Clinical Services Scheduling Protocol Overview

Medication Management

Generally, medication management appointments are scheduled as recurring appointments every twenty-one (21) days once patients are established a with a mental health provider.

Neurofeedback Therapy

We have found patients achieve optimal results with 2 to 3 30-minute appointments weekly with a Neurofeedback Technician with those visits supported by a follow-up telehealth appointment weekly with a mental health provider. We request that patients provide a two-hour window of availability for neurofeedback appointments as our technicians are subject to traffic and other delays en route to your home or location.

Neuropsychological Testing

Depending on the patient needs and circumstances, neuropsychological testing is generally scheduled weekly or biweekly.

Therapy/Counseling

Scheduling frequency can vary for therapy/counseling based on patient needs and circumstances. Once established with one of our therapists/counselors they will collaborate with you to recommend an appropriate appointment frequency.

If you have any questions or concerns regarding our services or scheduling, our dedicated team of Patient Experience Coordinators are available
M – F from 9 am EST to 7 pm ET and are happy to assist you.

Thank you for trusting Golden Victory Medical with your care.

Informed Consent Form

I consent to engaging in services with Golden Victory Medical, LLC. These services may vary based on my needs and my recommended treatment plan. I understand that these services may include the option for telehealth visits. These visits will occur primarily through interactive audio, video, telephone, and/or other audio/video communications. I understand that I have the following rights with respect to my care:

1. I have the right to withhold or remove my consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information apply to all services I may receive under the care of Golden Victory Medical, LLC. As such, I understand that the information released by me during my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including, but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from telehealth interaction to other entities shall not occur without my written consent.

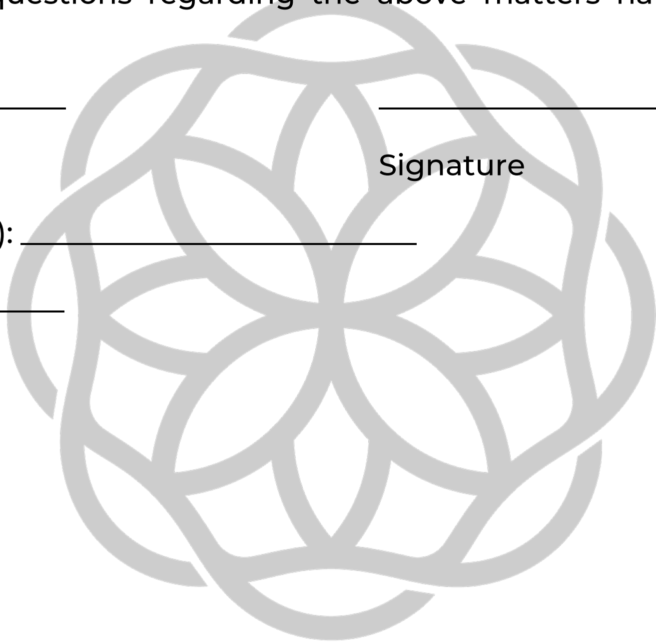
3. I understand that there are possible risks and consequences from telehealth specifically including, but not limited to, despite reasonable efforts on the part of Golden Victory Medical, LLC that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my provider believes I would be better served by other interventions; I will be referred to a mental health professional in my area who can provide those services. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and despite my efforts and the efforts of my provider, my condition may not improve, or may potentially get worse. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Golden Victory Medical, LLC or its stall liable for gathering or use of client information by these service providers.

4. I understand that a head to shoulder photo may be kept on record in my electronic medical records chart.

5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based medication management services. If I am in crisis or in an emergency, such as thoughts of hurting or harming myself or others or have uncontrolled psychotic symptoms, I should immediately call 911 or go to the nearest hospital or crisis facility. I acknowledge that I have been told that if I feel suicidal, I am to call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433.

6. I agree to Golden Victory Medical, LLC billing my insurance on file. Should my insurance not be valid or current, I agree to the outstanding bill or balance for visits rendered.

7. I understand that I have the right to access my personal information and copies of notes. I have read and understand the information provided above. I have discussed these points with my provider and all my questions regarding the above matters have been answered to my approval.



_______________________________ _______________________________

Printed Name Signature

Relationship (if applicable): ___________________________

Date: _________________________

Golden Victory Medical

Patient Information

First Name: ______________________ Last Name: ______________________

Date of Birth (MM/DD/YY): ______________ SSN: ______________________

Address: ____

City: __________________ State: ________________ ZIP: ______________

Phone(H): ______________ (W): ______________ (C): ________________

E-mail: ____

Preferred method of communication: ☐ E-mail ☐ Text ☐ Phone

Marital Status: ☐ Single ☐ Married ☐ Other: ____________________

Insurance Information

Policy Holder Name: ________________ DOB: __________ SSN: ____________

Address: ____

City: __________________ State: ________________ ZIP: ______________

Insurance Company: __________________ Member Subscriber ID: ______________

Provider Services Phone # (on back of card): ________________________________

Insured's Employer: ______________ City: ___________ State: ______ Zip: ______

Insurance Information-Secondary

Policy Holder Name: ________________ DOB: __________ SSN: ____________

Address: ____

City: __________________ State: ________________ ZIP: ______________

Insurance Company: __________________ Member Subscriber ID: ______________

Provider Services Phone # (on back of card): ________________________________

Insured's Employer: ______________ City: ___________ State: ______ Zip: ______

I authorize the release of any medical record or other information necessary to process the claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Printed Name: ______________________

