PATIENT CONSENT & PAYMENT AGREEMENT

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

******PAYMENT IS REQUIRED AT THE TIME MEDICAL SERVICE IS RENDERED******

Deemed Consent for Designated Blood Borne Pathogens & Consent for Medical Care: 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.

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.

_____ (patient initials)

Fees & Payments: As a courtesy to its patients, Femme Care, Inc. (through its affiliate, M.E.D.I.C., Inc.) is pleased to assist in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that the provider that I see at Femme Care, Inc. is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due.

I understand that it is my responsibility to provide Femme Care, Inc. with appropriate and current insurance information – and to notify Femme Care, Inc. (or its affiliate, M.E.D.I.C., Inc.) immediately upon any change in my insurance coverage – to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services rendered to me, and I understand that I may be fully responsible for my entire account balance.

Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by Femme Care, Inc. If my insurance company requires a referral and I do not have one, then I understand that I will be responsible for the entire bill for rendered services, or have the referral delivered to the office before I leave.

I understand that I will be responsible for paying co-payments, deductible, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies).

I understand that if my insurance requires a co-pay, the co-pay is required at the time of service, and that a $10 service charge may be added to any bill sent to collect a co-pay.

_____ (patient initials)

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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)

Missed Appointment Fee: I understand that I may be assessed a fee ($35 for established patients) if I miss an office visit without having provided 1 business day's notice of cancellation.

_____ (patient initials)

Assignment of Benefits: I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Femme Care, Inc. for services rendered. I further consent to the use and disclosure of protected health information as regulated by HIPAA, and authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing these insurance claims. A copy of this authorization may be used in place of the original.

I understand that I am financially responsible for charges not paid by my insurance company.

_____ (patient initials)

Transfer of Records: I understand that I will be charged a fee to transfer my records to another physician: $.50 per page up to 75 pages, and $.25 per page for all pages in excess of 75 pages. Additionally, I may be assessed a $10.00 administration fee. This payment is due in full prior to the copying and forwarding of records.

_____ (patient initials)

I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS INSURANCE INFORMATION & PAYMENT AGREEMENT. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS, OR OTHERWISE OBTAIN PAYMENT, AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE(S) NOT COVERED BY INSURANCE. I FURTHER AUTHORIZE USE OF MY SIGNATURE BELOW ON ALL INSURANCE SUBMISSIONS FOR SERVICES RENDERED. 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: ____/____/_____