Name: _____ Home #: _____

Address: _____ Work #: _____

_____ Date of Birth: _____

Treatment Permission:

You consent and understand the following:

- The physician taking care of you, the clinical staff and technical employees may give any treatment or perform any procedures as advised for your care and treatment.
- You have the chance to discuss other plans for treatment.
- In the event that a healthcare worker has come in contact with your blood or body fluid in a way which may transmit HIV, Hepatitis B virus, or Hepatitis C virus, you consent to the testing of blood and/or body fluids for these infections and to report your test results to the healthcare worker who has been exposed.

****If the patient is a minor by the Commonwealth of Virginia, please provide the following information:**
Parent/Legal Guardian's Name: _____
Telephone Number: _____ Are you able to give permission to treat? _____

Privacy and Disclosure:

Our Notice of Privacy Practices (NPP) provides information about how we may use and release your Personal Health (PHI). Our NPP may change according to Federal Regulations. You may request a current copy at any time or review the notice in our waiting room or on our website.

- You have the right to review the NPP before signing this agreement.
- You have the right to ask that we limit how your PHI is used or released.
- By signing this paper, you allow our use and release of PHI for treatment, payment and healthcare operations (e.g. appointment reminders, lab results, mailed materials, etc.).
- You have the right to revoke this agreement in writing **except** in the case where release was already made with prior consent.
- You have the right to ask employees of the medical office or the Privacy Officer questions about the NPP.

I have read, understand and agree to the Treatment and Privacy Policies described above.

_____ _____ _____
Signature (Patient or Guarantor) Relationship to Patient Date