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PATIENT CONSENT AND FINANCIAL RESPONSIBILITY AGREEMENT

Please read the following and sign below.

1. **MEDICAL TREATMENT RISKS:** I acknowledge that all medical treatment involves some risks and that no guarantees can be given regarding the outcome.
2. **NOTICE OF RELEASE OF PRESCRIPTION HISTORY:** I understand any nurse practitioner or physician who is treating me on behalf of Health & Wellness services may request and receive any and all information regarding my medication history including information maintained by the Virginia Prescription Monitoring Program.
3. **HIV TESTING DISCLOSURE:** Under Virginia law, if a Health and Wellness employee comes in contact with your blood or body fluids during your care, UHWS has the right to do a current HIV, Hepatitis B or C screening. This means that you, the Patient, may be tested for HIV, Hepatitis B or C viruses without your actual consent if this type of exposure occurs during your medical care. The law also requires that the results of these tests be released to the person who is exposed to your body fluids without your consent.
4. **REPORTING COMMUNICABLE DISEASES:** Should you be diagnosed with a disease, toxic exposure or condition that is listed on the Virginia Reportable Disease List, by the Virginia Department of Health, UHWS is obligated under Virginia law to report this condition to the Department of Health without your consent. In addition, Virginia law will require you to give the health department all names of persons who have been exposed to your disease.
5. **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE:** I understand that I am responsible for all fees associated with my care and treatment in UHWS and that those fees are payable at the time of service. I will be responsible for any legal and / or collection fees resulting from non payment. I agree to pay a \$30 fee incurred for any returned checks. If any UHWS bill is not paid in full at the time of service, I assign all my rights to collect any unpaid bill to Riverside Business Health Services (RBHS). RBHS reserves the right to charge interest at the rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and attorney fees associated with recovering any outstanding balance. I agree this Agreement is an original, direct independent promise to pay based on the independent credit worthiness of the Patient or Responsible Party, and is not a collateral or contingent promise to pay the debt of another.
6. **DISCLOSURE OF MEDICAL INFORMATION:** I understand that UHWS does not file for insurance. In the event I am able to file myself for reimbursement, or for off campus services that are filed with my insurance I authorize UHWS to release any information to any agency involved in the payment of my treatment or to any provider I am referred to for consultation and /or treatment.

7. **PRE AUTHORIZATION RESPONSIBILITY:** In the event that I am referred off campus for treatment I understand that it is my sole responsibility to obtain all the required pre –authorizations for testing/treatment and to fully comply with all pre-authorization requirements as stated by my insurance company. I understand that if I elect to be tested / treated without knowing what my insurance will authorize, it is my sole responsibility to pay for that service.

8. **TRANSPORTATION:** No UHWS or other CNU employee may transport patients to off campus facilities. I understand it is my responsibility to arrange my own transportation (either by myself, friend, family member or taxi).

9. **PATIENT CONDUCT:** While in UHWS I agree to be respectful and courteous to the UHWS Staff and other patients. I realize the importance of honoring my scheduled appointments and agree to provide adequate notice for rescheduling appointments. I understand that if I am 15 or more minutes late for an appointment I will have to reschedule.

10. **RESPONSIBILITY FOR PERSONAL ITEMS:** UHWS will not be responsible for any loss, theft or damage to any personal property of the Patient (including money, jewelry, documents, clothing, eye glasses, cell phones, books or other personal articles).

I am eighteen (18) years of age or older.

PATIENT'S SIGNATURE _____ **Date:** ____/____/____
(No treatment will be given if not signed.)

**Or, if a Minor
 Parent/Guardian
 Signature** _____ **Date:** ____/____/____
(This consent is effective from the date of signature until the minor turns 18 years of age).

NOTICE OF PRIVACY PRACTICES

I have received the UHWS Notice of Privacy Practices & the Riverside Notice of Privacy Practices brochure. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my written medical records.

However, I hereby give permission to the professional medical staff to verbally discuss any and all of my medical conditions(s) with the following person(s).

 Print Individual Name & Phone #

 Print Individual Name & Phone #

 Print Individual Name & Phone #

 Print Individual Name & Phone #

For Office Use Only:

Patient requested and was provided a copy of this document

Patient does not want to receive a copy of this document