

NEUROLOGY CENTER OF VIRGINIA, LLC
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 Neurology Center of Virginia, LLC (hereinafter referred to as "NCV"). I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services.

X _____
Responsible Party Date

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) 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.

X _____
Responsible Party Date

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.

X _____
Responsible Party Date

Financial Agreement:

In consideration for healthcare services provided to me by NCV for this and all subsequent services, I, the responsible party, hereby agree to pay all charges in accordance with NCV's regular rates and terms of payment submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care contract organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which may arise during the course of treatment. I assume full financial responsibility for payment of all charges associated with the healthcare services provided to me including any portion of physician charges not paid or not considered to be a covered service by my insurer and/or a third party insurer or other payer. 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/patient shall be brought in the county of Chesterfield.

X _____
Responsible Party Date

Co-Guarantor:

I, _____, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by NCV 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.

Co-Guarantor: _____ **Date:** _____

Signature

SS#: _____ Relationship to Patient: _____

Print Name

Release And Assignment Of Benefits To The Provider:

I, the undersigned responsible party hereby authorize NCV/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I authorize this office and/or its employees to release, via fax machine, medical records that are needed in order to provide the patient with the most appropriate medical care.

In consideration for healthcare services provided to me by NCV for this and all subsequent services, I hereby assign to NCV 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 authorized direct payment to NCV under and /or from any such policy of insurance or proceeds.

X _____
Responsible Party Date

Notice Of Privacy Practices:

I, the undersigned have received a copy and understand the Privacy Practices of the Neurology Center of Virginia, LLC.

X _____
Responsible Party Date

Neurology Center of Virginia, LLC may disclose my health care information to:

NAME: _____ RELATIONSHIP: _____

This authorization is effective from _____ to _____ and includes only personal health information pertaining to Neurology Center of Virginia, LLC and its providers.

X _____
Responsible Party Date

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 NCV.

Patient: _____
Print Name

Signature

Date: _____

Unable to Sign at Registration: Reason _____

Patient Received Above Information: Yes No

NCV Representative: _____ Date: _____
Print Name Signature

- Patients with Health Plans, please present your insurance ID Card and photo ID to the Front Desk after completing this form.
- Some contract Health Plans (HMO, PPO, IPA, etc) require a copayment or deductible at the time of service. All copayments and deductibles are due at the time of service.