RIVERSIDE MEDICAL GROUP AND OUTPATIENT
CONSENT and FINANCIAL RESPONSIBILITY

As a patient of Riverside Medical Group practice or Riverside outpatient facility, I agree to the following:

1. **RELEASE OF PRESCRIPTION HISTORY**: I understand that Riverside has the right to ask for any data regarding my medication history. I also understand that Riverside may get any data regarding my medication history. This includes data that may be held by the Virginia Prescription Monitoring Program and other sources.

2. **HIV TESTING DISCLOSURE**: Under Virginia law, I may be tested for HIV, Hepatitis B or C viruses without my written or oral permission. I will be tested only if contact occurs during medical treatment. The results of these tests will be given, without my permission, to the person that came in contact with my body fluids.

3. **ASSIGNMENT OF BENEFITS:** I assign to Riverside any money which I may receive from any insurance, workers compensation or disability benefits related to my medical treatment. I authorize any attorney paying out such money to pay Riverside directly for what I owe on any Riverside bill.

4. **PAYMENTS DUE AT TIME OF SERVICE**: Riverside will bill most insurance companies for patients, even though they do not have to do so. If my insurance company does not pay all or part of my bill, I will pay. Full payment is due at time of service. I may make other arrangements if I cannot pay at time of service. I will be charged $30 for any returned checks. I give permission to Riverside to apply any overpayment from another Riverside account to any other bill that I may owe.

5. **INSURANCE REFERRALS & PREAUTHORIZATIONS**: I understand that it is my duty to fully follow all my preauthorization steps. If I elect to be treated without a referral from an approved doctor, it is my sole responsibility to pay my bill. I understand that my insurance may not pay anything if I am treated without a referral.

6. **MULTIPLE BILLS**: I understand that while I am treated at a Riverside practice or outpatient facility, I may receive a separate bill from Riverside and a separate bill from other health care providers. For example, I may receive a separate bill from a laboratory, radiologist, pathologist, or other providers. I agree to pay any bills received that are not paid by my insurance company.

7. **PATIENT/FAMILY BEHAVIOR**: While in a Riverside office or facility, I will be polite to the Staff. I will be polite to all medical providers. I will be polite to other patients.

8. **RIVERSIDE IS NOT RESPONSIBLE FOR LOSS OF PERSONAL BELONGINGS**: Riverside is not responsible for any loss, theft or damage to my personal belongings.

9. **PATIENT E-MAIL**: By providing my e-mail address to Riverside, I permit them to use my e-mail address to send me messages on health related issues. I also permit them to use my e-mail address to send me messages on health services. In addition, I give permission to Riverside to e-mail me regarding clinical studies that match my medical situation. I understand I can choose not to receive such messages from Riverside by contacting them.

10. **NO SHOW FEES:** I understand the importance of keeping my scheduled visits. A 24 hour advance notice is necessary for appointment changes. A 24 hour advance notice is necessary for cancellations. Patients must pay $50.00 for a missed appointment. Patients must pay $100.00 for a missed physical, procedure, or surgery. Medicaid patients will be handled according to CMS guidelines. If I keep missing my scheduled visits I may be discharged from the practice.

11. **PHOTO RELEASES:** At registration, your picture may be taken and scanned into your medical records. We may also request a photo I.D. This is to protect your safety and prevent identity theft.

NOTICE OF PRIVACY PRACTICES:

I am aware of Riverside's Notice of Privacy Practices. I have been offered a copy of Riverside's Notice of Privacy Practices. If I am asked for by name while being treated at Riverside, I agree that Riverside may confirm my location at the facility, and my general medical status

I AGREE TO THE TERMS OF THIS AGREEMENT.

_____ _____ _____

Print Patient's Name | Date of Birth | Date & Time

_____ _____

Patient or Responsible Person Signature | Relationship to Patient

FOR RIVERSIDE MEDICAL GROUP PATIENTS ONLY:

I give permission to my physician & office personnel to verbally discuss my medical condition(s) with the following person(s) below.
Please check below whether this release applies to all of your physicians or just the ones listed below.

❑ This release applies to all my Riverside physician offices
❑ This release only applies to the Riverside physician offices listed below:

_____

_____

_____

List Name of person(s) who you give permission to discuss your medical condition:

_____ _____

Print Individual Name & Phone Number | Relationship to Patient

_____ _____

Print Individual Name & Phone Number | Relationship to Patient

_____ _____

Patient Signature | Date

FOR OFFICE USE ONLY:

❒ Patient Unavailable for Signature If Patient unable to sign, Give Reason _____

❒ Patient does not want to receive a copy of this document. ❒ Patient requested and was given a copy of this document.

❒ No Responsible Person Available Staff Member Initials:_____ Date:_____