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AGREEMENT & CONSENT TO CONDITIONS OF TREATMENT

1. **MEDICAL AND SURGICAL CONSENT:** I request hospital admission to or outpatient treatment from a VH hospital or entity and consent to all associated treatment and services including but not limited to laboratory procedures, x-ray or other imaging (e.g. photo, video, MRI, ultrasound) for medical, clinical or diagnostic purposes, anesthesia, and surgical procedures, as ordered by my attending physician. In addition to my attending physician I understand that various caregivers may be involved in my care including medical residents who are employed by Valley Health.

2. **MEDICAL SERVICE PROVIDERS:** I understand that many physicians and other medical service providers furnishing services to me are independent contractors and are not employees of Valley Health. I further understand that the professional fees for these independent contractors are not included in hospital fees and will be billed separately by the practitioner providing the service.

3. **FINANCIAL AGREEMENT:** I understand and agree that payment for services rendered is due upon completion of services, and I acknowledge I am responsible for payment in full for such services. I authorize payment of physicians and medical service providers, including all independent contract medical providers whose services are advisable or necessary in my physician's judgment. I assign payment for the unpaid charges for physician, and/or other health care provider's services furnished whether the account is billed through Valley Health or directly by the attending physician or other medical service provider. I understand that I am responsible for all health insurance deductibles and coinsurance, and for any non-covered or unpaid charges. I understand that if my insurance company has a precertification requirement that it is my responsibility to obtain this pre-certification. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed and prerecorded messages) and/or text messaged (including SMS messaging) at that wireless number from the hospital and its successors, and the affiliates, agents and independent contractors, including servicers and collection agents and attorneys, regarding my hospitalization, services rendered or my related financial obligations. The benefits of Homestead Exemption are waived as to any debt created incident to this account for the services covered by this Consent Form. I understand that I remain financially responsible to Valley Health and the physicians and other medical service providers who attend me, for any and all charges not met by the proceeds of this assignment, and for all charges if payment is not received within a reasonable time after charges are filed or if payment is deemed retroactively. I acknowledge that any payments received directly by me are the property of Valley Health, and that if I receive any payments, I hold those as a fiduciary of Valley Health. I agree to pay in full Valley Health, together with any attending physicians or medical service providers, whether the bill comes from Valley Health or from the attending physicians or medical service providers. If I am not the patient, my liability for payment of the charges is joint and several with the patient, and agreement made by Valley Health with any other person for the payment of the bill shall be ancillary to, and not in lieu of, this agreement. In the event that the bill is not paid in full by me when due, I acknowledge and agree that the bill will be considered as delinquent by the hospital immediately after the bill is due and owing. Once the bill is considered delinquent, I acknowledge and agree that the hospital may charge a late charge, which may accrue and become part of the bill, in consideration of the delay in payment. Said late charge will accrue as interest on the unpaid balance at a predetermined rate of interest, currently seven (7%) commencing on the date of which the bill was due and owing, as simple interest on the unpaid balance. In the event that this account is referred to an attorney for collection, I will pay reasonable attorney fees of 25% of the balance sure and owing plus collection expenses, to the extent allowable by law. Any collection action may be filed in the City of Luray, Virginia or; any action which I file based on healthcare I receive or should have received while a patient at Valley Health must be brought in the Circuit Court of Virginia.

4. **RELEASE OF INFORMATION:** I authorized Valley Health and any physician or other medical service providers who renders service to me to release to my physician and other health care providers treating me, insurance company, reimbursing agency, Valley Health system affiliated entities, attorneys and others as allowed by law, whatever information, including a copy of, or access to, my medical record for determination of benefits payable or for additional medical care. Further, I authorize the Social Security Administration to release any information regarding my benefits of Medicare eligibility to any health care provider or other independent medical care provider.

5. **PERSONAL VALUABLES:** I understand that a safe for the storage of valuables is maintained for the convenience of patients. I release Valley Health from any responsibility for the loss or damage of valuables, money and/or other personal possessions brought into Valley Health by or for me unless they are deposited in the safe for safekeeping.

6. **PATIENTS RIGHT TO DECIDE:** I understand that I have the right to make decisions about my care. I have the right to refuse or accept treatment. I have the right to have a "Living Will", Advance Directive or to designate someone to make decisions for my by using a "Durable Power of Attorney for Health Care".

7. **TEXT MESSAGE APPOINTMENT REMINDERS:** I understand that Valley Health will utilize text messaging to my mobile phone listed in my chart. I realize that I can opt-out of texting at any time by replying STOP to any text I receive.

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 and amended in 1993 which authorizes healthcare providers to test their patients for HIV, Hepatitis B and C antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to the release of the test results to the healthcare provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained, and you will be given the opportunity to ask any questions.

8. **ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION:** I hereby give permission to the person(s) listed to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share my date of birth.

1. _____ _____
   Name Relationship
2. _____ _____
   Name Relationship

I, the undersigned, have read and understand this Consent for Treatment and agree to be bound by all its terms.

_____ _____
Witness Date Patient Date / Time

_____ _____
Witness / Interpreter Spouse/Guarantor/Patient Representative

_____

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL