PATIENT CONSENT & PAYMENT AGREEMENT

Femme Care, Inc.
18 Haggerty Lane, Suite 103, Staunton, VA 24401
(540) 414-8585 / (540) 414-8597 (f)

_____
(patient initials)

Payment for Medical Services: Payment is required at the time medical service is rendered. I understand I must pay for my office visit in full when I check in for my appointment.

_____
(patient initials)

Consent for Medical Care: I voluntarily consent to medical care at Femme Care, Inc., which may include examination, tests, and treatments by health care providers and staff. No promises have been made to me as to the results of this treatment or examination.

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(patient initials)

Missed Appointment Fee: I understand that I may be assessed a fee ($50 for established patients) if I miss an office visit without having provided 1 business days' notice of cancellation.

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(patient initials)

Deemed Consent for Designated Blood Borne Pathogens: I understand hepatitis B and C or HIV (AIDS) Virus testing on a sample of my blood may be done if a health care worker is exposed to my blood or body fluids. I understand that the following notice is to advise me that this policy is in effect at this facility: Whenever any health care worker associated with or working for Femme Care, Inc. is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or hepatitis B or C, Femme Care, Inc. will proceed to test the patient through his or her physician and the health care worker(s) who was/were exposed. When a person is tested, Femme Care, Inc. automatically tests for hepatitis B and C for the safety of all concerned.

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(patient initials)

Laboratory Billing: As a courtesy to patients, Femme Care, Inc. includes medical insurance information with lab specimens, to be billed to the patient's insurance carrier by the laboratory.

I understand that it is my responsibility to provide Femme Care, Inc. with appropriate and current insurance information at the time of my appointment. In the event that I fail to provide all necessary and current insurance information, I understand that it is my responsibility to contact the laboratory's billing department to provide new or corrected insurance information.

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(patient initials)

Patient Discharge/Collections Fees: In the event of failure to pay for medical services rendered, I understand that I may be discharged from the services of Femme Care, Inc. until such time as my account is paid. Additionally, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by Femme Care, Inc. I understand that I will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance due ***in addition to*** the collection agency fee. Further, I understand that my Protected Health Information will necessarily be revealed in these efforts to collect payment of monies owed.

_____
(patient initials)

Returned Check Fee: I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or certified check for the full amount of the payment owed, in addition to a $40.00 returned check charge. If a second check is presented and returned from the bank, Femme Care, Inc. will request that all future payments be made with cash, credit or debit cards.

_____
(patient initials)

Transfer of Records: I understand that I will be charged a fee to transfer my records to myself or to another physician: A $10 administration fee plus $.50 per page. This payment is due in full prior to copying and sending the records.

_____
(patient initials)

Notice of Privacy Practices: I acknowledge that I have been given an opportunity to review and request a copy of the privacy practices and my rights as a patient.

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THIS INSURANCE INFORMATION & PAYMENT AGREEMENT. I HEREBY ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE(S). I AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL REVOKED BY ME IN WRITING.

Patient or Parent/Guardian Signature: _____ Date: ____/____/_____

Patient Name (Please print): _____