Pratt Healthcare Consent for Treatment & Financial Agreement

CONSENT FOR TREATMENT: Pratt Medical Center, Ltd. (DBA: Pratt Healthcare) accepts the below-named patient for outpatient treatment and treatment and diagnostic testing. The Undersigned hereby consents to Pratt Medical Center, Ltd. providing its standard services.

FINANCIAL AGREEMENT: The undersigned agrees to pay all charges made by Pratt Medical Center, Ltd. for services rendered and for supplies used in providing care and treatment to the patient. The undersigned understands that any prepayment is for estimated charges only and agrees that the final bill may be different. Pratt Medical Center, Ltd. is not in the business of extending credit. All charges shall be paid when due (within 28 days of initial billing). If all charges are not paid when due, the undersigned agrees they may be assessed up to 33 1/3% attorney's fees and any collection agency fees, which shall be deemed incurred upon referral for collection, plus costs and interest, at the current rate applicable by Statute to Virginia Judgments.

Return check fee is $50.00 per check.

There may be a $50.00 fee for appointments not cancelled within 24 hours prior to appointment time.

The patient and the undersigned responsible parties are primarily liable for payment of the patient's account. Each of them consents to Pratt Medical Center, Ltd. and it's agent's use of any telephone number they provide or publish, to message or contact them regarding their accounts. It is their sole responsibility to comply in a timely manner with all requirements, and supply all information and documents necessary to obtain payment of benefits with any insurer or third-party source of benefits/payments.

ASSIGNMENT OF BENEFITS from claims made by or on behalf of patients for any insurance coverage, workers' compensation, governmental agency or disability benefits, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is made to Pratt Medical Center, Ltd. without offset. It is agreed that such assignments shall not be revoked. Medical providers are given a lien in like amount and are authorized to receive direct payment of all assigned benefits/proceeds. Any attorney, insurance carrier or agency handling or disbursing such benefits or proceeds is ordered, authorized and directed to withhold and promptly pay over to Pratt Medical Center, Ltd. the lesser of the full amount of their charges or the total net proceeds or benefits available without offset.

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immuno-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Acknowledgement: In providing my e-mail address, I authorize Pratt Medical Center, Ltd. to use the address for the purpose of communication health-related information or services. I acknowledge that I may opt-out of such communication at any time and my e-mail information will not be shared with any organization outside of Pratt Medical Center, Ltd. and it's affiliated companies.

NOTICE OF PRIVACY PRACTICES (Effective October 14, 2018)	
I have been offered and **accepted** a copy of Pratt's Notice of Privacy Practices on this date. (initials_____ date_____)	I have been offered and **declined** a copy of Pratt's Notice of Privacy Practices on this date. (initials_____ date_____)
YOUR PATIENT RIGHTS AND RESPONSIBLITIES / NOTICE OF NONDISCRIMINATION	
I have been offered and **accepted** a copy of Pratt's Your Patient Rights and Responsibilities / Notice of Nondiscrimination on this date. (initials_____ date_____)	I have been offered and **declined** a copy of Pratt's Your Patient Rights and Responsibilities / Notice of Nondiscrimination on this date. (initials_____ date_____)

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS READ AND FULLY UNDERSTANDS THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT.

Date	Patient Name (Please Print)	If Applicable-Other Responsible Party (Please Print)	Relationship
Date	Patient Signature	Other Responsible Party Signature	Date

MEDICARE SIGNATURE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made, either by me or on my behalf, to Pratt Medical Center, Ltd. and the physicians employed by Pratt Medical Center, Ltd. for any services furnished by my physician/provider. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information to determine these benefits or the benefits payable for the related services.

Beneficiary's Name (Please Print Patient Name)	Medicare Number	Patient Date of Birth
Signature of Patient	Today's Date	