Carilion Clinic Physician Practice
Financial Agreement and General Consent

1. **CONSENT TO TREATMENT:** I hereby authorize the employees, agents, and staff of Carilion Clinic and its affiliates ("Carilion") to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures, as may in the opinion of my/the patient's physician(s) be deemed necessary and advisable. If I/the patient fails to follow the direction of the health care providers or to carry out the recommended follow-up medical care, I/the patient do so at my own risk.
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, testing, or examinations. I understand that the risks of treatment may include, but are not limited to, infections.
3. **TEACHING FACILITY:** I am aware that Carilion Clinic is a teaching facility and that certain patient services may be performed or observed by students or trainees in the health profession under the supervision of employees of Carilion or other health care providers. I hereby authorize and consent to students, trainees, or residents performing or observing certain patient services, including medical treatment, examinations and diagnostic procedures. I understand that at any time I can decline to have a student, trainee or resident physician participate in my care and treatment by advising my health care provider; however, medical education facilities may not be able to continue to provide my care if I refuse to see a resident physician.
4. **DEEMED CONSENT FOR BLOOD TESTING:** I understand that, under Virginia state law, if a health care provider, or a person employed by, under the direction of, or control of a health care provider, is directly exposed to 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. For example, exposure could occur due to an accidental needle stick. Patients who have a confirmed positive test result will be given the opportunity for individual face-to-face disclosure of results and appropriate counseling.
5. **ASSIGNMENT OF PAYMENT:** In consideration of medical services to be rendered to me/the patient or at my/the patient's request, I assign payment to Carilion for medical service rendered to me/the patient or at my/the patient's request paid by my health insurance or liability policy or other arrangements, or plan with a third party that provides payment for medical or health care services or policy of insurance, or from any settlement or judgment that comes from any related incident that caused the medical treatment. Pursuant to this assignment, I recognize and understand that, if Carilion has a contractual relationship with my insurer, Carilion will bill my insurer and accept payment in accordance with that contractual agreement. If Carilion does not have a contractual relationship with my insurer, I acknowledge and understand that Carilion may choose not to accept assignment and/or not to bill my insurer directly. Without a contractual relationship I may be responsible for all service charges, regardless of any representations made by my insurer, and it will be my responsibility to seek reimbursement from my insurer. If I have any questions as to whether my insurer has a contractual relationship with Carilion, I may direct those questions to Carilion Clinic Billing Customer Service.
6. **REFERRAL/AUTHORIZATION AND NON-COVERED SERVICES:** I understand that my/the patient's insurance, HMO, or health benefit plan may require a referral and/or authorization prior to the delivery of this service. I also understand that my/the patient's insurance, HMO or health benefit plan may deny payment for failure to obtain a referral and/or authorization, failure to properly identify my/the plan or coverage, receipt of services that are not covered or for which the patient is not eligible under the plan or coverage at the time

the services are rendered or a determination under the plan or coverage that the services were not medically necessary. I acknowledge and agree that, in the event payment for these services is denied based on the provisions of my/the patient's insurance, HMO or health benefit plan, I am fully personally responsible for payment of charges for these services and will be billed directly.

7. **PROMISE TO PAY:** I understand that I owe and unconditionally agree to pay to Carilion the full contracted allowable rate or discounted rate as determined by Carilion policy for the charges for the services rendered to myself, my child, and/or any patient for which I am legally responsible that are not paid on my/the patient's behalf by a third party within sixty (60) days from billing of medical services rendered. I understand that separate bills may be generated for some services. Examples include but are not limited to: emergency department, hospital, physician, specialist, diagnostic studies, laboratory, radiology, and/or anesthesia. Additionally, I agree to pay my insurance co-payment, co-insurance, or known out-of-pocket expenses at the time of service. I agree that, if Carilion must initiate collection efforts to recover amounts owed by me, then, in addition to amounts incurred for the services rendered, I will pay, to the extent permitted by law: (a) any and all costs incurred by Carilion in pursuing collection, including but not limited to reasonable attorneys' fees; and (b) any court costs or other costs of litigation incurred by Carilion.
8. **RELEASE, DISCLOSURE, AND USE OF PATIENT INFORMATION** (including protected health information): I understand that Carilion uses an Electronic Medical Record. I authorize Carilion to obtain my/the patient's health information from other health care providers and health care facilities and to release my/the patient's health information to any physician involved in my treatment; any health care facility to which I/the patient is discharged, transferred, and/or presents for treatment; other health care providers; affiliates of Carilion and business partners for the purposes of treatment, payment, and health care operations including but not limited to billing, health care management, discharge planning, quality assurance, bill collection, defense of litigation or anticipated litigation; and/or to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by Carilion. I also authorize use of information to determine if I have insurance coverage or other benefits and, if I do, agree that Carilion Clinic may bill discovered coverage according to the scope of this consent. I consent to the use, release, and disclosure of my/the patient's protected health information for all the above reasons. I understand that my health information may be transmitted in electronic or paper format or verbally. I authorize Carilion to access and use my patient prescription information from any health care provider or benefits manager, including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment and health care operations, and that Carilion is not required to agree to such a restriction request.
9. **MEDICARE LIFE-TIME SIGNATURE AUTHORIZATION AND ASSIGNMENT:** If I/the patient is a Medicare or Medicaid beneficiary, I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf for any services furnished by Carilion or in a Carilion facility, including physician services. I authorize any holder of medical or other information about me/the patient 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.

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I understand that I am responsible for any deductibles, co-payments, and/or any applicable amount of remaining charges.

10. **CONSENT TO WIRELESS TELEPHONE CALLS:** If, at any time, I provide a wireless telephone number to Carilion at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages, automated appointment reminders) at that wireless number from Carilion, its successors and assigns, and its affiliates, agents, and independent contractors, including collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.
11. **VALUABLES:** I understand that Carilion will not be responsible for any valuables, money, or other such personal property left unattended or retained by myself/the patient. Accordingly, I/the patient assume the risk of loss or theft of any personal property not deposited with Carilion for safekeeping and agree to hold Carilion harmless from any and all liability which may result from the loss of any such personal property or valuables.
12. **ADDITIONAL PROVISION APPLICABLE FOR MINOR OR OTHER PATIENT FOR WHICH THE UNDERSIGNED IS LEGALLY RESPONSIBLE:** I, the undersigned, acknowledge and verify that I am the legal guardian, custodian, or otherwise legally responsible for the patient.
13. **ACKNOWLEDGEMENT: I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, AND AGREE TO FOLLOW AND BE BOUND BY THEM.** I certify that all information supplied by me as a part of the registration process is correct. By signing this form, I acknowledge that I have been offered and/or received the Carilion Notice of Privacy Practices.
14. **HIE GENERAL CONSENT:** To improve the coordination of my care, I authorize Carilion Clinic to electronically release my protected health information to other health care providers involved in my care and treatment who participate in local, state, national and/or international Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

_____ _____

Patient/Responsible Party Signature Date/Time

_____

Relation to Patient

_____ _____

Witness (if applicable) Date/Time

PATIENT IDENTIFICATION