PRIVIA
MEDICAL GROUP

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: ______________________________ **Email:** _________________________

➔ Signature: ____ **Date:** _______________

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: _______________________________________

****Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.***

PRIVIA MEDICAL GROUP

Financial Policy

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out.

You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility.

Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $70.00 fee for a missed appointment or a $300 fee for a missed procedure appointment. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least fourty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!

imc
Internal Medicine Consultants

172 Linden Drive,
Winchester, Virginia 22601

Main: 540.722.8172
Fax: 540.723.8772
www.internalmedconsultants.com

Confidential Patient Information and Agreement

PLEASE PRINT CLEARLY

Patient Name: ____

Address: ____

City:__________________________State:________Zip:____________

Home Phone: ( ) _______________Work Phone: ( ) ______________

Cell Phone: ( ) _________________ Email: _____________________

Date of Birth: ____/____/____ Gender Identity: ______________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaska Native White Other Race

Black or African American Native Hawaiian or Pacific Islander

Occupation: ____

Pharmacy (Local): ____

Pharmacy (Mail): ____

Emergency Contact: _________________________Ph: ( ) __________

Emergency Contact Relation: __________________________________

Responsible Person Name: ____________________Ph: ( ) __________

Primary Insurance: ____

Secondary Insurance: _______________________________________

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Patient and Responsible Party Authorization

I authorize Internal Medicine Consultants on behalf of ___________________________ (your insurance company) to apply for benefits on my behalf for their covered services rendered and request payments from the above named insurance company be paid directly to INTERNAL MEDICINE CONSULTANTS for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN, AND/OR PARENTS RESPONSIBILITY. Patient or responsible party further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest agreed to or that may be adjudicated for the collection of past due debt on accounts for ____ (your name). A missed appointment, not canceled with 24 hours notice, will be billed for the time allowed and is not covered by insurance. If Medicare and/or my commercial insurance should deny any or all charges then I agree to be personally and fully responsible for any and all balances due.

Print Name:____

Date:_____________________________

Signature: ____

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Acknowledgement of 2024 Updated IMC Policies & Regulations

1. You may be asked to schedule an appointment for prescription refills. We will occasionally refill certain prescriptions over the phone, but that will be left up to the discretion of the provider and based on patient follow up compliance. Prescription refill requests for non-emergent issues may take up to 72 hr to process.
2. **Narcotics**: This practice does not treat conditions involving chronic pain and the use of narcotics. This office takes pain very seriously and therefore this office is not comfortable treating ongoing pain management. Ethically, we believe individuals suffering from chronic pain should be treated by physician specialists. We would be delighted to provide you with a list of those specialists who can meet your needs.
3. **Co pays and balances are collected** at check in.
4. You may be asked to **reschedule** your appointment if you are **late** for your scheduled appointment.
5. **Canceling appointments and No-Shows:** Any patient wishing to cancel or reschedule an appointment must **call 24 hours prior** to the appointment; otherwise they will be charged a non-negotiable **fee** of **$70.00**. This fee will be due before the next patient visit. A **$100.00** fee will be charged if the appointment is for a well exam, physical exam, pap smear, or pre-op exam.
6. All **questions** regarding a **lab order will be addressed by Privia Lab.** Please contact the lab at **540-546-2620**. If you do not use Privia Lab, please get your lab order at the time of your appointment.
7. **You consent to receive test results** on your **patient portal**. You can access this portal by giving the receptionist your email and they will give you a temporary password which you can later change under the security settings. You can also visit www.priviamedicalgroup.com and sign up on your own. There will be a note left by the doctor or nurse with any important information needed.
    a. Be aware that Internal Medicine Consultants Primary Care is not responsible for any test, procedure, or radiology ordered by physicians/providers outside of the primary care practice. Please follow up with the ordering physician/provider to receive your results.
    b. It is your responsibility to check lab results over the patient portal and to follow up with your provider.
    c. If you need urgent medical help, or need a response within 72 hr, do *not* leave a portal message - instead, please call the office.

Please sign and date, showing that you understand our Policy & Regulations.

Print Name: ______________________ Date: ___________________

Signature: ____

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HIPAA Statement

The ***Notice of Privacy Practices*** document has been made available and explained to me and my questions about the document have been answered.

I hereby authorize Internal Medicine Consultants (IMC) to furnish my insurance company or other authorized agency my protected health information (PHI) for the purpose of treatment, payment, or healthcare.

I also authorize Internal Medicine Consultants to discuss my medical condition and treatments with the following people:

Name Relationship

1. ______________________________ ___________________________

2. ______________________________ ___________________________

3. ______________________________ ___________________________

4. ______________________________ ___________________________

I authorize Internal Medicine Consultants to be able to leave detailed messages regarding:

- ☐ Test results
- ☐ Medical Information
- ☐ Diagnosis

on my voice mail / email given below. If you DO NOT give permission for this, DO NOT fill out the information:

____________________ ___________________________ Phone Number Email

Patient Authorization (Print Name & Sign Below):

Print Name: ____

Signature: ____________________________________**Date:** __________________

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Health Questionnaire

Patient Name:____

Date: ____________________

Allergies to medications, X-Ray Dyes, or Other Substances: ___ No ___ Yes

If yes, please list allergies: __________ __________ __________

__________ __________ __________

Current Medications:

	Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

Past Medical History – Family History:

