MOUNTAIN CONVENIENT CARE

106 Frogtown Lane, Franklin NC 28734

Referred by: □ Physician:_____ □ Friend □Phonebook □ Newspaper □ Sign □Other

Name:_____**Date of Birth:** ___ /____/____
First Middle Last

Address: _____
Street City State Zip

Please Check One: □ Male □ Female **Social Security Number**: _____-_____-_____

Telephone #:_____ **May we leave a message on this number** □ Yes □ No

Cell#: _____ **May we leave a message on this number** □ Yes □ No

Work #: _____ **E-Mail Address:** _____

If under 18: Mother's/Father's Name:_____

Emergency Contact: _____ **Phone #:**_____ **Relationship:**_____

Pharmacy(where you get your prescriptions filled):_____ **Location of Pharmacy**:_____
May we obtain your medication history □ Yes □ No

Name of Family Physician/Pediatrician: _____

Address: _____ **Phone #:** _____

INSURANCE:

Primary Insurance: _____**Policy #**_____**Group#**_____

Policyholder's Full Name (The person who holds the policy)_____

Policyholder's Date of Birth: _____/_____/_____ **Relationship to Patient**:_____

Secondary Insurance:_____**Policy #**_____**Group#**_____

- Notice of Privacy Practice Patient Acknowledgement:

I have received and/or reviewed this patient's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

- Release of Information:

Your doctor is not allowed to release information to anyone but the patient. If you would like our office to be able to discuss results with anyone besides yourself, please indicate this below:

□ Only to myself

□ Other: _____ Relationship:_____

By signing below I acknowledge that I have read and understand the above information. Please feel free to ask any questions.

Signature: _____**Date:**_____/_____/_____

(If you are younger than 18 years old, forms must be signed by a parent or guardian)

Consent to bill insurance plan: _____ Signature

Date:_____

MOUNTAIN CONVENIENT CARE

NEW PATIENT MEDICAL HISTORY FORM

Patient Email:_____

Patient Pharmacy:_____

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	**DATE**	**LOCATION/FACILITY**

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

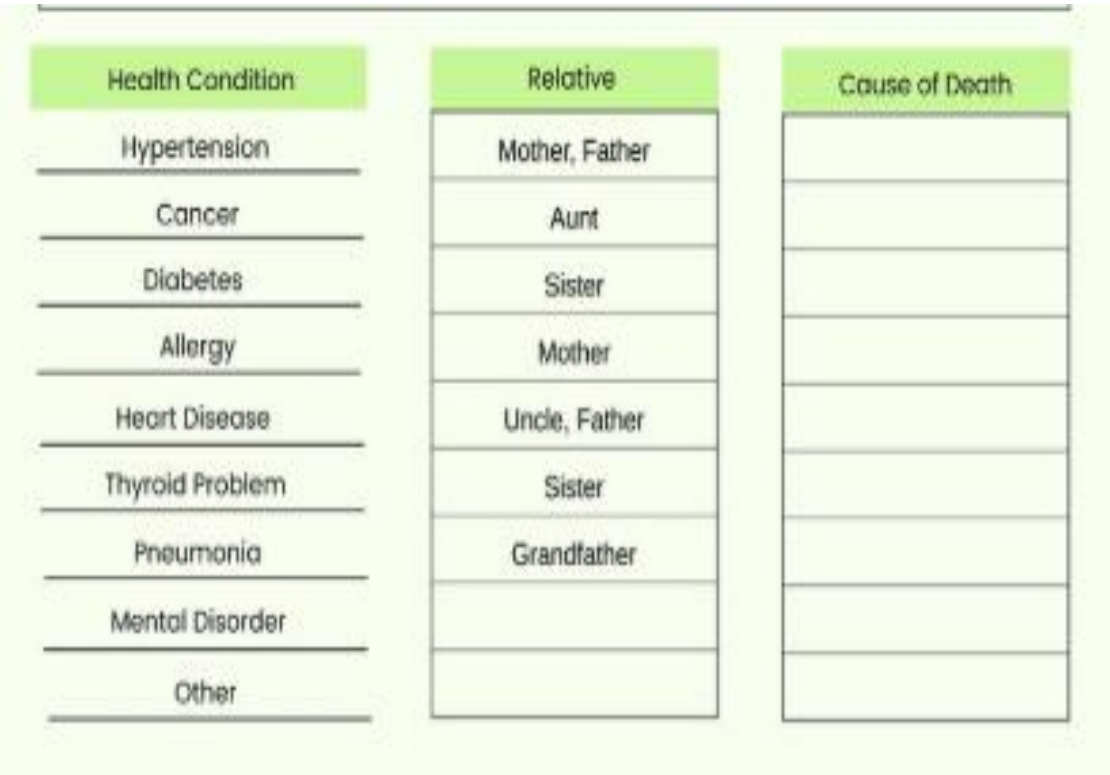
Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity change	☐ Chest pain	☐ Color change
☐ Appetite change	☐ Leg swelling	☐ Pallor
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding	☐ Food allergies
HEAD, EAR, NOSE & THROAT	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**NEUROLOGICAL**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**ENDOCRINE**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
☐ Sneezing	☐ Difficulty urinating	☐ Adenopathy
☐ Sore throat	☐ Dysuria	☐ Bruises/bleeds easily
☐ Tinnitus	☐ Enuresis	**PSYCHIATRIC**
☐ Trouble swallowing	☐ Flank pain	☐ Agitation
☐ Voice change	☐ Frequency	☐ Behavior problem
EYES	☐ Genital sore	☐ Confusion
☐ Eye discharge	☐ Hematuria	☐ Decreased concentration
☐ Eye itching	☐ Penile discharge	☐ Dysphoric mood
☐ Eye pain	☐ Penile pain	☐ Hallucinations
☐ Eye redness	☐ Penile swelling	☐ Hyperactive
☐ Photophobia	☐ Scrotal swelling	☐ Nervous/anxious
☐ Visual disturbance	☐ Testicular pain	☐ Self-injury
RESPIRATORY	☐ Urgency	☐ Sleep disturbance
☐ Apnea	☐ Urine decreased	☐ Suicidal ideas
☐ Chest tightness	**MUSCULAR**	
☐ Choking	☐ Arthralgias	
☐ Cough	☐ Back pain	
☐ Shortness of breath	☐ Gait problems	
☐ Stridor	☐ Joint swelling	
☐ Wheezing	☐ Myalgias	
	☐ Neck pain	
	☐ Neck stiffness	

