Coverage
This form covers all services or goods provided or to be provided to the patient by Mary Washington Healthcare, or its subsidiaries or affiliates (collectively referred to as MWHC). In addition, this form covers all services or goods provided to the patient by any healthcare provider rendering care to the patient while the patient is receiving services or goods from MWHC.

Consent for Examination and Treatment
I have a condition requiring inpatient or outpatient care and I voluntarily consent to such care, including diagnostic and laboratory procedures and medical treatment by my physician and health system/hospital personnel. I understand that the practice of medicine and surgery is not an exact science and I know that treatment results cannot be guaranteed. I understand that the majority of the physicians or physician extenders providing services to me are not employees of MWHC, but are independent practitioners providing professional services. I understand that MWHC participates with healthcare education programs and students may be involved in my care. I understand that medical residents who have completed medical school may be involved in my care. I agree that MWHC and my physician may obtain specimens and tissues as appropriate for my diagnosis and treatment and their respective health care operations, and I hereby authorize MWHC to dispose of any specimens or tissues taken from my body. I consent to video or the use of other electronic monitoring or recording method necessary for my treatment or safety. I understand that MWHC is not able to prepare certain compounded medications. In the event that I need compounded medications that MWHC is not able to prepare, I consent to receive compounded medications prepared by non-MWHC pharmacies.

Patient Rights, Grievance Process, Advance Directives
I have received or have been informed of my rights and responsibilities as a patient. I understand that MWHC has a formal process to address and resolve any concerns or grievances as detailed in the Patient Rights and Responsibilities Form. I understand that, under Virginia law, I have the right to determine in advance, or to choose in advance someone to determine for me, what kind of medical or surgical treatment I would want if I am incapable of communicating to my doctor what kind of treatment I wanted, or if I am incapable of making an informed decision about my care. I acknowledge that I have received or have been offered information regarding these "advance directives." If I already have an advance directive, I will provide MWHC with a copy to be placed in my medical record and understand that MWHC cannot follow the directives of my Advance Directive until I do provide it or draft a new one. If I do not already have an advance directive, I may request more information from my nurse or physician.

Interpreter Services and Auxiliary Aids
I understand that MWHC provides professional medical interpreters to patients and their companions who are limited-English-proficient or who are deaf. Interpreters are available 24/7 to all patients and families for appointments, procedures and hospital stays. There is no cost to patients or families for interpretation services. MWHC provides appropriate auxiliary aids free of charge, including: TTYs, written materials, telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, closed caption decoders, and open and closed captioning of most MWHC programs.

Deemed Consent/Prescription Monitoring
I understand that under Virginia law if, while examining or treating me, any person employed by or under the direction and control of MWHC or any other healthcare provider is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person. I understand that MWHC participates in the Virginia Prescription Monitoring Program. This means that prescribers in this facility may request information from the Program regarding prescriptions previously dispensed to me. I may ask my healthcare provider for more information about the Program, or visit the website https://www.dhp.virginia.gov/dhp_programs/pmp/.

Personal Valuables
I assume full responsibility for all of my personal items, including, but not limited to, my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items and release MWHC from responsibility and liability for such personal items and valuables.

Joint Notice of Privacy Practices
I understand that MWHC may use and disclose my protected health information for purposes of treatment, payment and operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Joint Notice of Privacy Practices for MWHC which provides information about how MWHC and individuals involved in my care at MWHC may use and disclose my protected health information.

_____Initials _____Date

Mary Washington Healthcare

General Consent for Treatment/Guaranty of Payment

Business Communications
I authorize MWHC to contact me after discharge for performance improvement purposes such as conducting patient satisfaction surveys. Further, by providing MWHC with my residential, cellular, or wireless telephone number, I authorize the use of an automatic telephone dialing system to contact my residential, cellular or, wireless telephone for normal business communications such as appointment reminders, billing inquiries, or debt collection efforts.

Responsibility for Payment
In consideration of the services provided at MWHC, I understand and acknowledge that: (1) I am financially responsible for the charges for all goods and services provided to the patient that are not covered by third party payor; (2) at all times, I shall have the responsibility to determine and to meet the requirements of any third party payor; (3) where MWHC or any health care providers may provide advice and assistance to the patient, such advice and assistance shall not relieve me of the responsibility to determine and to meet the requirements of any third party payor; (4) I shall not assert any claim that I was relieved of this responsibility in the absence of an express written agreement to the contrary; and (5) In the event litigation is filed for nonpayment for charges, I agree to pay all expenses incurred by MWHC or any health care provider because of such litigation, including reasonable attorney's fees and medical expert witness fees.

Assignment of Benefits
I hereby assign to MWHC, my physician(s) and other healthcare professional(s) involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Workers Compensation or any other programs that I identify for which benefits may be available to pay for the medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Third-Party Providers: I understand that certain professional services may be rendered during my hospital stay or procedure by third-party health care providers (such as ambulance services, emergency physicians, radiologists, pathologists, anesthesiologists) that are not covered by my insurance or plan. I also understand that some of the third-party health care providers who render care to me during my stay may not be participating providers with my health insurance company or benefit plan. In either instance, I agree that I will be financially responsible to these third-party providers for their charges in performing these professional services.

Financial Assistance
If I am uninsured or am having difficulty paying my MWHC bill, I understand MWHC has many financial options that may be of assistance, including free care, discounted care or interest-free payment plans. I understand that I will be required to provide financial information to determine my eligibility for these programs. MWHC's financial counselors can help me apply for these programs. Financial counselors can be reached at (540) 741-3555.

Authorization for Verification of Information
I hereby authorize MWHC to obtain and release my information for the purpose of verifying any information that I have provided to MWHC or that another individual has provided to MWHC on my behalf (including credit and employment information).

Certifications
I certify that I have read this entire form, that I was given a chance to ask any questions I had about this form, that all of my questions about this form have been answered to my satisfaction, and that I understand the content and purpose of the form. I acknowledge that I have received a copy of this form.

I certify that I am the patient, or that I am a person authorized by the patient and/or in accordance with Virginia law to sign this form and accept its terms. I certify that the information provided and to be provided to MWHC and all healthcare providers is and will be true and correct. I agree to pay any expenses incurred by MWHC and all health care providers because of incorrect information provided by me. I further acknowledge that, should I provide false or fraudulent information relative to the services provided, MWHC may contact law enforcement to initiate civil and/or criminal proceedings.

_____	_____	_____
Patient or Legal Surrogate	**Date/Time**	**Relationship to Patient**