	No/Yes	**Who** (Mom, Dad, Siblings, Children)
Bleeding Disorder	______	______________________
Cancer (please list type)	______	______________________
Diabetes	______	______________________
Heart Attack	______	______________________
Heart Disease	______	______________________
Hypertension	______	______________________
Kidney Disease	______	______________________
Mental Illness	______	______________________
Stroke	______	______________________
Thyroid Disease	______	______________________

Please list any others ______________________________

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Gynecological and Obstetric History:

Age at onset of periods ________
Frequency ________
Length of period ________
Date of last period ________
# of Pregnancies ________
Births ________
Miscarriages ________

	NO/YES	Please Describe
Prolonged or abnormal bleeding	______	______________________________
Leakage of urine	______	______________________________
Pelvic Pain	______	______________________________
History of abnormal PAP smear	______	______________________________

Prevention:

NO/YES

Do you wear seatbelts? _______ If no, why not? ______________________

Do you or have you ever smoked? _______ # of packs per day _______

# of years________

date quit_________

Do you drink alcoholic beverages? _______ If yes, how much per week? ____________

Do you drink coffee? _______ If yes, how much per week? ___________ regular/decaf

tea? ______ If yes, how much per week? ____________ regular/decaf

soda? ________ If yes, how much per week? ___________ regular/decaf

NO/YES

Do you use drugs? (Marijuana, Cocaine, etc.) _______ If yes, please explain:

____

____

Do you wish to be tested for HIV? _______ If yes, please explain:

____

____

Have you ever worked with chemicals, paints, ______ If yes, please explain:
asbestos, or other hazardous materials?

____

____

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NO/YES

Do you use sunscreen? ________

Do you have a donor card? ________

Method of birth control (by you or your partner):

____

Please list and supply the names and dates of:

Operations: ______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

Hospitalizations other than surgery :

______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

______________________________ ________

Immunization History – have you had:

	NO/YES	When?		NO/YES	When?
Hepatitis B Vaccine?			Pneumonia Shot?		
Tetanus Shot?			Flu Shot?		
COVID-19?			Other?		

When was your last:

Full Physical? ______________ Pap Smear? ______________ Breast Exam? ______

Stool check for blood? ______________ Colonoscopy? ______________ Mammogram? ______

Cholesterol Check? ______________ Prostate exam? ______________

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Please CIRCLE if *YOU* are complaining of any of the following symptoms TODAY:

Constitutional	Respiratory	Genito-urinary	Psychological
Chills	Asthma	Blood in urine	Agitation
Fatigue	Bronchitis	Difficulty urinating	Alcohol abuse
Fever	Cough (persistent)	Vaginal or penile discharge	Anxiety
Loss of height	Expectoration	Frequent urination	Depression
Sweats	Pneumonia	Painful urination	Drug abuse
Weight gain/weight loss	Shortness of breath	Sexual difficulty	Insomnia
Eyes	Snoring	Urinating at night	Relationship problems
Change in vision	Tuberculosis	Urinary incontinence	
Wear contacts/glasses	Wheezing	Urinary infections	
Eye disease		Urinary urgency	
Eye injury		Venereal disease/STD	
Ear/Nose/Throat	**Gastrointestinal**	**Musculoskeletal**	**Hematologic/Lymphatic**
Deafness	Abdominal pain/discomfort	Arthritis	Anemia
Difficulty swallowing	Anorexia	Back pain	Blood/platelet disorder
Dizziness	Blood in stool	Deformities	Cancer
Ear ache	Change in appetite	Gout	Leukemia
Hay fever	Colitis	Head pain	Lymphoma
Headache	Constipation	Joint pain/swelling	Swollen lymph nodes
Nasal drainage	Diarrhea	Muscle pain	
Post nasal drip	Gallbladder disease	Neck stiffness/pain	
Ringing in ears	Heartburn/indigestion	Radiating leg pain	
Sinus problems	Hemorrhoids		
Sore throat	Hepatitis/jaundice		
Cardiovascular	Kidney disease	**Neurological**	**Allergic/Immunologic**
Chest pain/tightness	Kidney stones	Confusion	Auto-immune disease
Edema (hands, ankles, etc)	Nausea	Lightheadedness	Immune deficiency
Fainting	Painful bowel movements	Memory loss	Itching
Heart disease	Ulcers	Tingling/numbness	Rash
High blood pressure	Vomiting	Tremors	
Palpitations		Unsteady gait	
Rheumatic fever			
Shortness of breath lying flat			

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Authorization to Release Health Care Information

Patient's Name: ______________________________Date of Birth:_________________

I request and authorize ___________________________________ to release health care information of the patient named above to:

Internal Medicine Consultants
172 Linden Drive, Ste 100
Winchester, VA 22601
Phone (540) 722-8172
Fax (540) 723-8772

This request and authorization applies to:

Service dates requested from ________________ to _________________

_____Last Two Years _____Surgical Reports _____Entire Chart
_____Office Notes _____Lab/Path Reports _____Other
_____Radiology Reports _____Testing - Be Specific________________

List any records that you DO NOT authorize for release:

___________________ ___________________ ___________________

___________________ ___________________ ___________________

Purpose of Disclosure:
_____Referral To Specialist _____Insurance _____Workers Comp
_____Leaving Practice _____New Primary Care _____Legal Investigation
_____Disability Determination _____Personal _____Relocation/Moving

Note: A fee of $0.25 per page will be charged for personal copy/transfer of records. This includes labor and supplies. Prepayment is required prior to release of records.

I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Patient Signature: _________________________________Date: ______________