



## PATIENT RESPONSIBILITY AND FINANCIAL AGREEMENT

AS A PATIENT OF OBSTETRICS AND GYNECOLOGY ASSOCIATES OF HAMPTON, I AGREE TO THE FOLLOWING:

1. **Medical Treatment Risks:** I acknowledge that all medical treatment involves some risks and that no guarantee can be given regarding the outcome.
2. **Release of Prescription History:** I authorize any physician who is treating me on behalf of OB/GYN Assoc. of Hampton to request and receive any and all information regarding my medication history, including information maintained by the Virginia Prescription Monitoring Program.  Yes  No
3. **HIV Testing Disclosure:** Under Virginia law, if an OB/GYN employee comes in contact with your blood or body fluids during your care, OB/GYN Assoc. has the right to do a current HIV and 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 was exposed to your blood or body fluids, without your consent.
4. **Financial Responsibility:** I assign any benefits to OB/GYN Assoc. of Hampton that I may have for reimbursement for my medical treatment received by OB/GYN Assoc. of Hampton, which I may be entitled to from any insurance coverage, workers compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay my outstanding balance, I understand OB/GYN Assoc. of Hampton will have a lien against any such settlement, judgment, or verdict equal to the full amount of any unpaid bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay OB/GYN Assoc. of Hampton the full amount of any outstanding balance owed by me, the Patient, to OB/GYN Assoc. of Hampton for medical services rendered. I also understand and agree to pay a \$30.00 fee incurred for any returned checks.
5. **All Payments Due at Time of Service:** While OB/GYN Assoc. of Hampton, as a courtesy to our Patients, will bill most insurance companies; we are under no obligation to do this. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I accept full responsibility of all OB/GYN Assoc. of Hampton charges. Full payment is required at time of service unless other arrangements have been made. If any OB/GYN Assoc. of Hampton bill is not paid in full at time of service, OB/GYN Assoc. of Hampton reserves the right to charge interest at a 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/or 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. Moreover, I authorize OB/GYN Assoc. of Hampton to apply any overpayment from another Mid-Atlantic Women's Care medical bill to any other accounts owed by the Patient to OB/GYN Assoc. of Hampton as a result of any prior treatment or admissions.
6. **Preauthorization Responsibility:** I understand it is my sole responsibility to obtain all required pre-authorization for treatment and to fully comply with all pre-authorization requirements as stated by my insurance company. I also understand that if I elect to be treated without a referral from an authorized physician, it is my sole responsibility to pay that treating physician.
7. **Multiple Bills:** I understand while I am receiving medical treatment at OB/GYN Assoc. of Hampton, that I may receive a separate bill from a healthcare provider and/or laboratory other than a bill from the office listed above. For example, I may receive a separate bill from a laboratory, radiologist, pathologist, and other providers. I agree to pay any outside bills received to the extent that it is not paid by my insurance.
8. **Disclosure of Medical Information and Assignment of Benefits:** I authorize OB/GYN Assoc. of Hampton to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment.

10. **OB/GYN Assoc. of Hampton is not Responsible for Loss of Personal Items:** OB/GYN Assoc. of Hampton will not be responsible for any loss, theft, or damage to any personal property of the Patient (including money, jewelry, documents, clothing, spectacles, dentures, prosthetic devices, or other personal articles.)

**EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH TERM AND PROVISION OF THIS AGREEMENT.**

_____	_____	_____
Patient's Printed Name	Date of Birth	Date
_____		_____
Patient or Responsible Party Signature	Relationship to Patient	

**NOTICE OF PRIVACY PRACTICES:**

I am aware of and/or received Mid-Atlantic Women's Care, PLC's Notice of Privacy Practices brochure. Upon receiving an inquiry as to the presence or condition of the Patient, OB/GYN Assoc. of Hampton may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion: the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. 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 my permission to my physician & office personnel to **verbally discuss** any and all of my medical condition(s) with the following person(s).

_____	_____	_____
Print Individual Name	Relationship	Phone #

_____	_____	_____
Print Individual Name	Relationship	Phone #

_____	_____	_____
Print Individual Name	Relationship	Phone #