

PATIENT TREATMENT POLICY/ HIV CONSENT

PATIENT TREATMENT POLICY:

® I, _____, by becoming a patient of Family Medicine of Malta, request treatment from Dr. Marc D. Price, D.O. and his agents.

® I understand that it is my responsibility to make sure services provided are covered benefits under my particular insurance policy. I shall be responsible for payment in the form of co-payment, co-insurance, deductible, and for any uncovered charges related to the services provided.

® I further understand that if I do not present valid and sufficient information of my health insurance coverage, or if Dr. Price, D.O. and his agents do not participate with my insurance carrier, or if I have no insurance coverage, that I will be responsible for all incurred charges in full.

Signature: _____ Date: _____

Print Name: _____

Authorized Witness: _____

INFORMED CONSENT TO PERFORM AIDS/HIV TESTING:

Check here that you have read the AIDS/HIV Policy before signing below.

® New York State Public Health Law requires that an offer of HIV related testing be made to all persons between the ages of **13 and 64** receiving hospital or primary care services except under specific circumstances. This includes inpatients, persons seeking services in emergency departments, those receiving primary care on an outpatient basis at a clinic, or from a physician, physician assistant, nurse practitioner, or midwife.

® HIV is the virus that causes AIDS and is passed from one person to another during unprotected sex (oral, anal, or vaginal sex without a condom) with someone who has HIV. HIV is also passed through contact with blood as I sharing needles (piercing, tattooing, or injecting drugs of any kind) or sharing "works" with a person who has HIV.

® If your test is negative, you can learn how to protect yourself from being infected in the future. If you are positive, you can take steps to prevent passing the virus to others, and you can receive treatment for HIV and learn about other ways to stay healthy.

® I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care Provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

YES, I would like to speak to someone about HIV testing.

NO, I do not wish to have HIV testing performed at this time.

Patient Name: _____ Date: _____

Signature: _____

(Patient or person authorized to consent)