



**AUTHORIZATION FOR TREATMENT**

I hereby authorize treatment by Sentara Medical Group and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren.  
The possibility exists (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

**RELEASE OF INFORMATION**

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payors, HMOs, Workers Compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record.  
I hereby authorize the release of the minor's immunization record to the school nurse or the daycare center at which my child is enrolled. \_\_\_\_\_ (initials)  
I hereby authorize release of the Physician Request for Administration of Medication and give permission for that request to be faxed to the school nurse or daycare center at which my child is enrolled. \_\_\_\_\_ (initials)

**OBLIGATION OF PAYMENT**

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is to be made to Sentara Medical Group. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to Sentara Medical Group for any charges not covered by my insurance, including but not limited to co-payments, deductibles and fees for non-covered services. The patient and the undersigned guarantor are primarily liable for payment of the Patient's account and unless otherwise indicated by my initialing here, Sentara will send all appointment reminders and billing information to the person responsible for payment of my bill. \_\_\_\_\_ (initials) It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans (i.e., Medicare, Blue Cross, Champus) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

**PAST DUE BALANCES AND PROCEDURES FOR COLLECTION**

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service.  
The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that Sentara Medical Group may take action to collect its fees. I agree to pay all costs incurred by Sentara Medical Group for collecting its fees, including an attorney's fee of thirty-five percent (35%) of the unpaid bill. The return check fee is \$38.00.

**ACKNOWLEDGMENTS**

I the Patient/Guardian acknowledge that I was provided with a Sentara Medical Group Patient Rights & Responsibilities form and given an opportunity to ask questions about the information provided in this form.  
**NOTICE OF PRIVACY PRACTICES.** Effective April 14, 2003, I acknowledge that I have received, have previously received, or have been offered but decline to receive the Sentara HealthCare Notice of Privacy Practices. \_\_\_\_\_ (initials)  
In providing my E-mail address, I authorize Sentara HealthCare to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time and my E-mail information will not be shared with any organization outside of Sentara HealthCare and its affiliate companies.

*Thank you for selecting Sentara Medical Group as your Health Care partner.*

Patient Name (Please Print) \_\_\_\_\_ Med. Record No. \_\_\_\_\_  
Patient/Guarantor (Signature) \_\_\_\_\_ Date \_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_