Signature: __________________________ Date: ____________________

Messages

Please call: ☐ My Home ☐ My Work ☐ My Cell: ______________________________

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

The best time to reach me is (day) ______________ between (time) ______________________________

Additional Information

Emergency Contact Information

Name: _________________________ Relationship: ___________________

Phone Number: ____________________

Name: _________________________ Relationship: ___________________

Phone Number: ____________________

Name: _________________________ Relationship: ___________________

Phone Number: ____________________

Pharmacy Information

Name of Pharmacy: ____

Address: ____

Phone Number: ____

Fax Number: ____

Cross Streets: ____

Other Medical Information

Primary Care Physician (PCP): ____

PCP Address: ____

PCP Phone Number: ____________________________ Fax: ______________________

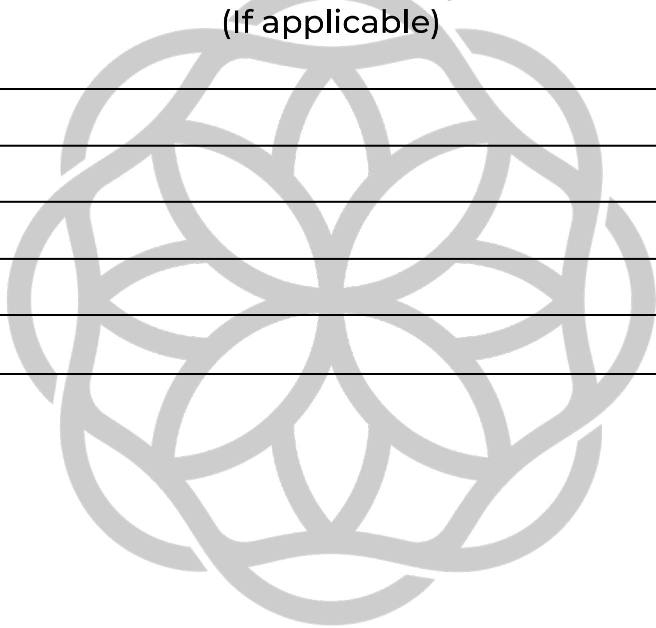
Are you being seen by: [ ] Psychiatrist [ ] Psychologist [ ] Therapist [ ] N/A

Name: ____

Address: ____

Phone Number: ______________________ Fax: ______________________

Group Home/Assisted Living Information (If applicable)



Facility Name: ____

Address: ____

Phone Number: ____

Fax Number: ____

Director: ____

Contact Person: ____

Medical History Questionnaire

Primary Care Physician(s): ____

Medication Allergies

No known Drug Allergies________________

- *Allergy* ________________ *Reaction* ____
- *Allergy* ________________ *Reaction* ____
- *Allergy* ________________ *Reaction* ____
- *Allergy* ________________ *Reaction* ____

FAMILY MEDICAL HISTORY ****Please be specific and be sure to include appropriate familial designations (maternal grandmother, paternal grandfather, etc.)*

Cancer ________________________________ *Epilepsy* ________________________________

High Blood Pressure _______________________ *Asthma*_________________________________

*Anemia*_________________________________ *Mental Illness*___________________________

*Migraines*_______________________________ *Thyroid Disease*__________________________

*Depression*______________________________ *Kidney Disease*___________________________

*Stroke*__________________________________ *Allergies*________________________________

*Drug/Alcohol Abuse*_______________________ *COPD*__________________________________

*Obesity*_________________________________ *Leukemia*_______________________________

*High Cholesterol*__________________________ *Ulcer*__________________________________

*Diabetes*________________________________ *Glaucoma*_______________________________

PREVENTION/SCREENING: *Please provide date last performed*

Colonoscopy ____________________ *Bone Density Study* _____________________ *Chest X-Ray* __________

Mammogram ___________________ *Pneumonia Shot* ______________________

Pap Smear _____________________ *Tetanus Shot* __________________________

Past Medical History: *Please circle all that you currently have or have had in the past*

AIDS or HIV Positive	*Depression*	*High Cholesterol*
Allergies	*Diabetes*	*Mononucleosis*
Anemia	*Epilepsy/Seizures*	*Kidney Disease*
Anxiety	*Glaucoma*	*Mitral Valve Prolapse*
Arthritis	*Headaches/Migraines*	*Osteoporosis*
Asthma	*Heart Disease*	*Ovarian or Uterine Cyst*
Back Trouble	*Hemorrhoids*	*Stroke/TIA*
Bladder Infections	*Hepatitis (type______)*	*Thyroid Disease*
Cancer (type______)	*Hernia (location_____)*	*Tuberculosis*
COPD	*High Blood Pressure*	*STD*
Yeast Infection	*Others: ____*	

HAVE YOU EXPERIENCED ANY THOUGHTS OF HARMING YOURSELF OR OTHERS?

