

MONONGAHELA VALLEY ASSOCIATION OF HEALTH CENTERS, INC.

Monongahela Valley Association of Health Centers, Inc. (MVA) is a private, non-profit, West Virginia corporation that has been providing health care services to residents of north central West Virginia since 1958. MVA is the parent organization for Fairmont Clinic, Fairview Clinic, Shinnston Medical Center, MVA Home Health Service, MVA Hospice of Marion County, MVA Case Management, East Fairmont High School Wellness Center, and North Marion Campus Wellness Center. MVA is committed to providing quality health care, at a reasonable cost, to all residents of its service area.

MVA provides the following services to its patients:

- internal medicine
- Laboratory services
- cardiopulmonary testing
- ophthalmology
- pharmacy
- family practice
- radiology
- home health
- optometry
- physical therapy
- medicaid waiver case management
- pediatrics
- hospice
- optical shop
- social services

MVA providers can and will refer patients to specialists as required by diagnosis. All referrals will be within the guidelines of your insurance and any other third party payer. Clinical services are provided by Board certified or Board eligible, residency-trained physicians and certified mid-level providers (nurse practitioners and physician assistants). MVA is recognized in the community as a place to receive quality "Total Health Care in One Convenient Location."

MVA recognizes that providing health care requires recognizing and respecting patient needs, and patients accepting their responsibilities. The following is an overview of what MVA offers and what MVA expects from its patients.

All MVA employees are trained to consider each patient's right to confidentiality, privacy, security, respect of ethical and personal values, reasonable access to care, resolution of complaints, designation of a substitute decision maker, information about fee schedules and payment policies, information in order to make care decisions, and a means to resolve conflicts about care decisions.

You have the right to make your own health care decisions. You can expect your doctor or other health care provider to tell you about the nature of any proposed procedure or treatment, its probable benefits or effects, and any predictable discomfort, complications or risks. You have the right to know alternative treatments and their risks and benefits. You have the right to ask questions and to decide whether you want treatment or not. Your right to accept medical or surgical treatment also includes the right to refuse it. If you do not understand anything concerning your treatment or care, you have the responsibility to ask questions. Your responsibility as a MVA patient is to make your concerns known to your doctor or any other MVA health care provider with whom you are comfortable. In the event you wish to make life sustaining health care decisions in advance, please make this known and your provider and you will be directed to a staff member who will provide you with information to assist you with creating "Advance Directives for Health Care Decisionmaking." An advance directive may be helpful if you ever become incapable of making health care decisions for yourself.

MVA has a patient advocate to whom you can take any concern or complaint at any time while you are a MVA patient. MVA's patient advocate will assist you with any health care issues or other concerns you might have.

MVA's staff is dedicated to providing you, the patient, with the highest quality individualized care possible.

AUTHORIZATION FOR CARE

I hereby authorize the employees of Monongahela Valley Association of Health Centers, Inc. (MVA), to render health care to me which includes but is not limited to diagnostic procedures and medical treatment.

FINANCIAL RESPONSIBILITY

I hereby agree to be responsible for and guarantee the payment of charges for all services rendered. I understand that I am financially responsible for all co-payments, deductibles, and charges not covered by insurance or other third party payer.

LIABILITY RELEASE

I agree to keep all my personal property in my possession while a patient within a facility of Monongahela Valley Association of Health Centers, Inc. (MVA). MVA shall not be held liable or responsible for the loss or damage to any of my personal articles.

INSURANCE COVERAGE/ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Monongahela Valley Association of Health Centers, Inc. (MVA), and my physician/medical provider, who is an employee of or has a contract for the performance of a medical specialty for MVA.

I certify that the information given by me is correct. I authorize any holder of medical or other information about me to release it to MVA, the Social Security Administration or its intermediaries or carriers. I authorize MVA to release any medical information requested to local, state, or federal agencies; insurance companies; or other organizations or entities in order to comply with its requirements. I request that payment of authorized benefits be made to MVA on my behalf.

I, _____, Clinic # _____,
(print patient's name)

have read or have had read to me this document. I have had the opportunity to ask questions concerning my rights and responsibilities as a patient of MVA. I have also been given a copy of "Your Rights and Responsibilities as a Patient of MVA."

(Patient's, surrogate's, or legal guardian's signature) Date: _____

(Witness's signature)

- If this authorization is signed by a person other than the patient, please answer the following questions:

Reason the patient did not sign: _____

Relationship of the person signing to the patient: _____

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FINANCIAL EVALUATION

Amount of Discount: _____ As of: _____

NAME	CHART #	INS? PHS? DW?	SOURCE OF INCOME	AMOUNT/ WHEN RECEIVED	TOTAL/ YEAR
1.					
2.					
3.					
4.					
5.					
6.					
TOTAL MEMBERS IN HOUSEHOLD?				TOTAL ANNUAL INCOME	

(Be sure to include sources other than employment earnings such as Social Security, SSI Pension Checks, VA, Worker's Compensation, Child Support, Alimony, Unemployment, Black Lung Benefits, etc.)

***** I certify that the above statements are true and I am willing to provide verification of the above stated income. I agree to notify Fairmont Clinic immediately of any change in the above stated information.

***** I understand that not all care is covered. Services that are NOT covered include, but are not limited to, Optical, Podiatry, Physical Therapy, Surgery, Urology, and Ophthalmology. Services received at the hospital are NOT covered including inpatient and outpatient services. Not all x-ray and lab services are covered; x-ray and lab services ordered for podiatry care are NOT covered. Prescriptions are NOT covered by this program. I understand that I will be responsible for payment in full of any services received which are not covered under this program. Payment is required on date of service. MVA reserves the right to cancel this program at any time.

Comments: _____

Application Date: _____ Date Received Documentation: _____ Interviewer: _____

Signature: _____

Comments: _____

Date Reviewed: _____ Date Verficiation of Current Income Received: _____ Interviewer: _____

Signature: _____