ValleyHealth

Healthier, together.

AGREEMENT & CONSENT TO CONDITIONS OF TREATMENT

1. **MEDICAL AND CLINICAL CONSENT:** I request treatment from VPE and consent to all: diagnostic evaluations, therapy services, diagnostic tests, medications and/or treatments that are ordered or performed by my attending physician, his or her associates, consultants, assistants, or designees, or other independent medical service providers as are advisable or necessary in my physician's judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion, or handicap.

2. **RELEASE OF INFORMATION:** I authorize VPE and any physician or other medical service provider who renders services to me to release to my physician and other health care providers treating me, insurance company, reimbursing agency, affiliated entities, attorneys and other 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 or Medicare eligibility to any health care provider or other independent medical care provider.

3. **MEDICARE BENEFICIARY**: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about to release to the Social Security Administration or its agents any information need for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

4. **FINANCIAL AGREEMENT:** I authorize payment of all medical benefits otherwise payable to me directly to VPE. I understand that I am responsible for all health insurance deductibles and coinsurance. I understand that if my insurance company has a precertification requirement that it is my responsibility to obtain this pre-certification. The benefits of the 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 VPE 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 accept responsibility for payment in full or agreed upon payment arrangements, for services provided within thirty (30) days of receiving a statement. In the event I do not meet my financial responsibility with VPE, I agree to pay costs for collection including the collection agencies fees 20% to 40%, court costs, and attorney fees up to the maximum of the Commonwealth of Virginia Statue.

5. **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".

6. **PATIENT NOTIFICATION RECEIPT**: I understand that as part of my healthcare, Valley Physician Enterprise originates and maintains health records describing my health history, symptoms, examination , and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among the many

health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided; and a tool for routine health care operations such as quality assurance, audits, and assessments.

7. **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. **CONTACT:** In addition with this authorization, Valley Health may call my home or other designated location and/or number and leave a non –specific message on my voicemail, contact me in person or by mail. For specific information, I am aware that I will need to complete the Consent to Release Protected Health Information form, prior to information being released, as specified in the VH HIPAA Notice of Information Practices.

9. **ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORAMTION:** 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

_____
Reason for Signature by Person Authorized to Sign
For Patient in Lieu of Signature of Patient

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