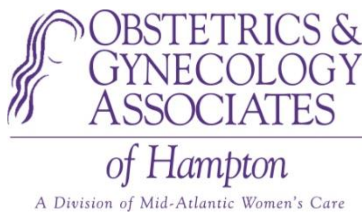


# PATIENT RESPONSIBILITY AND FINANCIAL AGREEMENT

AS A PATIENT OF OBSTETRICS AND GYNECOLOGY ASSOCIATES OF HAMPTON, I AGREE TO THE FOLLOWING:

1. **Medical Treatment Risks:** I acknowledge that all medical treatment involves some risks and that no guarantee can be given regarding the outcome. ______ **INITIAL**

2. **Release of Prescription History:** I authorize any physician who is treating me on behalf of OB/GYN Assoc. of Hampton to request and receive any and all information regarding my medication history, including information maintained by the Virginia Prescription Monitoring Program. ______ **INITIAL**

3. **HIV Testing Disclosure:** Under Virginia law, if an OB/GYN employee comes in contact with your blood or body fluids during your care, OB/GYN Assoc. has the right to do a current HIV and Hepatitis B or C screening. This means that you, the Patient, may be tested for HIV, Hepatitis B, or C viruses without your actual consent, if this type of exposure occurs during your medical care. The law also requires that the results of these tests be released to the person who was exposed to your blood or body fluids, without your consent. ______ **INITIAL**

4. **Financial Responsibility:** I assign any benefits to OB/GYN Assoc. of Hampton that I may have for reimbursement for my medical treatment received by OB/GYN Assoc. of Hampton, which I may be entitled to from any insurance coverage, workers compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay my outstanding balance, I understand OB/GYN Assoc. of Hampton will have a lien against any such settlement, judgment, or verdict equal to the full amount of any unpaid bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay OB/GYN Assoc. of Hampton the full amount of any outstanding balance owed by me, the Patient, to OB/GYN Assoc. of Hampton for medical services rendered. I also understand and agree to pay a $30.00 fee incurred for any returned checks. ______ **INITIAL**

5. **All Payments Due at Time of Service:** OB/GYN Assoc. of Hampton, as a courtesy to our Patients, will bill most insurance companies. I understand I am responsible for all co-pays, deductible, cost-shares, and non-covered services. By signing this agreement, I accept full responsibility of all OB/GYN Assoc. of Hampton charges. **Full payment is required at time of service unless other arrangements have been made**. If any OB/GYN Assoc. of Hampton bill is not paid in full within 60 days of service, OB/GYN Assoc. of Hampton reserves the right to charge interest at a rate of 1% (12% APR, minimum charge $2.50 per month) from the time of delinquency on any outstanding balance. If the account becomes delinquent, the undersigned agrees to be responsible for collection agency and/or attorney fees in the amount of 35%. I may also be responsible for court costs and litigation costs associated with any necessary collection procedures brought about by Obstetrics and Gynecology Associates of Hampton, Mid-Atlantic Women's Care, that that be necessary. Moreover, I authorize OB/GYN Assoc. of Hampton to apply any overpayment from another Mid-Atlantic Women's Care medical bill to any other accounts owed by the Patient to OB/GYN Assoc. of Hampton as a result of any prior treatment or admissions. ______ **INITIAL**

6. **Preauthorization Responsibility:** I understand it is my sole responsibility to obtain all required pre-authorizations for treatment and to fully comply with all pre-authorization requirements as stated by my insurance company. OB/GYN Assoc. of Hampton can assist in this process. ______ **INITIAL**

7. **Multiple Bills:** I understand while I am receiving medical treatment at OB/GYN Assoc. of Hampton, that I may receive a separate bill from a healthcare provider and/or laboratory other than a bill from the office listed above. For example, I may receive a separate bill from a laboratory, radiologist, pathologist, and other providers. I agree to pay any outside bills received to the extent that it is not paid by my insurance. ______ **INITIAL**

8. **Disclosure of Medical Information and Assignment of Benefits:** I authorize OB/GYN Assoc. of Hampton to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment. _______ **INITIAL**

9. **No-Show Policy:** If for any reason you are unable to keep your appointment, please call our office to reschedule or cancel at least 24 hours in advance, so that someone else may benefit from the appointment slot. I understand failure to call at least 24 hours in advance will result in a $30.00 no-show fee, which is not covered by my insurance. I understand that after three missed appointments without calling to cancel, OB/GYN Assoc. of Hampton will not offer any additional appointments and my care must be transferred to another practice. _______ **INITIAL**

10. **Surgery Cancellation:** A minimum of 72 hours (3 business days) notification is required for surgery cancellation. This allows the physician and their staff time to fill the slot with another patient. If you must cancel your operation, please call our office, 757-722-7401, and ask to speak with your physician's nurse. I have read this policy and understand that cancellation of my surgery may result in a fee of $150.00. _______ **INITIAL**

**EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH TERM AND PROVISION OF THIS AGREEMENT.**

| Patient or Responsible Party Signature | Relationship to Patient | |
|---|---|---|
| Patient's Printed Name | Date of Birth | Date |

NOTICE OF PRIVACY PRACTICES:

I am aware of and/or received Mid-Atlantic Women's Care, PLC's Notice of Privacy Practices brochure. Upon receiving an inquiry as to the presence or condition of the Patient, OB/GYN Assoc. of Hampton may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion: the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. I understand that a separate written consent is required for me and/or the person(s) listed below to receive copies of my **written** medical records.

However, I hereby give my permission to my physician & office personnel to **verbally discuss** any and all of my medical condition(s) with the following person(s).

| Print Individual Name | Relationship | Phone # |
|---|---|---|
| Print Individual Name | Relationship | Phone # |
| Print Individual Name | Relationship | Phone # |