

Treatment Authorization:

You consent and understand the following:

- That the attending physician, the clinical staff and technical employees may administer any treatment or perform any procedures deemed advisable for your care and treatment.
- That you have the opportunity to discuss proposed course of treatment with the physician to your satisfaction.
- That you have the right to consent or refuse any proposed course of treatment.
- That in the event of an exposure of a health care provider to your blood or body fluids in a manner which may transmit HIV (human immunodeficiency virus), hepatitis B or hepatitis C virus, you hereby consent to testing of your blood and/or body fluids for these infections and the release of test results to the health care provider who has been exposed.

Privacy and Disclosure

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information (PHI). The terms of our NPP may change in accordance to Federal Regulations. A current copy may be obtained by requesting a copy or by viewing the notice posted in the waiting room.

- That you have the right to review the Notice of Privacy Practices before signing this consent.
- That you have the right to request that we restrict how PHI is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound to said agreement.
- By signing this document, you hereby consent to our use and release of personal health information for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except in the case where disclosure was already made with your prior consent.
- You have the right to ask employees of the medical practice or the Privacy Officer designated to this location questions pertaining to any information contained in the Notice of Privacy Practices.

Payment Arrangements

- By signing this document, you hereby authorize all payments to James River Surgical Associates of any insurance benefits otherwise payable to you for services provided under any policy of insurance (major medical, workers' compensation, or any other insurance or benefit plan).
- By signing this document, you authorize the release to insurance companies or other third party payors or their agents any medical information which may be necessary to determine coverage or which may be required for utilization and quality review, utilization management or continued care oversight.
- You are required, and you agree, to pay at the time of services any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance.
- Unpaid balances will be billed to your permanent address. You are responsible for paying the bill in full unless other arrangements have been approved in advance. There is a fee of \$25.00 for returned checks. Delinquent accounts will be turned over to a collection agency at which time you will be responsible for a collection charge of 35% and all associated legal fees in addition to the amount owed.
- You understand that failing to cancel an appointment 24 hours in advance will result in a \$25.00 fee that will be billed to your permanent address.
- By signing this document, you authorize any photocopies of this document to be as valid as the original.

I have read, understand, and agree to the Treatment, Privacy and Payment Policies described above.

Patient or Guarantor signature: _____

Patient or Guarantor Name (Printed): _____

Relationship to Guarantor: _____

Date: _____