

## Deemed Consent for Designated Blood Borne Pathogens

As a healthcare provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any healthcare worker associated with or working for Dermatologic Surgery of Central Virginia is directly exposed to body fluids of a patient in a manner, which according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Dermatologic Surgery of Central Virginia will proceed to test the patient through its Employee Health provider and the healthcare worker(s) who was/were exposed.

## Consent to Medical Care & Assignment

By signing below, I voluntarily consent to medical care at Dermatologic Surgery of Central Virginia, which may include examinations, tests, photographs and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examinations. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

## Notice of Privacy Practices

Dermatologic Surgery of Central Virginia has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your acknowledgement and consent. By signing below, I give consent to Dermatologic Surgery of Central Virginia and its staff to use and/or disclose my protected health information for the purpose of treatment, payment and healthcare operations (TPO). Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me. With my consent, Dermatologic Surgery of Central Virginia may call or mail to my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. By signing below, I acknowledge that I have received or been offered a copy of Dermatologic Surgery of Central Virginia's Notice of Privacy Practices.

## Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any billing questions that we cannot answer directly, please call (434) 654-8632 or (800) 295-0526 or email [CentralBilling@mjh.org](mailto:CentralBilling@mjh.org).

Dermatologic Surgery of Central Virginia participates and accepts assignment of insurance benefits of most insurance organizations. Of course, you are still responsible for the timely payment of deductibles, coinsurance, and/or copayments. Copayments are due at the time of your visit. If you have insurance with an organization that we do not participate with, provide us with adequate information, and we will bill your insurance company for you. In these cases, payment of your bill remains your responsibility, including any balance after your insurance company settles your claim.

If your insurance company requires a referral from your primary care physician, and one was not obtained, you are responsible for any balances not paid by the insurance company. It is your responsibility to make sure your PCP does the necessary referrals to Dr. John Hendrix. I understand by signing below that I will be responsible for any balances not paid by my insurance as a result of a missing referral or authorization from my primary care physician. If my account becomes assigned to a collections agency, I also agree to pay all costs of collections, including agency, attorney and court fees.

If I do not sign this consent, Dermatologic Surgery of Central Virginia may decline to provide treatment to me.

Print Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

REPRESENTATIVE'S RELATIONSHIP TO PATIENT:                      Spouse                      Parent                      Child                      Sibling  
(PLEASE CIRCLE)                      Other: \_\_\_\_\_