______ Yes _______ No

PLEASE LIST ANY CURRENT HEALTH DIAGNOSIS (IF ANY)

____

____

PLEASE LIST THE REASON(S) FOR YOUR VISIT WITH US TODAY

____

____

____

____

Office: (904) 273-4094| Fax: (904) 395-2781 | Billing: (904) 257-1030

pontevedrascheduling@goldenvictorymedical.com

100 Executive Way, Suite 211, Ponte Vedra, Florida 32082

goldenvictorymedical.com

Golden Victory Medical

Medication Reconciliation Form

Date: Month ___________ Day ___________ Year __________

Patient Name: First ________________________ Last _______________________________

DOB: Month ___________ Day ___________ Year __________

Medication Allergies: ____

Source of Information: [ ] Patient [ ] Family Member [ ] Other

List all the Medications you are taking, including Over the Counter and Herbal:

Medication	Dose	Route	Frequency	Comments	Continued	Discontinued

Practitioner Signature: ________________________ Date: ____________________ Time: __________

Patient Signature: ____________________________ Date: ____________________ Time: __________

Authorized Delegate Form

What is the purpose of this form?

This form allows Golden Victory Medical to share information about your healthcare account with someone else for the purpose of coordination of care. For instance, you might want us to share your private healthcare information with your spouse, another family member, your child's guardian, your employer, or a parent.

If you fill out and sign this form, we will share your claims, benefit, and health information with anyone you choose. The person or organization you choose becomes your authorized delegate. Your authorized delegate can only receive information. They cannot act on your behalf or change anything about your health insurance policy or benefit plan.

If you do not wish to fill out this form, we will continue to serve you. However, we will not be able to share your information. Once we receive your completed form, we can share your information with your authorized delegate for one year unless otherwise specified or revoked.

If this authorization covers a minor child, it will end on that child's 18th birthday.

After you complete this form, please send it to us:

- Email: lasvegasscheduling@goldenvictorymedical.com
- Fax: 702.442.9793
- Mail: Golden Victory Medical, 2870 S. Maryland Pkwy, Suite 200, Las Vegas NV 89109

Frequently Asked Questions

Q: Does this form allow your authorized delegate to receive a copy of your medical record?
A: *No. To obtain a copy of your medical record, please complete and submit the Authorization to Disclose Protected Health Information form.*

Q: Can I just provide a verbal approval?
A: *Verbal approval is temporary. If you have called us to name an authorized delegate and have received temporary approval from us, you must fill out and sign this form so that your authorized delegate can continue to receive information from us. Your verbalapproval is only valid for 24 hours after we talk to you.*

Q: Can I change my decision?
A: *Yes, you may change your decision about sharing your information at any time. If you decide that you nolonger want us to share your information with an authorized delegate, please contact Golden Victory Medical immediately. Changing your decision does not affect actions that Golden Victory Medical took while this authorization was valid.*

This form authorizes Golden Victory Medical to share your information with someone else for the purpose of coordination of care. If you do not wish to fill out this form, we will continue to serve you. However, we will not be able to share your information with your authorized delegate.

PART 1: PATIENT WHOSE INFORMATION WILL BE SUBJECT TO DISCLOSURE

Patient Name

Date of Birth (MM/DD/YYYY)

Address

State

Zip

Phone Number

PART 2: AUTHORIZED DELEGATE

We understand that you want to name the following person(s) or organization as your authorized delegate. Note: If the people or organizations you name are not required to follow the federal health information privacy laws, they may share your information with someone else and federal privacy laws may no longer protect your information.

If your authorizeddelegate is aperson, please fill out this section.

Name

Date of Birth (MM/DD/YYYY)

Address

State

Zip

Phone Number

If your authorizeddelegate is an organization, please fill out this section.

Organization Name

Address

State | Zip | Phone Number

PART 3: INFORMATION TO BE SHARED (Please check where applicable)

☐ All information about eligibility, enrollment, plan benefits, claims, correspondence to or from Golden Victory Medical and prior authorization or determinations for services provided by any treatment provider.

☐ Only specific information: ____

PART 4: SIGN HERE IF YOU ARE THE PATIENT

By signing here, you give Golden Victory Medical permission to share any of your personal information that is protected by federal or state law with the authorized delegate(s) named in Part 2 of this form. You understand that this personal information may include detailed medical information about you, including information about substance abuse and mental health conditions if you have approved it in Part 3 of this form. That information does not include psychotherapy notes, HIV information, or genetic information.

This authorization is valid for one year unless otherwise specified or revoked. If this authorization covers a minor child, it will end on that child's 18th birthday. You may change your decision about sharing your information at any time. Changing your decision does not affect actions that Golden Victory Medical took while this authorization was valid.

