BASSETT FAMILY PRACTICE (BFP) OR RIDGEWAY FAMILY HEALTH (RFH)
CONSENT FORM: TREATMENT AND PHOTOGRAPHY

Patient Name: ____ SSN: ________________________DOB: ______________

________ **(Please initial)** I hereby authorize the employees, agents, and staff of BFP or RFH to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures and blood transfusion, as may be necessary in the opinion of the physician.
________ **(Please initial)** I further authorize photographs or video recordings to be taken and maintained as part of my medical records for security or health care operational purposes only (e.g., quality assurance, medical identity fraud).
________ **(Please initial)** I further authorize the exchange of data between different electronic health systems participating in my care (e.g., UVA, Wake Forest University Baptist Medical Center, Carilion).

NO GUARANTEE: I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, or examinations. I understand that the risks of hospitalization, if needed, may include but are not limited to, infection with multi-drug resistant organisms.

DEEMED CONSENT FOR BLOOD TESTING: I understand that under Virginia law, if a health care provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV, or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) Patients who test positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

ASSIGNMENT and PROMISE TO PAY: In consideration of medical services to be rendered to me or at my request, I assign to BFP or RFH, to the extent necessary to satisfy any outstanding debts, the right to receive all sums payable to me, or on my behalf under the terms of any health or liability policy or other arrangement, or plan with a third party that provides for payment for medical or health care services, or policy of insurance, or pursuant to any settlement or judgment arising out of or related to any incident which caused the admission or medical treatment. I understand that I owe and unconditionally agree to pay to BFP or RFH the full amount charged for the services rendered to myself or my child that are not paid on my behalf by a third party, within sixty (60) days of the date medical services were rendered. I also understand that the BFP or RFH bill is payable in full within ninety (90) days of the date medical services were rendered. I further agree to pay reasonable attorney fees and collection costs if my account is placed for collection.

RELEASE OF INFORMATION: I authorize the clinic to release any and all patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment; to affiliates of BFP or RFH for purposes of treatment, billing, quality assessment, collection or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the clinic. I consent to use and disclosure of my protected health information to carry out treatment, payment or health care operations by the affiliates of BFP and RFH.

MEDICARE LIFE-TIME SIGNATURE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare/Medicaid benefits be made on my behalf for any services furnished by or at BFP or RFH, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services, and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare and/or Medicaid for payment. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency. I understand that I am responsible for any deductibles, co-payments, sliding fee schedule payments and any applicable percentage of remaining charges.

VALUABLES: I understand that BFP or RFH will not be responsible for any valuables or other such personal property left unattended in the center. Accordingly, I assume the risk of loss or theft or any personal property not deposited with the center for safekeeping and agree to hold BFP and RFH harmless from any and all liability which may result from the loss of any such personal property.

CERTIFICATION AND ACKNOWLEDGEMENT: I certify that all foregoing information and all information supplied by me as part of the admission/registration process is correct. I also acknowledge receipt of the Bassett Family Practice and Ridgeway Family Health notice of Privacy Practices ("Notice") and that I have been provided an opportunity to review it. I understand that: I have certain rights to privacy regarding my protected health information; Bassett Family Practice and Ridgeway Family Health can and will use my health information for purposes of my treatment, payment for treatment, and health care operations; the Privacy Notice explains in more detail how Bassett Family Practice and Ridgeway Family Health may use and share my protected health information for other purposes; I have rights regarding my protected health information listed in the Notice; and Bassett Family Practice and Ridgeway Family Health has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

____ ______________________________

Patient or Parent/Legal Guardian/Authorized Representative signature | Date

____ ______________________________

Relation to Patient | Witness Signature

Implemented 01/08
Revised 01/16; 03/18; 05/18, 09/18; 02/19