Virtua Medical Group

PATIENT CONSENT

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.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I assign to Virtua, and/or a Virtua based healthcare professional, all of my right, title and interest to medical and/or automobile insurance benefits and all other rights and benefits otherwise payable to me for those services provided at Virtua and/or by a Virtua based healthcare professional. I understand that Virtua may not be obligated to accept this assignment as payment in full. If my insuring company or agency refuses to pay any charges on the bill for whatever reason, I agree to be responsible for payment of fees, charges and costs associated with this Virtua service to the extent allowed by Law. If my insurer refuses to make payment to Virtua who provides care to me, I give my consent to Virtua who provided care to me to appeal the denial of payment. I give consent to access all of my electronic medication information in connection with providing a list of current medications.

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. I agree, in order for Virtua to service my account to collect any amounts owed, Virtua and its affiliates, may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Virtua and its affiliates, may also contact me by sending text messages or e-mails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. 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.

TELEHEALTH CONSENT

If my Virtua provider thinks it is appropriate, my care may be provided through telehealth (audio and/or video) technologies. The benefits, risks, and alternatives to the telehealth service were reviewed with me. My encounter will either be provided through a HIPAA-compliant application or, if unavailable during the COVID-19 national emergency, through a non-public facing application, as permitted by the Office for Civil Rights. I understand the potential privacy risks associated with the use of the non-HIPAA compliant application, including the potential for interception and the unauthorized access to and/or disclosure of my health information. I have been advised to enable all available privacy and encryption modes when using non-HIPAA compliant applications. A telehealth visit is <u>not</u> appropriate for a medical emergency and I should call 9-1-1 or go to a hospital in the event of a medical emergency.

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.
- The Health Information Exchange brochure has been made available for my review.

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

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

Revised 4/3/2020