Patient Signature

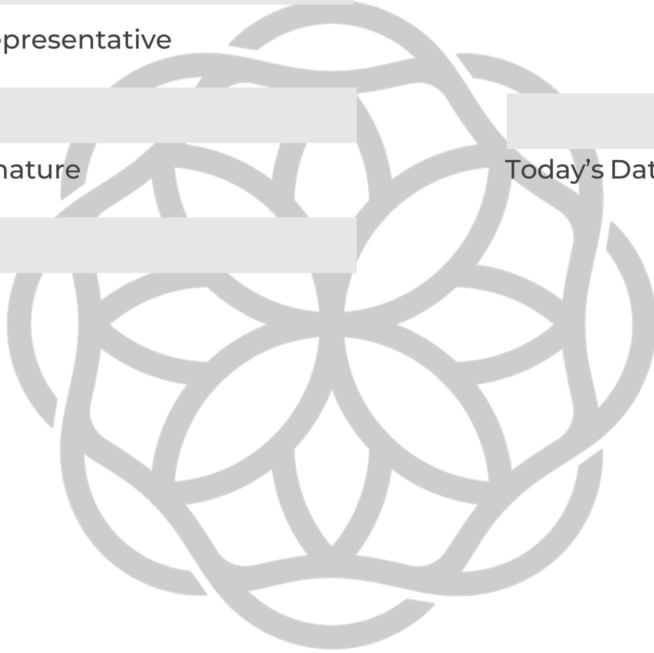
Today's Date (MM/DD/YYYY)

PART 5: SIGN HERE IF YOU ARE THE PERSONAL REPRESENTATIVE FOR THE PATIENT

To show that you are legally designated as the patient's representative, when you send us this form you must alsosend us copies of any legal documents that prove you have guardianship or power of attorney.

- I am authorized as a personal representative for the patient who is named in Part 1 of this form. I am legally designated as a parent of a minor, legal guardian, or holder of power of attorney.
- I understand that this authorization will be valid as long as the patient's health insurance with Golden Victory Medical is in effect. If the insurance is canceled, the authorization will end.
- If this authorization covers a minor child, it will end on that child's 18th birthday.

Printed Name of Personal Representative



Personal Representative Signature

Today's Date (MM/DD/YYYY)

Relationship to Patient

HIPAA Privacy Information and Authorization Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. Specifically, there are rules and restrictions on who maysee or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services and can be found at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provideservices or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers, as necessary and appropriate for your care. Patient files may be stored in openfile racks and will not contain any coding which identifies a patient's conditionor information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, electronic methods, U.S. mail, or by any means convenient forthe practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA in any transfer of PHI electronically or as physical documents.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or staff. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services. We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient. You have the right to request restrictions in the use of your PHI and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________________ do hereby consent and acknowledge my agreement to the terms set forth above and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature | Today's Date (MM/DD/YY)

Authorization for Release

Patient Name: ____

Medical Record#: ____

Date of Birth: ____

E-Mail Address: ____

I, __________________________ do hereby consent and request for Golden Victory Medical to release my Protected Health Information (PHI) to:

____

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize and disclose my PHI to anyone of my choosing for billing, condition, treatment, and

prognosis to the following individual(s):

Name: ____

Relationship: ____

Phone: ____

I request the following restriction(s) to releasing my PHI:

____
____

I understand that I am entitled to a copy of Golden Victory Medical's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the office directly. I understand that I have the right to revoke this authorization, in writing, at any time. I understand a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be in force and effect throughout my duration of receiving services from the company.

Patient Signature	Today's Date (MM/DD/YY)

Golden Victory Medical

Authorization to Disclose Protected Health Information (PHI)

The purpose of this document is to authorize Golden Victory Medical to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure. " Otherwise, please complete the form as indicated.

____ ______________________

Last Name First Name Middle Initial Date of Birth (MM/DD/YY)

I authorize Golden Victory Medical to release the following information (describe):

____

____

To the following individuals/organizations:

____

____

This authorization shall remain in effect until _______________(date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Golden Victory Medical.

____ __________

Signature of Member/Member Representative Date

____

Printed Name of Member Representative

____

Relationship to Member

____ ____________________________

Representative Address Representative Phone Number

______________________________________Witness Signature

100 Executive Way, Suite 211, Ponte Vedra, Florida 32082

Golden Victory Medical

Authorization to Disclose Protected Health Information (PHI)

The purpose of this document is to authorize Golden Victory Medical to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure. " Otherwise, please complete the form as indicated.

Last Name ____ First Name ____ Middle Initial ____ Date of Birth (MM/DD/YY) ____

I authorize Golden Victory Medical to release information to:

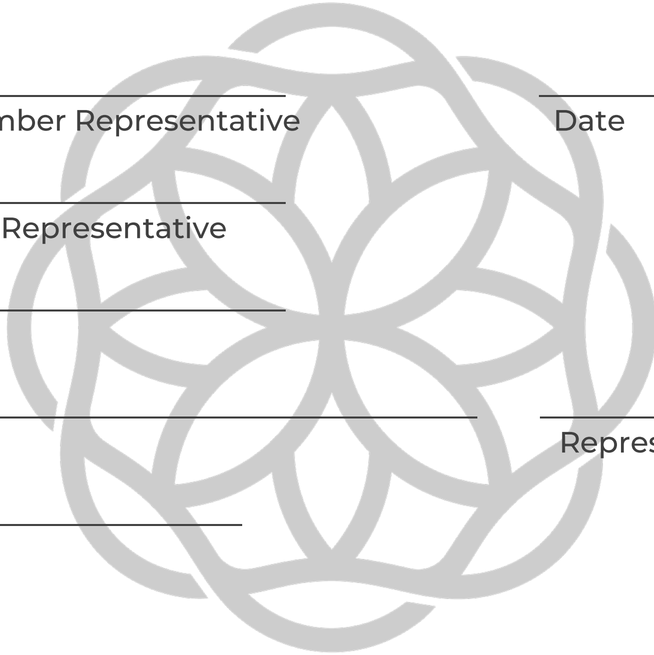
____

which shall include: (check each applicable item)