Patient Name: _____ DOB: _____



Health Condition	Relative	Cause of Death
Hypertension	Mother, Father	
Cancer	Aunt	
Diabetes	Sister	
Allergy	Mother	
Heart Disease	Uncle, Father	
Thyroid Problem	Sister	
Pneumonia	Grandfather	
Mental Disorder		
Other		

Mountain Convenient Care: Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by (Mountain Convenient Care, LLC); and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by (Mountain Convenient Care, LLC);; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the

medical providers employed by (Mountain Convenient Care, LLC);; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by (Mountain Convenient Care, LLC) I am aware of the potential side effects associated with compound weight loss therapy and telemedicine care, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____Date:_____

Mountain Convenient Care LLC

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation with (YOUR LLC).
2. I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with (Mountain Convenient Care, LLC) and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through (Mountain Convenient Care, LLC) will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through Mountain Convenient Care, LLC are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient_____ Date: _____

2025

MOUNTAIN CONVENIENT CARE

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

The standard meeting time for the initial visit is 45-60 minutes and follow up visits are 15-30 minutes.

Payment is due within 24 hours of your appointment. You may lose your appointment if payment is not received within 24 hours of your scheduled time.

Cancellations and re-scheduled visits will be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for an appointment, you may lose some of the allotted time for that appointment. Your card will automatically be billed 24 hours prior to your appointment if payment is not received.

TELEPHONE ACCESSIBILITY If you need to contact (Mountain Convenient Care) between sessions, please call our main number or send us a message through the website. We are often not immediately available; however, we will attempt to return your call or message within 24 hours. Please note that Face-to-face video visits are highly preferable to phone visits. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or go to your local emergency room.

ELECTRONIC COMMUNICATION

We cannot ensure the confidentiality of any form of communication through electronic media, including, but not limited to, text messages, telephone communication, the Internet, facsimile machines, and e-mail. Telemedicine is broadly defined as the use of information technology to deliver medical services and information between two parties that are at different locations. The above electronic means of communication are considered telemedicine. Utilizing telemedicine services through (Mountain Convenient Care) is voluntary in nature and you need to understand:

1. You have the right withhold or withdraw your consent for telemedicine services at any time. If this occurs, you need to understand that we cannot provide care for you any longer as (Mountain Convenient Care) is strictly a telemedicine practice.
2. We will protect your protected health information in the same fashion as a brick and mortar practice. You need to understand though that data breaches can happen, and we cannot assure your information is 100% protected.
3. We will not use your protected health information for research purposes unless you give us consent to do so.
4. There are potential benefits, risks and subsequent consequences of telemedicine. Potential benefits include, but are not limited to improved access to care, reducing costs, improving the quality of visits, and reduction of travel time associated with medical visits. The medical provider will make assessments, diagnoses, and treatment plans based off all the visual and auditory information provided during the video conference. You must understand that this is limited and posts potential risks including, but not limited to the provider's inability to make complete diagnostic assessments that might require a physical exam and to see the patient in person. During an in-person encounter, a medical provider has the ability to see the entire patient including but not limited to their gait, smell, general appearance, and demeanor. Potential consequences thus include the provider not being aware of clinically significant information that you may not recognize as significant to present verbally to the provider.

