Mary Washington Medical Group

CONSENT FOR PAYMENT AND GUARANTY OF PAYMENT FORM

Consent for Examination and Treatment
I consent to be treated by Mary Washington Healthcare Physicians (MWHP). I understand that the practice of medicine and surgery is not an exact science and I know that treatment results cannot be guaranteed.

Deemed Consent
I understand that under Virginia law if, while examining or treating me, any person employed by or under the direction and control of MWHP 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.

Joint Notice of Privacy Practices
I understand that MWHP 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 MWHP which provides information about how MWHP and individuals involved in my care at MWHP may use and disclose my protected health information.

_____Initials______Date

Responsibility for Payment
I understand that I am responsible for all charges for the treatment that I receive today. I authorize MWHP to bill my medical insurance for the care I receive and to release any information that the insurance carrier requires to process this bill. I authorize payment of medical benefits to MWHP, or to an outside laboratory as described below, for all services performed and billed by MWHP.

As a courtesy, MWHP will bill my medical insurance. If I do not provide complete and accurate insurance information to MWHP, I understand MWHP may not receive payment from my carrier and I will be responsible for all charges incurred. Even after my medical insurance company pays MWHP, I may owe MWHP payment for services not covered by my insurance and I agree to pay these charges promptly. I authorize any laboratory performing services for me to bill my medical insurance for its services. I understand that my medical insurance may not pay for all services provided by an outside laboratory and I agree to pay any remaining balance promptly to the laboratory. I understand that MWHP is not responsible for payment to outside laboratories for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, MWHP may choose not to bill my insurance and may decline credit/debit cards and checks as form of payment. I understand that if I fail to pay MWHP for services

provided to me, the balance owed will be sent to collections and I may incur collections fees in addition to the amount owed for services/treatment rendered. I understand that I may contact MWHP to set a payment arrangement that may prevent this additional cost.
In the event that my account is forwarded to a collections agency, I acknowledge that I may be discharged from MWHP practices.

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

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 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 MWHP is and will be true and correct. I agree to pay any expenses incurred by MWHP 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, MWHP may contact law enforcement to initiate civil and/or criminal proceedings.

Patient Name: ______________________ **DOB:** ___________

Patient or Legal Surrogate Signature: __________________ **Date:** ________________

Legal Surrogate/Patient Representative:______________**Relationship to Patient:** _______

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY

I,__________________________, understand that Mary Washington Healthcare (MWHC), of which this Mary Washington Healthcare Physician Practice (The Practice) is a wholly owned subsidiary, may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Notice of Privacy Practices for MWHC, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the notice may change. To obtain a copy of any current Notice, I may contact the Privacy Officer at 1- 800-442-8762.

I understand that I have the right to request that The Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that The Practice is not required to agree to a requested restriction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Mary Washington Healthcare Physicians to leave messages regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method (please circle Yes or No):

Yes No Home answering machine: ______________ **Yes No** Cell Phone/Voicemail: __________________
Yes No Work Voicemail: ____________________

I authorize Mary Washington Healthcare Physicians to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Mary Washington Healthcare Physicians may not release information to the named individuals and or entities unless you identify them below.

Name		Relationship to Patient		Contact Info	
Name	____________	Relationship to Patient	____________	Contact Info	____________
Name	____________	Relationship to Patient	____________	Contact Info	____________
Name	____________	Relationship to Patient	____________	Contact Info	____________
Name	____________	Relationship to Patient	____________	Contact Info	____________

Mary Washington Healthcare Physicians will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates. I will ensure this information is up to date at every visit.

Patient Name: ________________________________ **DOB:** ______________________

Patient Signature: ______________________________ **Date:** _____________________

Patient Representative: _________________________ **Relationship to Patient:** __________