- ☐ Services provided (appointment schedule and summary)
- ☐ Hospitalization Screening
- ☐ Admission Evaluation Report (Bio/Psycho/Social)
- ☐ Information related to referral and to follow up
- ☐ Treatment Plan(s) and Diagnosis Only
- ☐ Progress Notes
- ☐ Re-disclosure of other treatment, testing, evaluations
- ☐ Medical Reports
- ☐ Treatment Plan(s) and Diagnosis Only
- ☐ Progress Notes
- ☐ Re-disclosure of other treatment, testing, evaluations
- ☐ Verbal correspondence of information needed or requested
- ☐ Legal Reports
- ☐ Psychological Evaluation Report (If applicable)
- ☐ Education Reports
- ☐ HIV/AIDS Information
- ☐ Discharge Summary
- ☐ Alcohol and Drug Treatment Information
- ☐ Other: Please Describe ______________________________

This authorization shall remain in effect until _________________(date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Golden Victory Medical.



____ ____________

Signature of Member/Member Representative Date

____

Printed Name of Member Representative

____

Relationship to Member

____ ____________________________

Representative Address Representative Phone Number

____

Witness Signature

What is Neurofeedback Therapy and Neuropsychological Testing?

Think of your brain as a musical quartet. When all the musicians are in sync, the sound is harmonious. If but one musician is out of tune, the overall sound is affected; brainwaves work in the same manner. Neurofeedback therapy works by monitoring and assessing your brainwaves while correcting any irregularities by harmlessly speeding them up or slowing them down.

The purposes of a neuropsychological evaluation are:

I. To determine the pattern of brain-related strengths and weaknesses
II. To develop an understanding of nature and the origin of difficulties
III. To make a diagnosis and provide specific recommendations for appropriate intervention and treatment.

These two methods work hand in hand in treating symptoms such as ADD and ADHD, Seizures, Depression and Anxiety, PTSD, Insomnia, Disruptive Behavior Disorders/Bipolar Disorder, Phobias, Autism, Migraines, Concussions and Traumatic Brain Injuries and more, all the while improving your overall cognitive functioning to peak performance! Neurofeedback guides the brain into more regular patterns, and over time, the brain will continue to maintain those patterns permanently!

Any adverse effects reported after the treatment are used as feedback for the Tech/Provider to adjust the next treatment. Nothing dangerous to your health.

What Does the Neurofeedback Device Monitor Exactly?

There are five components to brain waves: Delta, Theta, Alpha, Beta, and Gamma. Each brain wave is associated with a certain frequency, state of mind, and cognitive function.

- Delta – Less than 4Hz, REM sleep, Pain Relief, Subconsciousness, and Loss of Body Awareness
- Theta – 4-7 Hz, REM, Deep Meditation, Addiction Help, Memory, Emotion, Limbic System (behavioral and emotional responses especially regarding survival), and Healing
- Alpha – 8-13 Hz (8-10; Low Alpha, 11-13; High Alpha), Creativity, Flow State, Focus, Learning, Serotonin, Brain at Rest – Cortisol (stress) Levels, and is Indicative of Processing Disabilities
- Gamma – 40+ Hz, Self-Control, Peak Awareness of Intelligence, Feeling of “Oneness”

<u>It is possible these symptoms may occur after your session if the protocol is not accurate for your specific symptoms.</u> but may include – nightmares, insomnia, feelings of anxiety, brain fog or headaches. Please inform your Tech or Provider right away, so we can adjust.

Neurofeedback Consent Form

Neurofeedback or neurotherapy is individual psychological therapy incorporating biofeedback as treatment for mental health disorders. It can be used for those with ADD/ADHD, anxiety, OCD, depression, bipolar, ODD, PTSD, schizophrenia, insomnia and much more.

I hereby certify by signing this consent form that I have read and understand the concept and purpose of neurofeedback training. I understand the expectations and nature of this treatment. I acknowledge that I have not been promised, guaranteed, or assured from anyone as to what results will be obtained from these treatments, trainings, or overall service. I understand that my failure to comply with the recommended regimen for treatment could prevent the treatment from working effectively. I understand that I am free to withdraw from this treatment at any time and have no obligation to continue any of said services.

PATIENT SIGNATURE ____

PATIENT PRINTED NAME____

PARENT OR GUARDIAN SIGNATURE ________________________________

DATE ____

Chronic Care Agreement

As a patient with two or more ongoing health conditions, you may benefit from a care management program our health center offers to Medicare patients. The services available through our Chronic Care Management Program include:

I. Help managing ongoing health conditions, checking in with your health care needs, making appointments for preventive care, and helping you understand and take your medications.
II. Making sure you can get in touch with your provider or healthcare team 24-hours-a-day, 7 days a week including by telephone, e-mail, and through your electronic health record.
III. Seeing that each time you come into the health center, you see a regular provider or healthcare team whenever possible.
IV. Working with you to plan for the best care for your health issues.
V. Helping to work with and coordinate care across different providers and settings, including specialists or other providers, hospitals, and emergency departments.