MINORS

We require parental consent for all visits done through telemedicine. We require your parents to be present during a portion of the visit to ensure that they are consenting to treatment.

If you are a minor, your parents may be legally entitled to some information about your treatment. We will discuss with you and your parent's what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

We can terminate treatment with you at any time. We will not terminate the medical relationship with you without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason, we will provide you with a list of qualified providers to continue your care. You may also choose someone on your own or from another referral source. Should you fail to not show up for your follow up appointments, not obtain lab work in a timely fashion or are non-compliant with treatment, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient/Parent Signature:_____

Date:_____

2025

Mountain Convenient Care Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health

information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact (Mountain Convenient Care, LLC) at EMR at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose.

You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Research; We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

Mountain Convenient Care

Please sign and date indicating you have read and understand your Patient Rights.

Name_____Date_____

WITNESS: _____ Date:_____

Revised 2025

Mountain Convenient Care

General consent for care and treatment consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards

involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient/Representative: _____

Date:_____

Revised 2025

Mountain Convenient Care LLC

106 Frogtown Lane

Franklin, NC 28734

HIPAA, Confidentiality, and Volunteer Orientation Acknowledgment

HIPAA: I have reviewed and received a copy of Mountain Convenient Care, LLC.

HIPAA TRAINING OUTLINE and agree to the Statement of Confidentiality as well as to Volunteer Orientation guidelines.

This training outline includes: • HIPAA definition • Covered entity • PHI and the usage • Minimum necessary standard • Patient Privacy Rights • Mountain Convenient Care, LLC Duties • Business Associate Agreement • Privacy Right Officer Statement of Confidentiality:

I understand that all aspects of the delivery of client services and the business affairs of the agency are not to be discussed with anyone inside or outside the organization, except when required in the usual course of my work.

Confidential information includes information about our clients, their families, home environment, medical records, waiting lists, source of client payment, agency financial or business operations, or information about any employee of the agency.

I understand that failure to comply with this confidentiality policy will result in termination of my service. Volunteer Orientation: I understand that I will receive training which includes reviewing volunteer role, code of ethics and community safety policies. I am aware that is my responsibility to read and follow these guidelines set forth in the policy.

_____ Print Name

_____ Signature

_____ Date

Mountain Convenient Care

106 Frogtown Lane, Franklin NC 28734

Revised 2025

YOUR PATIENT RIGHTS

Welcome to our Mountain Convenient Care, LLC. Our home town clinic. We respect our patients' dignity and pride.

Patient Rights

This document will explain your patient rights and responsibilities. It is part of your patient registration and is an important part of your health care plan. If you have any questions, please contact the Practice/Clinic leadership.

Our commitment to you, our patient, includes the following rights. We comply with applicable Federal civil rights laws and affirm that we will deliver high-quality health care to every patient without regard to:

age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, health condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law

Considerate and Respectful Care

- Fair, high-quality, safe and professional care
- Care regardless of color, race, religion, creed, etc.
- Consideration, respect, and recognition of you and your individuality
- Treatment privacy
- Safe environment
- Ask for (except in emergencies) a person of the same sex to be available for any part of an exam, treatment or procedures performed by a person of the opposite sex
- Not be undressed any longer than needed for the exam, test, procedure, or other reason
- Private and discreet consultation, exam, and care. See Notice of Privacy Practices (NOPP) for the full list of privacy and security of health information/medical record rights
- To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with your treatment or diagnostic procedures

Health Status and Care

- Be informed of your health status in terms and / or language that you, your family, and caregivers can be expected to understand
- Take part and be active in your care and treatment plan
- Participate in decisions in your care, unless your doctors or others believe it is harmful to you
- Know, be told, and understand:
    - the names, roles, and qualifications of your health care experts that provide your care
    - your follow-up care
    - risks, benefits and side effects of all medicines and treatment procedures for your diagnoses
    - innovative or experimental medicines and treatment procedures of diagnosis offered

