FAIRFAX FAMILY PRACTICE CENTERS

Consent for Treatment and Acknowledgement

1. **Treatment:** I consent to medical treatment by Fairfax Family Practice Centers and/or its affiliated entities, including without limitation any physician, other licensed provider, or clinical staff assigned to my care. This treatment may include exams, medication, laboratory or radiology tests, or any other services deemed necessary for my care and safety. Laboratory tests may include testing for human immunodeficiency virus (HIV), and I understand that I have the right to decline HIV testing. I also consent to release my prescription history to my FFPC provider from any pharmacy or drug monitoring agency.

   I further acknowledge:
   - No guarantee has been made about the results of the care I receive from FFPC.
   - Photographs and recordings may be taken of me during my care for purposes of identification, diagnosis, and treatment. As permitted by law, I further understand that recordings or photographs may be created and used for educational, quality improvement, research, and patient care or teaching purposes. This includes the digital recording of certain critical patient procedures and care for internal quality improvement purposes. To the extent required by law, FFPC will obtain my written consent for the use or release of photographs and recordings for any other purpose.
   - Fellows, residents, interns, medical students, and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of FFPC's education programs.
   - Virginia Code Section 32.1-45.1 provides that when either a person providing health care, or a patient, is directly exposed to the bodily fluids of the other in a way that may transmit HIV 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.

Authorization for Claims, Payments, and Reviews

2. **Assignment of Benefits:** I agree to provide information about all health insurance benefits to which I may be entitled, including without limitation group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits [Insurance Plan(s)]. I hereby assign payment(s), if any, from my Insurance Plan(s) to FFPC and each of the independent contractor physicians and/or professional corporations for the services they provide me. The direct payment assigned includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits payable to me under the terms of my policy, but is not to exceed the balance for the services provided to me.
3. **For Medicare Recipients Only:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to FFPC and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agent any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or the party who accepts assignment.
4. **Unauthorized, Non-Covered, or Out of Plan Services:** I understand and acknowledge:
   - If my Insurance Plan(s) does not consider any services rendered covered services, or has not authorized these services, they will not pay, and I agree to pay for these services.
   - One or more of my providers may not accept insurance or may be out of network with my health insurance.
   - In the case of an out-of-plan network provider or services, there may be reduced benefits, and I may be required to pay a higher co-pay, deductible, or co-insurance amount.
5. **Providers Who Are Not Employees or Agents:** I understand some of the providers furnishing services to me, including, but not limited to, independent contractors are not employees or agent of FFPC. I understand one or

more of these providers may not accept insurance or may be out of network with my insurance. I understand I may receive separate bills for such independent provider services.

6. **Financial Responsibility:** I agree to pay all charges for which I may be legally and/or contractually responsible, including without limitation self-payments, health insurance deductibles, co-payments, and non-covered services in the event my insurance does not pay, or I am uninsured. I also agree that if my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by FFPC.
7. **No Responsibility for Personal Property:** I understand and agree that FFPC is not responsible for any theft, loss, or damage to my personal property or items. I understand and agree that if any of my money or personal belongings are left behind at an FFPC facility and are not claimed within sixty (60) days, FFPC may, at its sole discretion, dispose of or destroy such items. I further acknowledge that any interest or right I may have had in those items will be considered forfeited after that time.
8. **Authorization to Receive Messages and Automated Communications:** I understand and agree that FFPC, its affiliates, agents, contractors, or designees (including but not limited to debt collectors) may contact me regarding services, payment for services, scheduling appointments and healthcare operations activities through various methods, including without limitation the use of manual representative outbound calls and voice messages, text messages, and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to FFPC. I understand that my calls may be monitored or recorded for any purpose. If I provide FFPC with an email address, I agree to receive email messages from FFPC. These emails may contain my health information and may not be encrypted. Unencrypted emails may create potential privacy and security risks. I understand that I am not required to accept messages in these formats as a condition of receiving services at FFPC. I also understand that I have the option to "opt out" of receiving such communications, which I may exercise at any time by notifying FFPC in writing. I understand that opt out processes may take a reasonable amount of time to go into effect. Unless I have opted out, communications may continue after the expiration of this form.

Tobacco Use/Tobacco Free Environment

9. **Tobacco Free Environment:** I understand and acknowledge that FFPC and their properties are tobacco-free. This means that tobacco products (cigarettes, cigars, pipe, chew, and/or vapes) are not allowed to be used in any FFPC location or property, including without limitation at the entrances, in the parking lots or garages, or inside the property.

