SENTARA
eCare Health Network

Patient Label

Consent for Treatment & Financial Agreement SMJH & SMJMG

FIN

CONSENT FOR TREATMENT: Martha Jefferson Hospital; d/b/a Sentara Martha Jefferson Hospital or Martha Jefferson Medical Group, LLC. ("Sentara" or "Hospital") accepts the above Patient for diagnostic testing, emergency or inpatient/outpatient treatment/surgery or telehealth services. The undersigned hereby consent(s) to Sentara providing its standard services and supplying or administering all services, supplies, medications and anesthesia ordered by Patient's or Sentara's physicians/assistants, and to the performance of all procedures they deem advisable, and to the disposal of removed tissues and the use of photography for clinical purposes.

FINANCIAL AGREEMENT: The undersigned agree(s) to pay all charges made by the Hospital based upon Sentara's current charge master and the charges of Martha Jefferson Medical Group, LLC. or medical providers at their current rate for services rendered and for supplies used in providing care and treatment to the patient. The undersigned understand(s) that any prepayment is for estimated charges only and agree(s) that the final bill may be different. Sentara is not in the business of extending credit. All charges shall be paid when due (within 30 days of initial billing.) The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If all charges are not paid when due, the undersigned agree(s) to pay 33 1/3% attorney's fees, or collection agency fees, which shall be deemed incurred upon referral for collection, plus costs, and interest at the current rate applicable by Statute to Virginia Judgments. The return check fee is $25.00 and financial aid may be available to eligible individuals by calling the business office.

The Patient and the undersigned responsible parties are primarily liable for payment of Patient's account. Each of them authorizes and consents to Sentara and its agents use of any telephone number (including Cell Phone), email address or text number they provide or publish, to message or contact them regarding their accounts or health related information. It is acknowledge that the patient may opt out of such communication at any time. It is the patient/responsible party's sole responsibility to provide any proof of insurance within 3 days of each date of service and to comply in a timely manner with all requirements, and supply all information and documents necessary to obtain payment of benefits by any HMO or insurer, TRICARE, Medicare, Medicaid, Workers' Compensation carrier, governmental agency or other third-party source of benefits/payments. Sentara is not required to submit claims to such payees unless the patient supplies adequate insurance information for each account within timely filing guidelines. The undersigned understand(s) that the hospital fees, professional fees, for Emergency Physicians, Radiologists, Pathologists, and other physicians' services are billed separately. Should there be cumulative payments to Sentara in excess of the charges incurred for Patient's admission or treatment, it is agreed that the excess may be applied by Sentara to any of the Patient's outstanding accounts resulting from other Sentara admissions and/or treatments. The undersigned agrees to pay for laboratory testing ordered for them by their physician, but performed in a Sentara reference laboratory.

ASSIGNMENT OF BENEFITS from claims made by or on behalf of patients for any insurance coverage, workers' compensation, governmental agency or disability benefits, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is made to Sentara and medical providers without offset. It is agreed that such ASSIGNMENTS SHALL NOT BE REVOKED. Hospital and medical providers are given a lien in like amount and are authorized to receive direct payment of all assigned benefits/proceeds. Any attorney, insurance carrier, responsible employer or agency handling or disbursing such benefits or proceeds is ordered, authorized and directed to withhold and promptly pay over to Hospital and medical providers the lesser of the full amount of their charges or the total net proceeds or benefits available without offset.

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immuno-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Personal Valuables: Sentara shall not be liable for loss of, or damage to, property not deposited with it for safekeeping.
(_____initials_____date)

Communication Assistance: I and/or my companion(s) have been offered Communication Assistance on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

Notice of Privacy Practices: I have been offered a copy of Sentara's Notice of Privacy Practices on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

Your Patient Rights and Responsibilities/Notice of Nondiscrimination: I have been offered a copy of Sentara's Your Patient Rights and Responsibilities/Notice of Nondiscrimination on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

EACH UNDERSIGNED REPRESENTS THAT HE/SHE HAS READ AND FULLY UNDERSTAND THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT, AND THAT SENTARA HAS MADE NO REPRESENTATION NOT HEREIN SET FORTH. CARBON COPIES AND PHOTOCOPIES HEREOF ARE DUPLICATE ORIGINALS FOR ALL PURPOSES.

_____	_____	_____	_____
Date/Time	Patient Signature	Other responsible party signature	Relationship

☐ No Responsible Person Available (If checked, two witness signatures required.)
☐ Patient unable to sign but has acknowledged an understanding of the above and consents to the undersigned witness printing his/her name.
☐ Verbal consent to treat obtained from responsible party _____.

_____	_____	_____	_____
Employee Witness Signature	Date / Time	Employee Witness Signature	Date / Time