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	

Pratt Healthcare Office Policies

Attention Patients and/or Guardians:

- **Copays:** If a copay is required by the patient's insurance, it will be due at the time of service.
- **Late Arrivals:** Patients who arrive 15 minutes past the appointment time may be asked to reschedule the appointment to a different time, or different day.
- **Appointments:** Our office requires a 24-hour notice in the event a patient is unable to keep an appointment.
- **No Call/No Show:** Failure to show for office appointments will result in a $50 fee. Procedures will result in a $150 fee.
- **Form Fees:** Third Party Forms may be subject to a fee ranging from $10-$25.
- **Prescriptions:**
    - Bring either all current medications in the original bottles, or a complete list of the medications including strength and dosage to all appointments.
    - Remember to closely track your number of refills available. Patients must call the office for ALL new prescriptions.
    - It is our patients' responsibility to monitor prescription refills and to ensure follow up appointments are scheduled a timely manner.
    - Refills of any current medications will only be authorized during office hours. Our office requires a 24-72/hour notice for medication refills
- **Cell Phones:** In order to serve patients in the most efficient manner, we kindly ask that patients refrain from cell phone use at the check in window and during the visit with provider.
- **Procedures:** Patients with scheduled procedures should refrain from bringing children. We cannot be held responsible for children left unattended.

By signing below, the patient agrees to allow the provider/Pratt Healthcare to access the Data Center for Prescription Monitoring for the Virginia Prescription Monitoring Program.

I have read the above instructions and understand my responsibilities regarding my healthcare.

Patient Name: _____ Patient Date of Birth: _____

Patient/Guardian Signature: _____

Date: _____

Revised 1/2019

Patient Contact Authorization

I_____ hereby authorize Pratt Medical Center, Ltd. (dba Pratt Healthcare) to discuss any and all aspects of my care and/or appointment reminders with the following person(s):

1._____ Relation: _____

2._____ Relation: _____

3._____ Relation: _____

4._____ Relation: _____

5._____ Relation: _____

NOTE: If patient does not wish to list anyone as a contact, please write "NONE" in space one above. Be sure to sign and date below.

I understand that I have the right to revoke this authorization at any time in writing. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

Signature _____ **Date_____**

Patient Registration Form

Last Name _____First Name _____ MI _____

AKA (Also Known As) /Previous Last Name(s) _____

Social Security # ____-____-____ Date of Birth__/__/____ Birth Gender:_____ Gender Identity:_____

Marital Status: ___Married ___Single ___Divorced ___Legally Separated ___Widowed _____Life Partner

Home Address _____

_____

City _____ State _____ Zip Code_____

Home Phone (____)_____ Cell Phone (____)_____

Alternate Phone (____)_____ Alternate Phone Info _____

E-Mail _____

Preferred Method of Communication: ❑ Home Phone ❑ Cell Phone ❑ Alt Phone ❑ E-Mail ❑ Text

Primary Care Physician/Pediatrician _____

If pediatric patient, please list siblings _____

_____

Race: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian

❑ Pacific Islander or Native Hawaiian ❑ Multiracial ❑ Other Race- Please Print_____

Ethnicity: ❑ Hispanic or Latino or Spanish Origin ❑ Not Hispanic or Latino or Spanish Origin

❑ Other/Unknown – Please Print if Other_____

Language Preference: If other than English- Please Print_____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, please check appropriate item(s): ❑ Vision ❑ Hearing

Patient's Employer_____

Address _____

City _____State _____ Zip Code_____

Work Phone Number (____)_____ Ext _____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ❑ Guarantor? ❑ Legal Guardian?

Guarantor/Legal Guardian Name _____Social Security #_____-_____-_____

Patient's Relationship to Guarantor/Legal Guardian: ❑ Spouse ❑ Dependent Child ❑ Student

Date of Birth _____/_____/_____ ❑ Other – Please Print_____

Revised 1/2019

Guarantor/Legal Guardian Home Address _____

_____

City _____ State _____ Zip Code _____

Home Phone (____)_____ Cell Phone (___)_____Work Phone (____)_____

Guarantor/Legal Guardian Employer Name & Address _____

_____

City _____ State _____ Zip Code _____

Emergency Contact - Who to call in the event of an Emergency

1. Name _____ Relationship _____

Cell/Hm Phone # (_____)_____ Work Phone# (_____)_____

2. Name _____ Relationship _____

Cell/Hm Phone # (_____)_____ Work Phone # (____)_____

Is your visit due to a job related injury or automobile accident? ❑ Yes ❑ No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ❑ Yes ❑ No

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Does the patient have insurance? ❑ Yes ❑ No

Primary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Primary Insurance***

Plan Name _____

Policy Holder's Name _____ Gender: ❑ Male ❑ Female

Policy Holder's # _____-_____-_____ Policy Holder's Date of Birth ____/____/_____

Secondary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance***

Plan Name _____

Policy Holder's Name _____ Gender: ❑ Male ❑ Female

Policy Holder's # _____-_____-_____ Policy Holder's Date of Birth _____/_____/_____

Patient/Guarantor Printed Name _____ **Patient DOB** ____/____/_____

Patient/Guarantor Signature _____ **Date** ____/____/_____