VICTORY HEALTH PARTNERS
PATIENT AGREEMENT

Victory Health Partners is a private (non-governmental), non profit agency which is designed to provide health care to uninsured families in Mobile County and the surrounding areas that who do not qualify for Medicaid, Medicare or private health insurance. To better serve you, we ask for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I will inform Victory Health Partners if my address, telephone number(s), income or insurance changes within 30 days of any change.
2. I will give Victory Health Partners 24 hours notice if I will be unable to keep my appointment.
3. If I miss three appointments without notifying Victory Health Partners, I understand that I may no longer be able to receive services at the Center.
4. I understand that my charge per office visit is due at the time of service. I also understand that if I schedule a doctor's appointment and I am unable to pay my office fee, I will call Victory Health Partners 24 hours prior to my appointment to reschedule.
5. I do hereby authorize a health care professional associated with Victory Health Partners to disclose any personal health information to other health care professionals, when medically necessary.
6. I do hereby authorize the administrative staff of Victory Health Partners to disclose my registration and screening information for purposes of obtaining health care at another facility.
7. I understand that if I schedule an appointment or choose to see any other health care provider without approval from the Center, I will be responsible for the bill and I may lose my eligibility for services at the Center.
8. I understand that I may choose to seek treatment with any doctor of my choice at any emergency room and that if I do so I will be responsible for the bill.
9. f I have any questions about an appointment or treatment, I will contact Victory Health Partners. For each outside appointment I will present the forms that I have been given at Victory Health Partners to the place of service.
10. I am solely responsible for following through on testing and treatment ordered by providers at the clinic. I understand that if I fail to follow the physician's orders my treatment may be unsuccessful.
11. I understand that if I am uncooperative, verbally or physically abusive, intoxicated or behaving in an inappropriate manner, I may not be eligible for services at Victory Health Partners.

I have received a full explanation of the Victory Health Partner's services. I understand and agree to all of the above. I understand that I can be terminated from the VHP if I have given wrong or misleading information or if I fail to follow the policies above.

Patient's Signature: _____ Date_____

Screener's Signature: _____ Date_____

Record of HIPAA Notification

I have received the Notice of Privacy Policy and Practices from Victory Health Partners.

Patient's Signature: _____ Date_____