Your Rights

As part of chronic care management services, you will receive a copy of your care plan. You have the right to stop chronic care management services at any time (effective at the end of a calendar month). Please contact Golden Victory Medical at (702) 703-1950 to rescind your consent.

You Agree and Consent to the Following by Signing This Agreement

You consent to Golden Victory Medical providing chronic care management services to you. You agree to allow Golden Victory Medical to bill Medicare for these services during any month that we provide at least 20 minutes of chronic care management services to you. You are aware that only one provider or hospital can provide and bill for chronic care management services for you during a calendar month. Please let us know if you receive these services from any other provider at any time. You agree to allow Golden Victory Medical to share your information electronically with other providers delivering care to you. You understand that co-insurance, copays, and deductibles apply to chronic care management services so that you may be billed for these services up to once a month, even if there is not a face-to-face meeting with your provider.

Date: ______________________________

Patient's Printed Name: ____

Patient's Signature: ____

Controlled Substance Agreement

The purpose of this agreement is to outline the conditions under which my provider at Golden Victory Medical will prescribe controlled substances. By signing this form, I acknowledge I have been informed that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medicines, stimulants, benzodiazepines, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this contract for my provider to consider prescribing or to continue prescribing controlled substances to treat my condition.

- I agree to abide by the terms of this agreement. I understand that upon my first violation of this agreement, my provider will not prescribe my controlled substance until the next original due date and that after the second violation my provider will stop prescribing me all controlled substances. They also have the right to discharge me from the practice and refer me elsewhere.
- I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family. ·All controlled substances used to treat my mental health condition must come from my provider at Golden Victory Medical, my pain management specialist, or during their absence, by the covering provider, unless specific written authorization is obtained from the office for an exception. Exceptions may be made for emergency acute care. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the provider and the pharmacy of the change.
- I will inform my provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
- I will inform my other health care providers of the medications I am prescribed and of the existence of this agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers. I will not allow anyone else to share, have, use, sell, or otherwise have access to these medications. The sharing of medications with anyone is forbidden and is against the law. I will store my medication in a secure location to prevent it from being lost, stolen, or unintentionally used by others.
- I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety. I understand that tampering with a written prescription is a felony, and I will not change or tamper with my doctor's written prescription. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

- I agree not to alter my medication in any way, and I will take my medication whole. It will not be broken, chewed, crushed, injected, or snorted.
- I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by my provider.
- I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
- I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication. Failure to comply may result in immediate discharge from the practice.
- I understand that the presence of unauthorized and/or illegal substances in the toxicology screenings may prompt referral for assessment for a substance use disorder or discharge from the practice.
- I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report will be required before additional prescriptions are considered. There is no guarantee my provider will prescribe my medication early. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice. I understand if legal authorities have questions concerning my treatment due to concern for any sale, misuse, or diversion that my provider will cooperate fully with any law enforcement agency and these authorities may be given full access to my records of controlled substance administration.
- I will not use any illegal substances (e.g., marijuana, cocaine, etc.) and I will not misuse or self-prescribe/ medicate with legal controlled substances.

I understand that my provider will use the resources available to verify my compliance with this agreement including, but not limited to, my pharmacy and the Prescription Drug Monitoring program. I understand that failure to adhere to these policies and/or failure to comply with the provider's treatment plan may result in cessation of therapy with the controlled substance prescribed by this provider and/or a referral for further specialty assessment, as well as discharge from the practice. I, the undersigned patient, attest that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

Date: ______________________________

Patient's Printed Name: ______________________________________

Patient's Signature: ____

Patient Abuse of Pain Medications and Prescription Refills

Prescription medications are generally safe, but only when they are taken as prescribed and for the intended purpose. When they are abused—taken in ways that are not prescribed—they can cause an array of adverse health effects, including overdose and death. The risk of injury or death is even greater when prescription medications are abused alongside other drugs or alcohol. At present, every 19 minutes, someone in the United States dies from an unintentional prescription drug overdose.

Golden Victory Medical (GVM) defines prescription drug abuse as the use of a prescription medication in a way not intended by the prescribing doctor. This abuse also includes activities beyond just misusing a prescribed medication. It includes illegal activities such from doctor/medical office shopping, forged prescriptions, theft, and fraud.

Be advised that GVM maintains a zero-tolerance policy as to any prescription medication abuse that is taking place in any form. As a healthcare organization, we are tasked with maintaining compliance with State and Federal laws as to it pertains prescription drugs. Therefore, be aware that any and all suspicious activity shall be reviewed and investigated by the office where you are receiving treatment. Further activities may include:

1. Documentation as to the nature of any suspicious activity.
2. A request for a meeting to discuss the concerns that prescription drug abuse is taking place.
3. A review of the patient file and treatment plan to determine if changes are necessary to avoid potential prescription abuse.
4. Termination of the individual as a patient is prescription drug abuse is confirmed
5. Referral of any illegal activities discovered to any relevant State or Federal law enforcement agencies.

At GVM, we realize that all our patients are facing their own personal challenges and struggles. As a healthcare organization, we are seeking to treat and provide a support network for our patients. However, we cannot facilitate nor tolerate situations in which prescription drug abuse is occurring with our patients.

In addition, we maintain a zero tolerance of any verbal or physical threats made to our healthcare providers which can result in immediate termination of your status as a patient with our organization and for law enforcement to be contacted in the event any form of verbal or physical violence occurs at one of our office locations.

