Patient Name:_____ **Date of Birth:**_____ **ID#**_____

VIRGINIA DEPARTMENT OF HEALTH

Patient Application and Consent for Health Care

PATIENT CONSENT FOR GENERAL PRIMARY CARE

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Virginia Department of Health (VDH) to examine and/or treat me and/or my dependent, as named above.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

HIV TESTING

If HIV testing is performed, you will be told ahead of time, be given information about the test, and allowed to decline testing. All results will remain confidential except as allowed by law.

PAYMENT FOR SERVICES

Some services are free, but we charge for many of them. You will be responsible for paying for those services. We have a sliding fee scale, based on your family income and family size, that may lower the charges. You will be liable for any charges not paid by third party payers according to this sliding scale. The percentage you pay will remain the same until your income or family size changes. Some services are charged on a flat fee basis, regardless of income or family size (everyone pays the same price). It is possible that our charges may change. We will try to discuss those changes with you. Your information is being entered into a statewide database that can be accessed from any local health department in the state. Based on the information you have provided, you are responsible for paying _____ % of the charges. If there is a charge for services and you do not pay at the time of visit, we will establish a payment plan for the amount due.

I give my permission for me and/or my dependent (as named above) to be interviewed about family income and family size. I understand that I am responsible for paying the bill.

OUTSIDE LAB SERVICES - NOT APPLICABLE FOR ALEXANDRIA TEEN WELLNESS CENTER

If my health care provider orders lab tests, I understand that I may receive a separate bill from an outside lab. If I am insured, my insurance company will determine the amount that I may owe to the lab provider, and I will be responsible for any payment. I understand that the sliding fee scale that may apply to other services provided directly by VDH will not apply to the lab bill from an outside lab provider. Sometimes the lab may have to perform additional testing on a specimen. This will result in extra charges that may be added to my account, and I may receive a bill from VDH. _____

Patient's Initials

Patient Name:_____ Date of Birth:_____ ID#_____

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.

CONSENT TO RECEIVE ELECTRONIC APPOINTMENT REMINDERS

VDH does not charge for this service, but standard text messaging rates may apply based on your wireless plan. I understand that this consent will apply to all future appointments unless I request a change in writing.

☐ **I do not consent** to receive text messages to remind me of an appointment.

☐ **I do not consent** to receive email messages to remind me of an appointment.

☐ **I consent** to receive text messages on my cellphone to remind me of an appointment, and I also agree to inform the health department if my cellphone number changes.

My cellphone number is _____

☐ **I consent** to receive email messages at my email address to remind me of an appointment, and I also agree to inform the health department if my email address changes.

My email address is_____

RECORD KEEPING

I understand that medical records will be retained for ten years after the date of the last visit, then destroyed in a manner that assures confidentiality throughout the process and in its results. In the case of a minor, the record will be retained for twenty-eight years after birth, then destroyed in a manner that assures confidentiality throughout the process and in its results. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, insurance or other health care benefits. I request the third party payer to pay any authorized benefits to VDH or its contractors on my behalf.

I understand that this consent will remain in effect as long as my dependent or I receive care from VDH or until I withdraw it.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information, or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date Signed**

_____ _____

Relationship (if signature is not of Patient) **Signature of Person Obtaining Consent**