

**CONSENT FOR THE TREATMENT/ASSIGNMENT OF BENEFITS**

I GIVE MY PERMISSION & CONSENT FOR THE TREATMENT OF THE PATIENT WHOSE NAME APPEARS BELOW, BY THE PHYSICIANS & EMPLOYEES OF PENINSULA NEUROLOGY. I REQUEST THAT AS LONG AS I AM A PATIENT, PAYMENT OF MEDICARE & OTHER HEALTH INSURANCE BENEFITS BE MADE ON MY BEHALF, TO PENINSULA NEUROLOGY & AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE REQUESTING REFERRING PHYSICIAN, INSURANCE COMPANIES, OR GOVERNMENT AGENCIES TO DETERMINE THOSE BENEFITS. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR CO-INSURANCE AT THE TIME OF SERVICE.**

I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE, PAYMENT OF SERVICES RENDERED IS MY RESPONSIBILITY AND I AGREE TO PAY EXPENSES INCURRED IN THE COLLECTION OF ANY DELINQUENT AMOUNTS, COURT COSTS, ATTORNEY’S FEE’S AND PAYMENT OF CHARGES FOR NON-COVERED SERVICES. **I ALSO UNDERSTAND THAT IF I MISS MY SCHEDULED APPOINTMENT OR CANCEL WITHOUT A 24-HOUR NOTICE THERE IS A FEE THAT I AM RESPONSIBLE FOR. ALSO, ANY FORMS THAT MAY NEED TO BE FILLED OUT BY THE DOCTOR WILL BE ASSESSED A CHARGE BASED ON THE TIME SPENT TO FILL OUT THE FORMS. I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPH.**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



**NOTICE OF DEEMED CONSENT TO HIV & HEPATITIS B OR C TESTING**

A LAW WAS PASSED IN VIRGINIA IN 1989 WHICH AUTHORIZES HEALTH CARE PROVIDERS TO TEST THEIR PATIENT’S FOR HIV ANTIBODIES AND HEPATITIS B OR C VIRUSES **WHEN THE HEALTH CARE PROVIDER IS EXPOSED** TO THE BODY FLUIDS OF A PATIENT IN A MANNER WHICH MAY TRANSMIT HIV OR HEPATITIS B OR C VIRUSES. PURSUANT TO THIS LAW, **IN THE EVENT OF SUCH AN EXPOSURE**; YOU WILL BE DEEMED TO HAVE CONSENTED TO THE RELEASE OF THE TEST RESULTS TO THE HEALTH CARE PROVIDER WHO MAY HAVE BEEN EXPOSED. HOWEVER, YOU WOULD BE INFORMED BEFORE ANY OF YOUR BLOOD WOULD BE TESTED FOR HIV ANTIBODIES OR HEPATITIS B OR C VIRUSES, PURSUANT TO THIS PROVISION, THE TEST WOULD BE EXPLAINED AND YOU WOULD BE GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS YOU MAY HAVE. PLEASE NOTE THAT THIS IS **NOT** CONSENTING TO DRAW BLOOD. **THE PURPOSE OF THIS IS TO INFORM YOU OF THE VIRGINIA LAW.** I HAVE READ & UNDERSTAND THE ABOVE “NOTICE DEEMED CONSENT TO HIV AND HEPATITIS B OR C BLOOD TESTING”.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



**PATIENT ‘CALL REMINDER’ RELEASE**

I GIVE PENINSULA NEUROLOGY PERMISSION TO CALL & REMIND ME OF MY UPCOMING APPOINTMENT. I ALSO GIVE PERMISSION TO LEAVE A MESSAGE ON MY ANSWERING MACHINE OR WITH ANOTHER PARTY IF NO ONE IS AT HOME.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_