    - alternative treatment options offered
    - your procedure and to “give informed consent” before it begins
    - possible outcomes of your care and treatment
    - the assessment and management of your pain
- When and if the Practice recommends other health care institutions:
    - to participate in your care
    - to know who these other health care places are and what they will do
    - to refuse their care
- Get help from the doctor and others for follow-up care, if available
- To change providers or get a second opinion, including specialists at your request and expense

Decision Making and Notification

- Choose a person to be your health care representative or decision-maker
- Exclude those you do not want help from or to join in your care or decisions
- Ask for, but not have the right to demand, services the Practice does not think are needed or appropriate
- Refuse treatment
- Be included in experimental research only with your written consent
- Refuse experimental research including new drug and medical device investigations
- Receive the information necessary to approve a treatment or procedure
- Give consent to a procedure or treatment

Access to Services

- Receive free services of a translator, interpreter, or other necessary services or devices to help you communicate with the Practice in a timely manner (i.e. qualified interpreters, written information in other format or languages, etc.)
- Bring a service animal except where prohibited pursuant to Practice policy
- Have access to our facility buildings and grounds in compliance with The Americans with Disabilities Act, a law that stops discrimination against people with disabilities. The ADA policy is available upon request
- Prompt and reasonable response to questions and requests for service
- If you need any of the above services, contact the Practice management team

Ethical Decision

Talk to and join in with your doctor about:

-conflict resolutions -withholding resuscitative services

-foregoing or withdrawing life sustaining care

-investigational study or clinical trials

Know that if your health care expert decides your refusal to accept treatment prevents you from getting the right care (as stated by its ethical and professional standards), it can end the relationship.

Payment and Administrative

- Review your health care bill regardless of your ability to pay it or the payment source
- Receive information about available financial resources
- If uninsured, to receive, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding any discount or charity policies for which the uninsured person may be eligible.
- Know if the Practice, doctors and other team members accept Medicare, the government's health insurance for those aged 65+ or disabled
- Know and understand the Medicare charges for your services and treatment provided
- Receive if you ask, with explanation, a reasonable estimate of your health care charges before treatment
- To be free from any requirement to purchase drugs, or rent or purchase medical supplies or equipment from any particular source (specifically in accordance with the provisions of the CA Section 1320 of the Health and Safety Code) and also to receive patient choice in these type of decisions

Protective Service

- Receive available protective and advocacy services
- Receive, as offered by state law:
    - care and treatment for mental illness or development disability
    - all legal and civil rights as a citizen
- Understand and expect emergency procedures without unneeded delay within Practice scope
- Get needed information to approve a treatment or procedure
- Be given the Practice's policies and procedures for:
    - Initiation, review, resolution of patient complaints, including the address and phone number to file complaints

- Discuss complaints, issues, or problems regarding discrimination in access to services with your doctor and/or the Practice management team. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please contact us and we can help you.
- File a complaint with the Ethics Line, the Department of Health and Human Services*, Office of Civil Rights* or others with your concerns about patient abuse, neglect, misuse of your property at the Practice, other unresolved complaints, patient safety, and quality concerns
- Have a fair review of alleged patient right violations

*Contact information for HHS or OCR: US. Department U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html or https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

YOUR PATIENT RESPONSIBILITIES

You are an important and active member of your care plan. You have certain responsibilities to yourself and to your care team.

In the spirit of shared trust and respect, we ask you to:

- Give true and complete information about your:

-Health status -Medical history -Hospitalizations -Medicines

-Other matters about your health

-Contact information, family members and caregivers and other needed information

- Let us know:

-any risks about your care -Changes in your care, illness, or injury

-Safety concerns -Violation of your patient rights

-If you understand your care plan and what we expect from you

-If you don't understand your care plan or its information

-If you have or need to ask questions

- Please:
    - Follow your care plan and instructions created by your doctor, nurses or other health care team members
    - Keep appointments and, if you cannot make your appointments, let us know at a minimum 24 hours before your appointment. We want it to be the best experience possible.
    - Be responsible for your actions if you refuse care or don't follow doctor's orders
    - Pay your health care bills in a timely manner

- Follow practice procedures, rules and regulations for everyone’s benefit
- Be thoughtful of the rights of other patients and our staff
- Be respectful of yourself and our staff
- Help staff to assess your pain, to assist you to discuss and get prompt relief, communicate your concerns about pain medicines and develop a pain management plan
- Treat the doctor and our health care staff with respect and consideration
- Accept that bad language or behavior is not tolerated and may be grounds for dismissal
- Accept we may end our relationship if you do not follow your doctor's orders or care plan