

# Patient First®

## VIRGINIA TREATMENT AND PAYMENT POLICIES

Thank you for choosing Patient First for your health care services.

We believe that the physician-patient relationship is strengthened when there is a clear understanding between both parties as to their rights and obligations. We ask, therefore, that you review and sign the following statement of our Treatment and Payment Policies prior to receiving treatment. If you have any questions about our treatment or payment policies, please do not hesitate to ask.

### **Treatment Policy:**

You\* consent to, understand and agree that:

- You will have the opportunity to discuss the risks and benefits of proposed procedures and therapeutic courses of treatment, together with any available alternatives, with the physician or health professional to your satisfaction;
- You have the right to consent to or refuse any proposed procedure or therapeutic course of treatment;
- Patient First will provide the best care possible consistent with the prevailing standards of medical practice but has made no assurances or guarantees as to the results of treatment; and
- Subject to the foregoing, the attending physician and physician extenders of Patient First and its clinical and technical employees may administer any treatment or perform any procedures deemed advisable in your care and treatment.
- In the event that a Patient First health care provider is exposed to your blood or body fluids in a manner which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, you hereby consent to testing of your blood and/or body fluids for these infections and to the release of test results to the health care provider who has been exposed. You will be offered the opportunity for face-to-face disclosure of test results and counseling.

### **Payment Policy:**

Patient First is a private organization which relies solely on income from patients and their insurers. In order to provide the best possible medical care at the lowest possible cost, we need your assistance and agreement to our payment policies:

- By signing this document, you agree to assign to Patient First any and all health care benefits to which you are entitled under any policy of insurance (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan) and authorize, to the extent permitted by law, payment of those benefits directly to Patient First. We will protect the privacy of your health information and will not use it or disclose it except in a manner that is permitted by state and federal law, as more fully described in the Patient First Notice of Privacy Policies that has been made available to you. By signing this document, you consent to our use and disclosure of your health information in accordance with the Notice of Privacy Policies and applicable law.
- If you have health care benefits, Patient First will submit a claim to your insurance company on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts. For your convenience, we accept cash, checks and credit cards.

- If you do not have health care benefits, you are required, and you agree, to pay at time of service all charges as well as any outstanding balances and delinquent accounts.
- Patient First allows more than the legal and customary amount of time after filing a claim to be reimbursed by insurance companies. If Patient First has not received a response within 60 days of having filed a claim for a visit, we will assume that the visit is not covered and is, therefore, your responsibility. At that time, to the extent permitted by law, we will bill you for the visit charges. Questions regarding non-payment by your insurance company should be directed to your insurance company, not to Patient First.

- **By signing this document, you agree that you have been advised that your insurance company may determine that the services to be provided by Patient First during your visit are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services.**
- **In the event that your plan requires approval or referral from your Primary Care Physician or insurer prior to a visit and you did not obtain that approval or referral, you will be responsible for, and agree to pay, any costs of care that your insurance company determines are not covered under your insurance policy and for which you may be held liable under applicable law.**

Initial \_\_\_\_\_

- TRICARE Patients: By signing this document, you agree that you have been advised that, under your health benefits plan, sports physicals are not covered and school physicals are covered only under specific, defined circumstances. You also agree that you shall be responsible for and pay for sports physicals and that, if TRICARE denies the school physical as non-covered, you shall be responsible for and agree to pay for the cost of such service.
- You will be billed for all unpaid balances deemed by Patient First or your insurance company to be your responsibility. Unless you otherwise request, all bills and other communications from Patient First will be sent to your address of record at Patient First and will be in the name of the adult family member who initially established your account. You are responsible for notifying us in writing if you wish for a different mailing address or name to be used. You are responsible for paying the bill in full unless special arrangements have been approved in advance by calling the Patient Accounts phone number printed on the billing statement. Late fees of 1½% per month will be charged on balances that are still unpaid starting 30 days after the first statement. There is a fee of \$20 for returned checks. Delinquent accounts may be turned over to a collection agency at which time you agree to be responsible for collections charges and all associated legal fees in addition to the amount owed. Patient First reserves the right to deny non-emergency services if your account is delinquent.

I have read, understand, and agree to the Treatment and Payment Policies described above and understand that Patient First may refuse non-emergency treatment if I do not remain current in payments for medical services.

Patient or Guarantor Name (Printed)	Patient or Guarantor Signature	Relationship to Guarantor	Date
Minor Patient's Name	Relationship to Guarantor	Witness Signature	Date

\*The terms "you" and "your" as used in this document mean the Patient and the Patient's Guarantor, if applicable. A Guarantor is the individual who accepts financial responsibility for services rendered to a minor, incapacitated or otherwise legally dependent Patient. The Guarantor may be a family member or a non-family member with legal authority to act on the Patient's behalf, including the authority to consent to medical services. By signing this form as "Guarantor" on behalf of a minor, incapacitated or otherwise legally dependent person, you represent to Patient First that you have such authority.

**Please initial the following:**

\_\_\_ I (Patient/Guarantor) hereby acknowledge that I have been provided with a copy of the Patient First Virginia Notice of Privacy Practices.

**FOR OFFICE USE ONLY**

\_\_\_ A copy of the Patient First Virginia Notice of Privacy Practices was made available to the Patient/Guarantor, and the Patient/Guarantor refused to initial the acknowledgement.