PATIENT SIGNATURE ON FILE FORM

CONSENT FOR TREATMENT

Name: _____ **Date of Birth**: _____

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I consent to medical treatment and diagnostic procedures as provided by Virtua, its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Virtua

MEDICARE

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	Y	N	Has treatment been authorized by the VA?	Y	N
Do you or your spouse have other insurance?	Y	N	Are you covered under the Black Lung Program?	Y	N
Are you disabled or have end stage renal disease?	Y	N	Is there Medigap coverage secondary to Medicare?	Y	N
Is illness/injury the result of an auto accident?	Y	N	Is there Insurance coverage primary to Medicare?	Y	N
Did illness/injury occur at work?	Y	N	Is there employer supplemental coverage secondary to Medicare?	Y	N

MEDIGAP (MEDICARE AND SECONDARY INSURANCE)

I request that payment of authorized Medigap benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorize any holder of Medicare information about me to be released to _____ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

COMMERCIAL ASSIGNMENT OF BENEFITS

I authorize payment directly to Virtua for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the physicians. I understand and agree that I am financially responsible to the above party for charges not paid under my policy. I permit a copy of this authorization to be used in place of the original.

GENERAL

RELEASE OF INFORMATION

Virtua may disclose any or all parts of my clinical records to any insurance company or companies, or in the case of Worker's Comp claims, to my past or present employer(s), for purposes of satisfying charges billed by Virtua Health. This authorization does not cover requests from other parties seeking information regarding my account. I acknowledge receipt of and/or the opportunity to review the Virtua Joint Notice of Privacy Practices which explains how protected health information will be used and disclosed.
I give consent to access all of my electronic medication information in connection with providing a list of current medications. I give consent to access all of my electronic immunization information in connection with providing my complete list of vaccinations.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by Virtua Health to the below and named patient, the undersigned (jointly and several if more than one) guarantee payment of all charges incurred by all said patient in accordance with the policy of payment of such bills.

PATIENT BILL OF RIGHTS

- The patient Bill of Rights has been made available for me to review.
- I acknowledge receipt of the Health Information Exchange brochure.

□You may **not** discuss my medical care with anyone other than me.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____	_____	_____
Patient Signature	**Patients Agents Representative/Guarantor Signature**	**Date**