We thank you for your cooperation and understanding in this matter.

Patient's Rights

1) The privacy of all patients shall be always respected. Patients shall be treated with respect, consideration, and dignity, regardless of race, creed, sex, or national origin.

2) Patients shall receive assistance in a prompt, courteous and responsible manner.

3) Patient's medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patient's and/or designated representatives' express written approval.

4) Patients have the right to know the identity and status of individuals providing services to them.

5) Patients have the right to change providers if they choose.

6) Patients, or a legal authorized representative, have the right to thorough, current, and understandable information regarding their diagnosis, treatment options, prognosis (if known), and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.

7) Patients have the right to refuse treatment and to be advised of alternatives and consequences of their decisions. *Patients are encouraged to discuss their objectives with their provider.

8) Patients have the right to refuse participation in experimental treatments and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.

9) Patients have the right to express their complaints about the care they have received and to submit their grievance to the Clinical Supervisor who will then complete an Incident Report and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.

10) Patients have the right to be provided with information regarding emergency and after-hours care.

11) Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the second opinion rests solely with the patient.

12) Patients have the right to a safe and pleasant environment during their stay.

13) Patients have the right to have procedures performed in the most painless way possible.

14) Patients have the right to an interpreter if required.

15) Patients have the right to be provided with informed consent forms as required by the laws of the State of Florida, Nevada, Oklahoma, and Kansas.

Patient's Responsibilities

1) Patients are expected to provide complete and accurate medical histories, including information on all current medications, keep all scheduled appointments and comply with treatment plans to help ensure appropriate care.

2) Patients are responsible for reviewing and understanding the information provided by their provider. Patients are responsible for understanding their insurance coverage and the procedures for obtaining coverage.

3) Patients are responsible for providing insurance information at the time of their visit and notifying the receptionist of any changes in information regarding their insurance or medical information.

4) Patients will be provided, upon request, with all available information regarding services available at the Clinic, as well as information about estimated fees and options for payment.

5) Patients are responsible for paying all charges for co-payments, co-insurance, deductibles on noncovered services at the time of the visit unless other arrangements have been made in advance.

6) Patients are responsible for treating Clinic Providers and Staff in a courteous and respectful manner.

7) Patients are responsible for asking questions about their medical care and to seek clarification from their provider of the services to be provided until they fully understand the care they are to receive.

8) Patients are responsible for following the advice of their provider and to consider the alternatives and/or consequences if they refuse to comply.

9) Patients are responsible for expressing their opinions, concerns, or complaints in a constructive manner to the appropriate personnel at the Clinic.

10) I have read and agree with the above.

Patient Signature

Today's Date (MM/DD/YYYY)

Patient Financial Responsibility Disclosure & Acknowledgement

All patients receiving treatment from Golden Victory Medical must understand that there are financial obligations for services and treatment. We want to be open and transparent when it comes to patient financial responsibilities, including situations involving your medical Insurance provider(s) and billing, as well as your obligation to keep a scheduled appointment. Please read the following agreement regarding your financial responsibilities and policies concerning cancellations and rescheduling appointments. We are happy to answer any questions you may have regarding the terms provided below for your convenience.

Financial Responsibilities

I understand and agree that I am financially responsible for all charges of any services rendered. This includes any medical assistance or visit, routine examination, or any other treatment, service, or screening ordered by a medical professional or staff member at a Golden Victory Medical location. Furthermore, I understand that while my insurance may confirm my benefits, “confirmation of benefits” is not a guarantee of payment and that I am responsible for any unpaid balances.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network provider services, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive, and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes regarding my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office with both my Medicare Insurance ID Card and my Secondary Insurance ID Card. The secondary insurer will not be billed if the office does not have the proper information for the secondary insurer. It will be my responsibility to pay the balance and then file a claim with the secondary insurer for reimbursement.

Administrative Fees

Please note that Golden Victory Medical, LLC maintains the following fee schedule for treatment, services, and administrative requests.

- FMLA/Disability Documentation: $25
- Initial New Patient Visit for Psychological Services: $200/Continued Follow-Up Appointments: $80
- Initial Therapy Visits: $100/Continued Follow-Up Appointments: $80
- Initial Primary Care/Internal New Patient Visits: $300/Continued Follow-Up Appointments: $150
- Request for Printed Medical Records: 10 cents/page
- Request for Printed Letters (including Diagnosis Letters): $20
- Narrative Reports: $75 - $100/page depending on complexity and requirements

Cancellations/Rescheduling & Late Arrival Policy

We understand that sometimes a patient may not be able to keep their appointment, either remotely or face to face. We ask that if you cannot make your scheduled appointment and have previously “confirmed” your appointment with a Golden Victory Medical staff member, please notify the office <u>no less than 24 hours in advance of your scheduled appointment time.</u> Please note that out of fairness to our staff and other patients, we have implemented the following procedures:

- First time - "No Show" or "Same Day Cancellation" and subsequent missed appointments – including if you do not show for a confirmed appointment or give timely notice of cancellation or your need for rescheduling – Our office will contact you to notify you that you have missed your appointment or failed to provide timely notice. In addition, we will remind you that a second and/or subsequent "No Show" or "Same Day Cancellation" will result in a financial penalty as well as to discuss if you wish to make a new appointment at a more convenient day and time if you have not already done so with our office.
- Second - "No Show" or "Same Day Cancellation" and subsequent missed appointments – you will be charged a $50.00 "No Show" or "Same Day Cancellation" fee. This is a fee to you, as insurance companies do not pay for missed appointments.
- Late arrival – your specific appointment time may be forfeited if you arrive late for your scheduled appointment.

