Mary Washington
Medical Group

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system which will further enhance the quality of our services. This system allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect your medication history without limitation or exclusion as is required and/or reasonably necessary for your care and treatment. Please understand that your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking and for you to point out to us any errors in your medication history.

Patient Name:_____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to Patient:** _____

Mary Washington Medical Group

POLICIES AND PROCEDURES AGREEMENT

In the effort to serve all our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Late Policy: Every effort is made to keep our physicians' schedules on time; therefore, if you are more than **15** minutes late, we cannot guarantee that you will be seen immediately, but we will do our best to work you in to the schedule as time permits. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments, Procedures or Surgeries: Every effort is made to accommodate our patients' requests for appointment, procedure or surgery dates/times; therefore, it is important that you make every effort to keep your scheduled appointments. No shows and appointments cancelled within 24 hours will be subject to a fee of **$40.00**. Cancellation of a surgery or scheduled procedure, for any non-medical reason, within 5 business days of the procedure date will be subject to a **$150** cancellation fee. **Please be advised that multiple missed appointments may result in dismissal from our practice.**

Fee for Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from administrative and nursing staff as well as the doctors. A fee of **$30** will be charged for the completion of all forms.

Transferring of Records: All patients must sign a records release form to have their records copied, electronically downloaded, or sent to another provider or organization. There is no fee to transfer records directly to another provider or healthcare organization. For patients with very large charts who request a paper copy, we agree to release the medication list, problem list, up to the last 3 progress notes, most recent labs and radiology reports at a cost of **$0.50** per page. This will enable the patient to obtain the most critical documents for follow up at a nominal cost. If you chose to obtain a paper copy of your complete medical record the fee will be **$0.50** per page up to 50 pages and **$0.25** per page thereafter. An electronic copy of records can be provided to the patient for a **$5.00** fee. This will cover the cost of the CD and other administrative costs.

Payment for Services for Patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment /coinsurance at the time of service.

Payment for Services for Patients without Insurance: You will be responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and with approval of our billing department and office manager, you may set up a payment plan with our office. If you feel that meeting your payment obligations may be difficult, please ask to discuss our financial policies with the office manager.

Returned Checks: There is a **$50.00** fee for any check returned by your bank. In the event that a check is returned due to non-sufficient funds, you will be discharged from the practice.

Patient Name:_____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to Patient:** _____

Mary Washington Medical Group

CONSENT FOR PAYMENT AND GUARANTY OF PAYMENT FORM

Consent for Examination and Treatment
I consent to be treated by Mary Washington Healthcare Physicians (MWHP). I understand that the practice of medicine and surgery is not an exact science and I know that treatment results cannot be guaranteed.

Deemed Consent
I understand that under Virginia law if, while examining or treating me, any person employed by or under the direction and control of MWHP or any other healthcare provider is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person.

Joint Notice of Privacy Practices
I understand that MWHP may use and disclose my protected health information for purposes of treatment, payment and operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Joint Notice of Privacy Practices for MWHP which provides information about how MWHP and individuals involved in my care at MWHP may use and disclose my protected health information.

_____**Initials**_____**Date**

Responsibility for Payment
I understand that I am responsible for all charges for the treatment that I receive today. I authorize MWHP to bill my medical insurance for the care I receive and to release any information that the insurance carrier requires to process this bill. I authorize payment of medical benefits to MWHP, or to an outside laboratory as described below, for all services performed and billed by MWHP.

As a courtesy, MWHP will bill my medical insurance. If I do not provide complete and accurate insurance information to MWHP, I understand MWHP may not receive payment from my carrier and I will be responsible for all charges incurred. Even after my medical insurance company pays MWHP, I may owe MWHP payment for services not covered by my insurance and I agree to pay these charges promptly. I authorize any laboratory performing services for me to bill my medical insurance for its services. I understand that my medical insurance may not pay for all services provided by an outside laboratory and I agree to pay any remaining balance promptly to the laboratory. I understand that MWHP is not responsible for payment to outside laboratories for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, MWHP may choose not to bill my insurance and may decline credit/debit cards and checks as form of payment. I understand that if I fail to pay MWHP for services provided to me, the balance owed will be sent to collections and I may incur collections fees in addition to the amount owed for services/treatment rendered. I understand that I may contact MWHP to set a payment arrangement that may prevent this additional cost.
In the event that my account is forwarded to a collections agency, I acknowledge that I may be discharged from MWHP practices.

Business Communications
I authorize MWHP to contact me after discharge for performance improvement purposes such as conducting patient satisfaction surveys. Further, by providing the practice with my cellular or wireless telephone number, I authorize the use of an automatic telephone dialing system to contact my cellular or wireless telephone for normal business communications such as appointment reminders or collection efforts.

Certifications
I certify that I have read this entire form, that I was given a chance to ask any questions I had about this form, that all of my questions about this form have been answered to my satisfaction, and that I understand the content and purpose of the form.

I certify that I am the patient, or that I am a person authorized by the patient and/or in accordance with Virginia law to sign this form and accept its terms. I certify that the information provided and to be provided to MWHP is and will be true and correct. I agree to pay any expenses incurred by MWHP and all health care providers because of incorrect information provided by me. I further acknowledge that, should I provide false or fraudulent information relative to the services provided, MWHP may contact law enforcement to initiate civil and/or criminal proceedings.

Patient Name: _____ **DOB:** _____
Patient or Legal Surrogate Signature: _____ **Date:** _____

Legal Surrogate/Patient Representative:_____**Relationship to Patient:** _____

Mary Washington Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY

I,_____, understand that Mary Washington Healthcare (MWHC), of which this Mary Washington Healthcare Physician Practice (The Practice) is a wholly owned subsidiary, may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Notice of Privacy Practices for MWHC, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the notice may change. To obtain a copy of any current Notice, I may contact the Privacy Officer at 1-800-442-8762.

I understand that I have the right to request that The Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that The Practice is not required to agree to a requested restriction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Mary Washington Healthcare Physicians to leave messages regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method (please circle Yes or No):

Yes **No** Home answering machine: _____ **Yes** **No** Cell Phone/Voicemail: _____
Yes **No** Work Voicemail: _____

I authorize Mary Washington Healthcare Physicians to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Mary Washington Healthcare Physicians may not release information to the named individuals and or entities unless you identify them below.

Name	_____	Relationship to Patient	_____	Contact Info	_
Name	_____	Relationship to Patient	_____	Contact Info	_
Name	_____	Relationship to Patient	_____	Contact Info	_
Name	_____	Relationship to Patient	_____	Contact Info	_

Mary Washington Healthcare Physicians will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates. I will ensure this information is up to date at every visit.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to Patient:** _____