

Consent for Purposes of Treatment, Payment and Healthcare Operations

With my signature below, I hereby acknowledge and authorize the following:

1. Consent for treatment, administration of medications and performance of any procedures that may be considered necessary or advisable.
2. Assignment of insurance benefits to Medical Associates of Arlington. This is to include Medicare and Worker's Compensation benefits. In doing so, I authorize release of any information necessary to process the claim.
3. Financial responsibility. The undersigned agrees, in consideration of services rendered by Medical Associates of Arlington, to be responsible for payment in full including any collection or attorney's fees related to non-payment when payment is due. All payments are due upon receipt of the bill.
4. Acknowledge that according to Virginia state law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency Virus (HIV), Hepatitis B or Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, be directly exposed to my body fluids in connection with rendering care to me as a patient, in a manner which may, according to the current guidelines of the Center for Disease Control, transmit HIV, Hepatitis B or Hepatitis C viruses to such healthcare provider. Test results may be released to the person exposed.

Medical Associates of Arlington will submit your claim to your previously indicated 3rd party insurance plan. It is the responsibility of the patient to provide the practice with updated demographic and insurance information for accurate billing. You will be responsible for any co-payments, deductibles, or non-covered services at the time of service. Patients will be required to sign a waiver at the time of visit if your 3rd party insurance plan is a HMO, and a referral is needed to be seen by our clinicians. For patients who do not have health insurance, payment in full is required at the time of the visit for all services. A \$25.00 fee will be charged for all returned checks.

With my signature, I also acknowledge reading and being given a copy of the NOTICE TO PRIVACY PRACTICES.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian: _____ Date: _____

Relationship to Patient: _____ MAA Witness: _____