Patient Agreement & Consent Form

*Our clinic is part of a larger organization committed to supporting our providers and delivering exceptional patient care. You may see the name **Advanced Women's Care (AWC)** or **Valley Perinatal Services (VPS)** on some of the documents you are signing today—these are simply our affiliated organizations. Please know that your care team and services remain the same.*

No-Show & Cancellation Policy
We kindly ask that you notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment. This allows us to offer your time slot to another patient who may need care.

Due to an increase in missed appointments and last-minute cancellations, a $25 fee will be charged for all no-shows or cancellations made with less than 24 hours' notice. This fee is not covered by insurance and will be the patient's responsibility.

We appreciate your courtesy and cooperation in helping us provide timely care to all patients.

Consent to Contact
By providing any telephone number, I give written consent for Valley Perinatal Services to contact me via automated, prerecorded, or artificial voice calls and text messages to that number. I understand that I can change or revoke this consent at any time by visiting the Patient Portal "Contact Preferences" page.

Notice of Privacy Practices
We are committed to protecting your privacy and making sure your health information is used and shared appropriately. This notice explains how your information may be used and your rights regarding it.

I acknowledge that I have read and understand this notice. I also understand that a copy can be printed upon request or accessed on our website.

Release of Billing Information
I authorize Valley Perinatal Services to:

1. Share any information needed with my insurance company about my illness and treatment
2. Submit insurance claims for services provided to me; and
3. Use a photocopy of my signature for these purposes.

Assignment of Benefits

I agree to assign all medical and surgical benefits, including major medical benefits, to which I am entitled. I authorize my insurance, including Medicare, private insurance, and other health plans, to pay Valley Perinatal Services directly for services provided to me and/or my dependents. I understand that I am responsible for any charges not covered by my insurance.

Medication History

I agree that Valley Perinatal Services can access and review my medication history. I understand this information will become part of my medical record. A medication history shows the medicines that have been recently prescribed to me by my providers or other healthcare professionals. This information may come from pharmacies, health plans, or other healthcare providers.

Authorization to Receive & Release Medical Records

I authorize Valley Perinatal Services to send and/or receive the following medical information:

- Last three visit notes and any tests, labs, imaging, or EKGs from the past 6–12 months
- Complete medical records, including labs, pathology, and diagnostic imaging reports
- Abstract or summary records
- Other related information

I understand these records may include sensitive information such as HIV/AIDS status, cancer diagnoses, substance use history, or sexually transmitted diseases, and I authorize the disclosure of this information as part of this request.

Patient Rights & Responsibilities

Your Rights

- Be treated with respect, dignity, and without discrimination
- Receive safe, compassionate, and considerate care
- Be informed about your condition, treatment options, and care plan in a way you understand
- Know the names and roles of your healthcare providers
- Participate in decisions about your care, including the right to accept or refuse treatment as allowed by law
- Have your privacy protected and your medical information kept confidential
- Access your medical records and request copies
- Receive information about services, referrals, and costs of care
- Be informed before any transfer of care
- Have your pain assessed and managed appropriately
- Voice concerns or complaints without fear of retaliation
- Receive communication assistance or language support if needed
- Establish advanced directives and have them honored

Your Responsibilities

- Provide accurate and complete health information
- Ask questions when you do not understand your care
- Follow your treatment plan and communicate concerns
- Report changes in your condition, including pain
- Arrive on time for appointments or notify us if you need to cancel
- Treat staff and other patients with respect
- Follow office policies, including maintaining a smoke-free environment
- Respect the privacy of others and facility property
- Meet your financial obligations for care

Reporting Concerns

If you believe your rights have been violated, you may contact:

- Arizona Department of Health Services
- 150 N. 18th Ave., Suite 450
- Phoenix, AZ 85007
- Phone: 602-364-3030

Or reach VPS directly:

- management@valleyperinatal.com
- compliance@valleyperinatal.com

Patient Consent – Obstetrics (OB)

Consent for Medical Care

I give consent to Valley Perinatal Associates, LLC (VPS), its staff, and providers to provide medical care, testing, procedures, and services that are deemed necessary or beneficial to my health and well-being.
This may include, but is not limited to:

- Direct patient care
- Coordination and management of care with other healthcare providers
- Consultations related to my care
- Referrals to other healthcare providers

Prenatal Ultrasound

I understand that prenatal ultrasound is a valuable tool for evaluating fetal development. While most ultrasounds provide reassuring results, I acknowledge that:

- Birth defects may occasionally be detected, even in patients without known risk factors
- Certain ultrasound “markers” may appear in normal pregnancies
- Some findings may slightly increase the risk of chromosomal or structural abnormalities, although they are often not clinically significant and may cause unnecessary anxiety.

VPS physicians are experienced in obstetric ultrasound and fetal diagnosis and participate in ongoing clinical research to improve diagnostic accuracy. I consent to anonymous participation in such research; my identity will not be disclosed.

Follow-Up and Information Sharing
For quality assurance and research purposes, I agree that VPS or my physician's office may contact me later to determine pregnancy outcomes.
I authorize my physician and associated laboratories to share relevant blood test results and medical information necessary to assist in ultrasound interpretation.

Additional Imaging and Costs
I understand that obstetric ultrasound may require additional imaging methods, including, but not limited to:

- 3D ultrasound
- Transvaginal scans
- Doppler studies

These additional services may result in extra insurance charges. Blood tests and consultation fees may also apply if medically indicated.

Agreement & Acknowledgement

By signing below, I understand and agree with the following:

- I give permission to Valley Perinatal Services (VPS) to provide my medical care, including tests, treatments, and referrals.
- I am responsible for any costs not covered by my insurance. I authorize VPS to bill my insurance and receive payment directly.
- I understand the No-Show & Cancellation Policy and that I may be charged a $25 fee for missed appointments or late cancellations.
- I have received or can access the Notice of Privacy Practices, which explains how my health information is used.
- I agree that VPS may contact me by phone, text, or email (including automated messages) for appointments, billing, and care updates.
- I allow VPS to access my medication history and share or request my medical records, including sensitive information, when needed for my care.
- I have been informed of my Patient Rights and Responsibilities and agree to follow office policies.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____

Relationship to Patient (if applicable): _____