS

VMP will contact you if a result requires immediate action or changes the management recommendations while negative or benign results will be retained for discussion within a follow up appointment. Testing results will be provided to you within a follow up appointment when requested.

PAYMENT OF SERVICES & INSURANCE MATTERS

You agree to be held solely responsible for any & all charges from VMP. We are not contracted with any insurance company. VMP requests deposits and requires that balances be paid prior to or at the time of your appointment. It is your responsibility to fully understand your particular insurance coverage and to obtain any required referral from your primary care physician if such referral is necessary by your insurance. VMP does not bill insurance companies, nor Medicaid, nor Medicare but will provide claims forms as allowed by your insurance. Specifically, we have opted out of Medicare and if you have Medicare based insurance please fill out and return to us the supplied Medicare Patient Consent Form in addition to this Consent Form.

MEDICAL RECORD FEES

Records will be supplied directly to patients for free through our patient portal if the patient had an appointment within the last 14 months. Medical records for all others including 3rd parties will be at the fee set by the State of Georgia.

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, and of the associated HIPAA security risks.
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.

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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, opt out of any portion of it, 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 limitations and implications to you for any ordered testing,
10) Understand and agree that 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 that VMP may contact you by email, telephone, or mail periodically about appointment reminders, upcoming events, or other information that VMP determines may be of interest to you.
13) If you have a Medicare based insurance, you understand VMP has opted out of Medicare and will not issue a claim form. It is your responsibility to inform VMP that you have Medicare based insurance and provide VMP a fully executed Medicare Patient Consent Form in addition to this Consent Form.
14) 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.

I have read the contents of the 3 pages 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.

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PLEASE PRINT - PATIENT NAME **DATE OF BIRTH**

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

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SIGNATURE – PATIENT OR PARENT/GUARDIAN **DATE SIGNED**

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