Martha Jefferson Medical Group

ANNUAL CONSENTS, RELEASE OF INFORMATION, AND ASSIGNMENT OF INSURANCE BENEFITS

Consent to Treatment: I voluntarily consent to medical care at Martha Jefferson Medical Group, which may include examinations, tests, photographs, and treatment by physicians and other clinical staff. I understand that the general nature, purpose, risks and alternatives associated with any procedure or treatment will be explained to me by my doctor and, in the case of other services, by other physicians. I understand that I will have the opportunity at that time to ask for more information and to ask questions. I further understand that medical care and treatment is not an exact science. No promises have been made to me as to the results of examination or treatment.

Consent to Testing For Blood Borne Pathogens: Whenever any health care worker associated with or working for Martha Jefferson is directly exposed to bodily fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit human immunodeficiency virus (HIV or AIDS) or Hepatitis B and C, Martha Jefferson will proceed to test a sample of the patient's blood for the HIV (AIDS) virus or Hepatitis B and C. Martha Jefferson will also provide the results of the test to the patient through his or her physician and to the health care worker(s) who was/were exposed. In these circumstances, I understand that I will be deemed to consent to such testing. If there is a blood exposure from any healthcare worker, to any healthcare worker, or to me involving my bodily fluids, I consent and understand that a blood sample may be drawn and tested for Hepatitis B and C or the HIV (AIDS) virus for the protection of all concerned.

Notice of Virginia Prescription Monitoring Program Participation: This office participates in the Commonwealth of Virginia Prescription Monitoring Program for Controlled Substances and may access the computerized database to retrieve information on prescribed medications.

Protected Health Information: Martha Jefferson's Notice of Privacy Practices provides information about how Martha Jefferson and its providers may use and disclose my protected health information. I acknowledge that I have received or been offered a copy of Martha Jefferson's Notice of Privacy Practices.

Release of Information, Assignment of Insurance Benefits and Financial Policy: I hereby authorize the release of pertinent information to my insurance company, CMS, and any other physicians involved in my care. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services, non-covered co-payments, and non-covered co-insurances. I understand that if my account becomes delinquent, unpaid balances will be assigned to an outside collection agency. I agree to pay all costs of collections, including agency fees, attorney fees of 25%, and interest of 18%. I have read, understand, and agree to the other terms included in the Martha Jefferson Medical Group Financial Policy.

Signature:

Patient's relationship to signer: ○ Patient ○ Spouse ○ Parent ○ Child ○ Guardian ○ Other _____

_____ _____ _____

Printed Name Signature Date

_____ _____

Patient's Printed Name (if different from above) Patient's DOB

○ Patient is unable to sign or acknowledge

02/25/11 drr