Virginia Interventional
Pain & Spine Center

Patient Information

1. **CONSENT TO TREATMENT:** I hereby authorize the employees, agents and staff of VIPSC to perform, and hereby consent to such medical treatment and examinations, including diagnostic procedures and blood transfusions, as may in the options of the patient's physician be necessary.
2. **NO GUARANTEE:** I am aware that practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of any procedures, treatments or examinations.
3. **DEEM CONSENT FOR BLOOD TESTING:** I understand that under Virginia Law, if a health care provider , a person employed by, under the directions of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit virus causing, HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV and Hepatitis B and C, and to release such test results to the person who has been exposed, (Exposure could occur due to an accidental needle stick) Patients who test positive will be afforded the opportunity for individual face to face disclosure to test results and appropriate counselling.
4. **ASSIGNMENT AND PROMISE TO PAY:** In consideration of medical services to be rendered to me or at my request, I assign to VIPSC, to the extent necessary to satisfy any outstanding debts, the right to receive all sums payable to me, or on my behalf under the terms of any health or liability policy or other agreement, or plan with a third party that provides for payment for medical or health care services, or policy of insurance, or pursuant to any settlement or judgement arising out of or related to any incident which caused the admission or medical treatment. I understand that I owe and unconditionally agree to pay VIPSC the full amount charged for the services rendered to myself or my child that are not paid on my behalf by a third party, within 60 days of the date medical services were rendered. I further agree to pay reasonable attorney fees and collection costs if my account is placed in collections.
5. **RELEASE OF INFORMATION:** I authorize VISPC to release any and all patient medical and billing information to any physician involved in my treatment to any health care facility to which the patient is discharged or transferred for treatment; to affiliates of VIPSC for purposed of treatment, billing, quality assurance, collections, or defense of litigation or anticipated litigation; and to any insurance company, review organizations or other entity, which is directly or indirectly responsible for payment or review of services provide by VIPSC. I consent to use and disclosure of my protected health information to carry out treatment, payment or health care operations by VIPSC and affiliates.
6. **MEDICARE LIFE-TIME SIGNATURE: AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf for any services furnished by or in VIPSC, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid, The Virginia Department of Medical Assistance Services, and their agents, any information needed to determine these benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to Medicare and/or Medicaid for payment. I understand that I/ the patient am responsible for any deductible, co-payment, and any applicable percentage of remaining charges.
7. **VALUABLES:** I understand that VIPSC will not be responsible for any valuables, or other such personal property left unattended in the physician's office and agree to hold VIPSC harmless from any and all liability which may result from the loss of any such personal property.
8. **CERTIFICATION AND ACKNOWLEGEMENT:** I certify that all foregoing information supplied by me, as a part of the registration process is correct. I also acknowledge receipt of the VIPCS Notice of Privacy Practices.

Patient Name Printed: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

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