COMMONWEALTH VASCULAR INSTITUTE

Patient Name: _____

Date of Birth: _____

AUTHORIZATION FOR TREATMENT

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care, and by doing so also authorize the order of ancillary services deemed necessary for my treatment and care.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV, hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia Law.
- I understand that Commonwealth Vascular Institute utilizes an electronic medical record system and this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations.
- I understand that Commonwealth Vascular Institute utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to my local pharmacies and mail order pharmacies. I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician.

PAYMENT ARRANGEMENTS

- I agree to be responsible for payment of all services rendered to me or my dependents.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under **any** insurance policy.
- By signing this document, I authorize the release of my Protected Health Information (PHI) to my insurance companies or other third party payers, including their representatives, as necessary to determine coverage or as required for review, quality improvement, and/or management.
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services not covered by my insurance.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance and that all unpaid balances will be billed to my address on file.
- I understand that there is a $50 charge for returned checks.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read, understand and agree to the above terms

_____ _____

Signature of Patient or Guarantor **Date**

_____

Printed Name

PRIVACY AND DISCLOSURE

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

_____ _____ _____

Patient or Guarantor Signature **Relationship to patient** **Date**

_____

Printed Name