Balance Billing Protection for Out-of-Network Services

10. Balance Billing: When treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balanced billing.
    _____ **My initials confirm that I have received additional information about balanced billing.**

Notice of Privacy Practices

11. **Notice of Privacy Practices:** FFPC's Notice of Privacy Practices (NPP) describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of FFPC's health care operations. The NPP also describes my rights and FFPC's duties with respect to my protected health information. I understand that copies of the NPP are available in the registration areas of each facility and on FFPC's website at www.fairfaxfamilypracticecenters.com. I may request that a copy be mailed to me by calling 703-255-9100. FFPC reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing FFPC's website listed above to view the most current version.

_____ **My initials confirm that I have received or have been offered a copy of FFPC's Notice of Privacy Practices, and that I have a right to receive an additional copy upon request.**

Authorization to Release Substance Use and HIV/AIDS information for Payment Purposes

12. Release: If applicable, I authorize FFPC to release my substance use treatment and/or HIV/AIDS-related information to my Insurance Plan(s), Medicare, Medicaid, or Tricare, authorized private review entities, and/or utilization review entities acting on their behalf, the billing agents and collection agents or attorneys of FFPC and/or independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and, as applicable, the Social Security Administration, the Centers for Medicare & Medicaid Services, the Peer Review Organization acting on the behalf of the federal government, and/or other federal or state agency or person or entity for the purpose of satisfying payment for the services provide. This authorization will remain in effect unless I provide FFPC with a written notice of revocation. I understand that I may revoke this authorization at any time by providing written notification to FFPC, except that such revocation will not apply to the extent that disclosure has already taken place.

Patient Rights and Responsibilities

13. The following list of rights and responsibilities does not presume to be all-inclusive but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.
    As a patient, you have the right to…
    - Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment or discrimination.
    - Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
    - Receive visitors designated by the patient, including the right to withdraw or deny such consent at any time.
    - Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent, and understanding consent.
    - Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes), and discuss this information with your provider. You have the right to designate someone to receive this information on your behalf.
    - Have a designated representative present for any updates provided regarding your routine course of care. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person on your behalf. We will communicate to your designated representative any significant changes in your status, such as transfer to a higher level of care or need for unplanned emergency procedures as soon as clinical care allows.
    - Have an advance directive (such as health care proxy, organ donation, or living will) and the expectation that FFPC will honor the intent of the directive to the extent permitted by law and clinic policy.
    - Confidentiality of your treatment records, unless you have given permission to release information or if reporting is permitted or required by law.
    - Leave the clinic even against your provider's advice.
    - Know the name of the physician, or other practitioner who has primary responsibility for coordinating your care, treatment, or services.
    - Be told of alternatives when facility care is no longer appropriate.
    - Be informed by your provider of the continuing healthcare requirements following your visit to the clinic.
    - Access to interpreter services free of charge.

- The privacy of your medical information. Disclosures regarding you, your rights, and our obligations regarding the use and disclosure of your medical information are made in accordance with our Notice of Privacy Practices.
- Have a designated support person if you have a diagnosed disability and need ongoing support and assistance for that disability.
- If you have a complaint or wish to file a grievance, call our Compliance office at 703-255-9100. If you believe that FFPC has failed to provide these services or discriminated on the basis of race, color, national origin, age, religion, culture, sex, gender identity or expression, sexual orientation, marital status, disability, military status, pregnancy or childbirth, or related medical conditions, you can file a grievance in person or by mail, fax, email. If you need help filing a grievance, the Compliance Officer is available to help you.

  If you have a complaint or wish to file a grievance, you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800-955-1819.

As a patient, you are responsible for:

- Providing complete and accurate information about your health, including past illnesses, facility stays, use of medications, and other matters relating to your health.
- Asking questions when you do not understand what you have been told about your care or what you are expected to do.
- Following the care, service, or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record, or film any person or practice on FFPC property without prior permission from FFPC. This applies to your visitors as well.
- Telling your provider if you believe you cannot follow through with your treatment plan and understanding the possible results, if you decide not to follow the recommended treatment plan.
- Providing the office with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage, including deductibles, co-pays, and network coverage, including any patient financial responsibilities.
- Recognizing that the office cannot accept responsibility for any personal property.
- Being respectful of staff, patients, and office property, and following facility rules and regulations. This applies to your visitors as well.

By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions and my questions have been answered to my satisfaction. I accept the above conditions and terms. I understand and agree this document will remain in effect for my present visit and any future visits to FFPC, unless specifically cancelled in writing by me.

Patient/Designated Decision Maker (DDM) Signature: _____ Date: _____

If DDM, printed name: _____ Relationship: _____