Sentara®

Patient Label

Consent for Treatment/Financial Agreement

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CONSENT FOR TREATMENT: Sentara Health (to include its direct and indirect subsidiaries named below*) ("Sentara") accepts the named Patient for diagnostic testing, emergency or inpatient treatment or outpatient surgery/treatment. The undersigned hereby consent(s) to Sentara providing its standard services, telehealth services and supplying or administering all services, diagnosing, treating, addressing care needs, supplies, medications (which may be dispensed from an alternate site pharmacy) and anesthesia ordered by Patient's or Hospital's physicians or their assistants, and to the performance of all procedures they deem advisable, and to the disposal of removed tissues. I consent to the recording, photography, closed circuit monitoring or filming for the purposes of treatment (will be in the medical record) or quality of care and teaching.

FINANCIAL AGREEMENT: The undersigned agree(s) to pay all charges made by (i) Sentara based upon Sentara's applicable current charge master and (ii) the other medical providers at their current rate for services rendered and (iii) 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 undersigned consents to Sentara's furnishing and accessing credit information with consumer reporting agencies. The return check fee is $25.00. Financial Aid is 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. It is their sole responsibility 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 may submit claims to such payees as a courtesy only. It is NOT, unless by regulation or contract with the insurer or government agency, obligated to do so. The undersigned understand(s) that hospital fees, and professional fees for Emergency Physicians, Radiologists, Pathologists, and other physicians' services are billed separately. Sentara Health* reserves the right to charge the undersigned $40 for missed appointments and such charge will not be covered by insurance or a FSA/HSA. Should there be cumulative payments to Sentara in excess of the charges incurred for Patient's admission or treatment, it is understood and 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 Sentara for laboratory testing ordered for them by their physician but performed in a Sentara reference laboratory.

COMMUNICATIONS: The Patient and the undersigned responsible parties each authorize Sentara (including its representatives and agents) to contact them by phone using artificial voice, pre-recorded messages and/or automated dialing systems at any phone number associated with them or their personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise of products or services that may be of interest. Further calls or messages can be declined by following the reasonable instructions specifically provided by Sentara. There is no requirement to agree to receive such phone calls and messages in order to receive treatment or other Sentara services. By providing any email address and/or cell phone number, each authorizes Sentara (including its representatives and agents) to send them information, reminders, and messages using those means of communication. Understanding that email and text message are not completely secure means of communication (due to the potential for these messages to be addressed to the wrong person or accessed improperly while in storage or during communication) but that they allow Sentara to communicate more efficiently and provide better service, each further authorizes Sentara to send unencrypted messages using these means. Carrier rates may apply.

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. Sentara 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 Sentara 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 damage or loss of property not deposited with it. 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)

DRUG AND DEVICE DISCOUNTS: In some cases, Sentara may be able to obtain reimbursement for some of your medications and/or medical devices from the manufacturer. In the event this occurs, the charge for the medication or medical device is adjusted on your bill for that hospital stay. Your signature on this form gives Sentara permission to sign your name on the application, if needed, and view and release any personal, medical, and/or financial information required by the Patient Assistance Programs to apply for a free or discounted drug or device This information will remain confidential within Sentara and will only be given to the drug and device manufacturing companies sponsoring the program.

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ENTIRE AGREEMENT CLAUSE: EACH UNDERSIGNED REPRESENTS THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT, AND THAT SENTARA HAS MADE NO REPRESENTATION NOT HEREIN SET FORTH. ANY CHANGES TO THIS TYPED AGREEMENT MUST BE MADE THROUGH A SEPARATE WRITING SIGNED BY ALL PARTIES. 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 their name.
☐ Verbal consent to treat obtained from responsible party_____.

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

*Sentara Health includes: Sentara Medical Group; Martha Jefferson Medical Group, LLC; Albemarle Physician Services - Sentara, Inc.; RMH Medical Group, LLC; Dominion Health Medical Associates, Ltd.; Sentara Hospitals (including Sentara Williamsburg Regional Medical Center, Sentara Careplex Hospital, Sentara Leigh Hospital, Sentara Norfolk General Hospital, Sentara Obici Hospital, Sentara Virginia Beach General Hospital); Sentara Princess Anne Hospital; Martha Jefferson Hospital; Sentara RMH Medical Center; Potomac Hospital Corporation of Prince William; Sentara Albemarle Regional Medical Center; and Halifax Regional Hospital, Inc; Hospital for Extended Recovery; Sentara Enterprises; Sentara Advanced Imaging Solutions, LLC; Sentara Life Care Corporation; Sentara Reference Lab Solutions, LLC; Sentara Therapy Solutions, LLC.; SMG Anesthesia Specialists, LLC; SARMC Anesthesia Specialists, LLC; Proprium, LLC; and Velocity Urgent Care, LLC.