Glenside Medical Associates, P.C. 4000 A Glenside Drive Richmond, VA 23228
Phone (804) 262-4763 Fax (804) 264-9683

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Glenside Medical Associates, P.C. to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ _____
Patient/Guardian Date

PERSONAL HEALTH CARE INFORMATION CONSENT/BENEFIT ASSIGNMENT RELEASE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide standards for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.
As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.
We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you, such as laboratories that only interact with physicians and not patients, and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.
You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.
If you have and objections to this form please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.
I, hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, including Medicare and Medicaid, private insurance and third party payors to Glenside Medial Associates, P.C. A Photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Guardian Date

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customary fee schedule,* you will be responsible for the difference remaining.
If any payment is made directly to you for services billed by us, your recognized obligation is to promptly send the same to Glenside Medical Associates, P.C.
The above does not apply for those patients that are considered Worker's Compensation. However, be advised, if you claim worker's compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs associated with collecting monies owed, including court costs, **ATTORNEY FEES OF 25% OF THE OUTSTANDING BALANCE**, **FINANCE CHARGES** of 1.5% per month on balances over thirty days past due, which is an **ANNUAL PERCENTAGE RATE** of 18%. A photo copy of this contract shall be considered as valid as the original.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Center Representative Date