This policy may not apply to Neurofeedback patients based on their individual health circumstances. Please confirm with office personnel of your situation as you begin treatment and discuss this policy with a Golden Victory Medical staff member.

Definitions

Golden Victory Medical defines a "No Show" as any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives 15 minutes or more after the expected arrival time for the scheduled appointment.

Acknowledgement

By signing this form, I consent to the terms above and the use and disclosure of Protected Health Information (PHI) regarding my treatment, payment, health care operations, or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. This form is also provided for your convenience to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

____

Printed Patient Name: ______________________ Patient Signature: ____________________________

Guardian Name: __________________________ Guardian Signature: __________________________

Date: _____________________

Financial Policy for Golden Victory Medical

We at Golden Victory Medical, LLC provide the best possible care for you, and we want you to completely understand our payment policies.

1. Insurance
We participate in most insurance plans; Medicare, Medicaid, and most Commercial Insurances (please request a copy of our insurance list for verification). If you are insured by a plan that we do business with but do not have an up-to-date Insurance Card, we will require documentation before your next visit as a means of verification. Knowing your insurance benefits is YOUR responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Copayments and Deductibles
We believe that patients should receive the best treatment/care possible without worry of financial burden. We understand that copayments can be a financial hardship on you, the patient. Please specify below what type of financial hardship you are experiencing below (if you check a box, please see next page):

[ ] Covid-19 [ ] Low income

[ ] Job Stress [ ] Other

3. Proof of Insurance
All patients must complete our patient registration forms before being treated, and at periodic intervals when updates become available. We must obtain a copy of your valid Driver's License/proof of ID, and valid insurance. We reserve the right to reach out to your insurance company for verification and treatment purposes.

4. Claims Submission
We will submit your claims and assist you in any way possible to get your claims paid in a timely manner. Your insurance company may need you to supply certain information directly. It is YOUR responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. As such, if the information is incorrect, we may not be able to process your claim properly.

5. Coverage Changes
If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits.

I have read and understand the payment policy and agree to abide by these guidelines.

Printed Name: ____

Signature: ____

Date: ___________________________

Out of Network Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care. You are getting this notice because Golden Victory Medical, LLC as a provider is not in your health plan's network. This means that Golden Victory Medical does not currently have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask a representative from Golden Victory Medical if you need help knowing if these protections apply to you. If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You should not sign this form if you did not have a choice of providers when receiving care. For example, ifa doctor was assigned to you with no opportunity to make a change. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

Good Faith Estimate of What You Could Pay

Patient name: ____

Out-of-network provider(s) or facility name: Golden Victory Medical, LLC

Total cost estimate of what you may be asked to pay: $______________________

- Review your detailed estimate. See Page 3 for a cost estimate for each item or service you'll get.
- Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

By signing, I agree to get the following items or services from (select all that apply):

☐ [*doctor's or provider's name*] ______________________________

☐ [*doctor's or provider's name*] ______________________________

☐ [*doctor's or provider's name*] ______________________________

☐ [*facility name*] ______________________________

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced orpressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-networkcost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn'tin my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You do not have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

____

Patient's Signature

____

Guardian/Authorized Representative's Signature

____

Printed Name of Patient

____

Printed Name of Guardian/Authorized Representative

____

Date and Time of Signature

Patient name: ____

Out-of-network provider(s) or facility name: Golden Victory Medical, LLC

Total cost estimate of what you may be asked to pay: $ _______________________________________

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows thefull estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

Contact your health plan to find out how much, if any, your plan will pay and how much you may haveto pay.

Date of Service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

Golden Victory Medical

Self-Pay Rate Agreement

Disclaimer

I, the undersigned, understand:

I. Payment is due by me, the patient, or responsible party to Golden Victory Medical, LLC at time of service.
II. I have chosen not to use a third-party private insurance company's contracted agreement with Golden Victory Medical, LLC for reimbursement or provided services and accept full legal and financial ramifications, if any, for that choice.

I agree to maintain my credit card information securely on file with Golden Victory Medical, LLC. In providing them with my credit card information, I am giving Golden Victory Medical, LLC permission to automatically charge my credit card on file for the amounts listed above at the time of service. By signing this form, I authorize this agreement to remain in effect until the expiration of the credit card account and understand that I may revoke this authorization at any time by submitting a written request.

Printed Name of Patient: ______________________________

Patient Signature: ____________________________________ Date: ____________________

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type: [ ] Mastercard [ ] VISA [ ] Discover [ ] Amex [ ] Other	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	CVV:
Cardholder ZIP Code (from credit credit card billing address):	

I authorize Golden Victory Medical to charge my credit card above for agreed upon purchases. I understand that my information will be saved to my Electronic Health Record (EHR) for future transactions on my account.

______________________________ ____________________

Signature Date

____

Print Name