CARILION CLINIC

PATIENT CONSENT FORM -- CONFIDENTIAL

PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

Preferred Name _____ SSN _____ Date of Birth _____

Office Name _____

Office Address _____

Primary Care Provider _____ ☐ M.D. ☐ N.P. ☐ P.A.

Location_____ Phone_____ Fax _____

Please review the following guidelines:

1. **Consent to Treatment:** I hereby authorize the employees, agents, and staff of the hospital/clinic to perform, and hereby consent to such medical treatment and examinations, including diagnostic procedures and blood transfusions, as may in the opinion of the patient's physician by necessary.

2. **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 may include, but are not limited to, infection with multi-drug resistant organisms.

3. **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.

4. **Assignment and Promise to Pay:** In consideration of medical services to be rendered to me or at my request, I assign to the hospital/clinic, 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 the hospital/clinic 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 60 days of the date medical services were rendered. I also understand that the hospital/clinic bill is payable in full within 90 days of discharge. I further agree to pay reasonable attorney fees and collection costs if my account is placed for collection.

5. **Release Information:** I authorize the hospital/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 Carilion Clinic for purposes of treatment, billing, quality assurance, 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 hospital/clinic. I consent to use and disclosure of my protected health information to carry out treatment, payment or health care operations by the hospital/clinic and by affiliates of Carilion Clinic.

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We are required by law to inform an appropriate agency or individual in cases where the provider believes that you or another person is at risk of harm or in cases of abuse of children, elderly or the mentally disabled; in addition, we are required to comply with a subpoena or court order to provide medical records.

6. **Medicare Life-Time Signature Authorization and Assignment:** I request that payment of authorized Medicare/ Medicaid benefits be made on my/the patient's behalf or any services furnished by or in the hospital/clinics, including physician services. I authorize any holder of medical or other information about me to release to the Centers of 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 to submit claim to Medicare and/or Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments, and any applicable percentage of remaining charges.

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

8. **Certification and Acknowledgement:** I certify that all foregoing information and all information supplied by me, as a part of the admission/registration process is correct. I also acknowledge receipt of the Carilion Clinic notice of Privacy Practices.

Patient or Parent/Legal Guardian Signature _____ Date _____

Relation to Patient _____ Witness Signature _____

Thank you for choosing Carilion Clinic.