Elite WOMEN'S CARE
Giving You Our Best In Obstetrics & Gynecology

6161 Kempsville Circle, Suite 340 • Norfolk, Virginia 23502 • (757) 395-4455 • Fax (757) 233-

Patient Consent

Account #: _____

Patient's Name: _____ Date of Birth _____

Financial Agreement: I agree to pay all charges made by Elite Women's Care at their current rate for services rendered and for supplies used in providing care and treatment to me. I understand that any prepayment is for estimated charges only and agree(s) that the final bill may be different. All charges shall be paid when due (within 30 days of initial billing) the obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If all charges are not paid when due, I agree to pay 33 1/3% attorney's fees, or collection agency fees, which shall be deemed incurred upon referral of collections, plus costs, and interest at the current rate applicable by Statute to Virginia Judgments.

The Patient and the undersigned responsible parties are primarily liable for payment of the patient's account. It is their sole responsibility to comply in a timely manner with all requirements and supply all information and documents necessary to obtain payment of benefits by any HMO or insurer.

Balanced Due & Billing Questions: Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Charges not billed to my insurance company are due prior to leaving the office (ie. co-payments and deductibles). I have been informed that a $25.00 fee may be charged for missed appointments and for appointments cancelled without a 24-hour advance notice. A fee of $30.00 will be applied to my account for any returned checks. The **Returned Check Fee** is only payable in cash or by money order.

Release of Information: I hereby authorize the release of any and all medical and/or charge information as is necessary for the third party reimbursement from any governmental agency or insurance payor involved in the payment of my treatment. I authorize the release of any and all medical information to any physician and/or hospital involved in my care. In addition, I authorize the use of information from my medical record for the purpose of clinical quality improvement if such information is provided as required by applicable law in a manner that sufficiently protects my anonymity. I also authorize the taking and use of photographs. I understand that these photos will become part of my medical record. If a patient does not return to the practice or request their medical record to be transferred within six (6) years from the date of their last communication with the practice, their medical record may be destroyed without further notice.

Assignment of Benefits: I hereby authorize Elite Women's Care permission to furnish information to my insurance carriers concerning my illness and treatments, and I hereby assign to Elite Women's Care payment for medical services rendered to myself or my dependents. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Elite Women's Care for any services furnished by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Notice of Deemed Consent for Infectious Disease Testing: Virginia Code Section 32.1-45.1 provides that when either a person providing health care services or a patient is directly exposed to the body fluids of the other in a way that may transmit human immuno-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required. In the event of such direct exposure in a manner which may, according to the Center of Disease Control Guidelines, transmit AIDS (Acquired Immune Deficiency Syndrome) a sample of my blood will be tested for the presence of infectious diseases such as hepatitis, syphilis, and HIV. I consent that the results of the test will be released to me and the health care worker who suffered the exposure. I further understand that I will be given an explanation about the procedure and will be given an opportunity to ask questions about the procedure.

Notice of Privacy Practices: I have been offered and accepted a copy of Elite Women's Care Notice of Privacy Practices on this date: _____ initials _____.

Acknowledgement/ Certifications: I have read and agree to the terms of this **Patient Consent**. I certify that I understand the contents of this form. Furthermore, I permit a copy of the document to be used in place of the original.

Each undersigned represents that he/she has read and fully understands the meaning and effects of this entire agreement

Patient's Signature _____ Date _____

Other Responsible Party Signature _____ Date _____