Name:

MR #

(Patient Identification)

VCU Health System
MCV Hospitals and Physicians
Richmond, Virginia 23298

CONDITIONS FOR HEALTHCARE SERVICES

Authorization for Medical Treatment: I authorize and consent to healthcare services including, but not limited to, diagnostic procedures and medical treatment at and by the Medical College of Virginia Hospitals and Clinics (hereinafter collectively referred to as "MCVH") and MCV Physicians (hereinafter "MCVP"). I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services.

Teaching Hospital: I understand that MCVH is a teaching hospital and that as such, healthcare services may be provided by qualified individuals in training. I further understand that for teaching and research purposes, patient records may be reviewed by students, trainees, employees and faculty members of MCVH, MCVP and VCU. I also understand that clinical photographs may be taken and that biological materials may be retained following completion of necessary diagnostic and therapeutic procedures. Photographs and biological materials may be used for teaching, study and research purposes and may be published without individually identifying me.

Deemed Consent (HIV/Hepatitis): I understand that if a healthcare provider is exposed to my blood or other body fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV, the virus which causes Acquired Immune Deficiency Syndrome (AIDS)) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider, and that the Virginia Department of Health will be notified and appropriate counseling provided if the results are positive.

Medicare Lifetime Signature Agreement (if applicable): I authorize any holder of medical or other information about me, and their agents, to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made either to me or to the provider, physician or other supplier for services or supplies furnished by the provider, physician, or other supplier.

Financial Agreement: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I agree to pay MCVH and MCVP in accordance with their regular rates and terms of payment. I assume full financial responsibility for payment of all charges associated with the healthcare services provided to me including any portion of hospital or physician charges not paid by insurance carriers, workers' compensation or any other third party. Such unpaid charges may include, but are not limited to, deductible and coinsurance amounts and private room charges. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorneys fees, and I waive homestead and all other exemptions to such debt. I further agree that any lawsuit to collect sums owed by me shall be brought in the City of Richmond.

Assignment of Benefits: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I hereby assign to MCVH and MCVP any and all rights, benefits and claims I may have under any policy of insurance (hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to MCVH and MCVP under and/or from any such policy of insurance or proceeds.

Personal Belongings and Valuables: I acknowledge that I have been instructed to send home personal belongings, valuables and currency, including credit cards. I also acknowledge that I have been informed that MCVH has a safe for small valuables such as jewelry and currency and that it is my responsibility to request use of the safe for such items. I understand that valuables not picked up within 90 days of discharge will be disposed of by MCVH without further liability or responsibility. I also understand that MCVH and MCVP are not responsible for any damage to or theft or loss of dentures, eyeglasses, contact lenses, hearing aids, or any other valuables or personal belongings that I keep in my possession.

Patient Self-Determination Act: I acknowledge that I have been asked whether I have an advance directive such as a living will or healthcare durable power of attorney. I also acknowledge that I have been provided with written information concerning (1) a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to make advance directives, and (2) MCVH's policy regarding implementation of those rights. Living Will? ☐Yes ☐No Healthcare Durable Power of Attorney? ☐Yes ☐No

Co-Guarantor: I_____, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by MCVH and/or MCVP to the patient identified below. If the patient is unable to sign at registration, I accept this "Conditions for Healthcare Services" on behalf of the patient.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked by MCVH or MCVP. I certify I received a notice of privacy practices.

VCU Health System Is a Smoke Free Environment

Patient: _____ Date _____ Co-Guarantor: _____ Date _____
Signature Signature

_____ SS#: _____ _____ Rel. to Pt.: _____
Print Name Print Name

Witness: _____ Date _____ SS#: _____

Unable to Sign at Registration: ☐ Reason _____

Patient Received Above Information: ☐ Yes ☐ No VCU Representative: _____ _____ Date _____
Signature Printed Name

Special Service Indicator: