067272

ValleyHealth Urgent Care

AGREEMENT & CONSENT TO CONDITIONS OF TREATMENT

MEDICAL AND CLINICAL CONSENT: I consent to all associated treatment and services including but not limited to diagnostic or x-ray treatments, as ordered or performed by the attending healthcare provider considered medically necessary in his/her judgment. I consent to the use of telehealth as may be necessary for my treatment. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made or implied regarding my care and treatment.

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 me by using a "Durable Power of Attorney for Health Care". I will advise receptionist/healthcare provider if I have such document and will provide copy to Urgent Care Center.

FINANCIAL AGREEMENT: I authorize payment of all medical benefits otherwise payable to me directly to Urgent Care Center. I understand that I am responsible for all health insurance deductibles and coinsurance. I understand that I remain financially responsible to Urgent Care Center 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 Urgent Care Center, I agree to pay collection agencies fees up to 20%.

RELEASE OF INFORMATION: I authorize Urgent Care Center 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.

CONTACT: In addition with this authorization, Urgent Care Center 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. 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 services rendered at Urgent Care Center or my related financial obligations. 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.

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.

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. I have been given a copy of Valley Health System's Notice of Privacy Practices, version effective September 9, 2013.

_____	_____
Print Patient Name Date	Medical Record Number
_____	_____
Patient/Authorized Person Signature Date	Witness Signature Date
_____	
Print Authorized Person Name/ Reason Authorized Person signed for Patient	