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 $100.00 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 canceling at least twenty-four (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!

SHENANDOAH UROLOGIC SPECIALISTS
A Division of imc Internal Medicine Consultants

148 Linden Drive, Suite 103
Winchester, Virginia 22601

Main: 540.722.0627
Fax: 540.722.9533
www.susurology.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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Please list your primary care physician's information:

Primary Doctor (PCP): _____

PCP Phone: _____

PCP Fax: _____

Please list ALL of your current doctors besides your PCP (i.e. pulmonologist, oncologist, internist, cardiologist, etc...):

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Please list your referring doctor's information:

Referring Doctor: _____

Referring Doctor Phone: _____

Referring Doctor Fax: _____

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Patient and Responsible Party Authorization

I authorize SHENANDOAH UROLOGIC SPECIALISTS 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 SHENANDOAH UROLOGIC SPECIALISTS 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 SUS 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 **$100.00**. This fee will be due before the next patient visit. A **$300.00** fee will be charged if the appointment is for an in-office procedure such as a prostate biopsy or vasectomy.
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/provider or medical staff with any important information needed.
    a. Be aware that Shenandoah Urologic Specialists is not responsible for any test, procedure, or radiology result ordered by physicians/providers (including Internal Medicine Consultants' primary care providers) outside of the Shenandoah Urologic Specialists 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 Shenandoah Urologic Specialists (SUS) 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 Shenandoah Urologic Specialists to discuss my medical condition and treatments with the following people:

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I authorize Shenandoah Urologic Specialists 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: _____ _____ _____

_____ _____ _____

Are you taking Blood Thinners Such As:

☐ Aspirin ☐ Advil ☐ Eliquis

☐ Plavix ☐ Fish Oil ☐ Other (please list):

☐ Coumadin/Warfarin ☐ Vitamin E _____

☐ Xarelto ☐ Pradaxa _____

Current Medications:

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

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Past Medical History – Family History:

	No/Yes	**Who** (Mom, Dad, Siblings, Children)
Diabetes	_____	_____
Enlarged Prostate	_____	_____
High Blood Pressure	_____	_____
Kidney Stones	_____	_____
Kidney Failure	_____	_____
Prostate Cancer	_____	_____
Stroke	_____	_____
Urinary Tract Infections	_____	_____
Cancer, type: _____	_____	_____
Other (please list):	_____	_____
	_____	_____

Prevention:

NO/YES

Do you or have you ever smoked? _____

# of packs per day___ # of years_____

date quit_____

NO/YES

Do you drink alcoholic beverages? _____

If yes, how many drinks per week? _____

NO/YES

Do you use drugs? (Marijuana, Cocaine, etc.) _____

If yes, please list drugs and frequency of usage:

_____

_____

_____

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Reason I am here:

☐ Urinary Infection	☐ Overactive Bladder	☐ Prostate Cancer
☐ Urinary Leakage	☐ Kidney Stones	☐ Sexual Problems
☐ Difficulty w/ Urination	☐ Kidney Tumor	☐ Testicle Problems
☐ Frequency of Urination	☐ Kidney Cyst	☐ Low Testosterone
☐ Blood in the Urine	☐ High/elevated PSA	☐ Fertility Problems
☐ Bladder Cancer	☐ Prostate Infection	☐ Other (please specify):

_____

_____

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My other medical problems are or have been:

☐ Heartburn	☐ Diverticulitis	☐ Liver Disease
☐ Anemia	☐ Enlarged Prostate	☐ Low Testosterone
☐ Arthritis	☐ Glaucoma	☐ Lupus
☐ Asthma	☐ Gonorrhea/Chlamydia	☐ Migraine Headaches
☐ Atrial Fibrillation	☐ Gout	☐ Multiple Sclerosis
☐ Blood Clots in Legs or Lungs	☐ Gynecological Problems	☐ Overweight/Obesity
☐ Chronic Back Pain	☐ Heart Attack	☐ Osteoporosis
☐ Cancer, type: _____	☐ Heart Failure	☐ Parkinson's
☐ Chronic Urinary Infections	☐ Hepatitis C	☐ Peptic Ulcer Disease
☐ COPD/Emphysema	☐ High Blood Pressure	☐ Peripheral Vascular Disease
☐ Crohn's	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Dementia	☐ HIV	☐ Seizures
☐ Depression	☐ Irritable Bowel	☐ Stroke
☐ Drug/Alcohol Abuse	☐ Kidney Disease	☐ Thyroid Disease
☐ Sugar Diabetes	☐ Kidney Stones	☐ Other (please list):

_____

_____

_____

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Please list and supply the names and dates of:

Operations: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

Constitutional	**Respiratory**	Urinary Leakage/Accidents	**Hematologic/Lymphatic**
Chills	Asthma	Night time urination	Anemia
Fatigue	Bronchitis	Blood in the Urine	Blood/platelet disorder
Fever	Cough (persistent)	Urinary Urgency (can't hold)	Cancer
Loss of height	Expectoration	Venereal disease/STD	Leukemia
Sweats	Pneumonia	Foreskin problems	Lymphoma
Weight gain/weight loss	Shortness of breath		Swollen lymph nodes
Eyes	Snoring		**Allergic/Immunologic**
Change in vision	Tuberculosis	**Musculoskeletal**	Auto-immune disease
Wear contacts/glasses	Wheezing	Arthritis	Immune deficiency
Eye disease	**Gastrointestinal**	Back pain	Itching
Eye injury	Abdominal pain/discomfort	Deformities	Rash
Ear/Nose/Throat	Anorexia	Gout	
Deafness	Blood in stool	Head pain	**Female Health**
Difficulty swallowing	Change in appetite	Joint pain/swelling	Change in Libido (sex drive)
Dizziness	Colitis	Muscle pain	Heavy Period Bleeding
Ear ache	Constipation	Neck stiffness/pain	Painful Intercourse
Hay fever	Diarrhea	Radiating leg pain	Vaginal Dryness
Headache	Gallbladder disease	**Neurological**	Vaginal Discharge
Nasal drainage	Heartburn/indigestion	Confusion	Vaginal Bleeding
Post nasal drip	Hemorrhoids	Lightheadedness	Irreg. Monthly Cycles
Ringing in ears	Hepatitis/jaundice	Memory loss	Fertility Problems
Sinus problems	Kidney disease	Tingling/numbness	Irregular Monthly Cycles
Sore throat	Kidney stones	Tremors	Recent STD
Cardiovascular	Nausea	Unsteady gait	
Chest pain/tightness	Painful bowel movements	**Psychological**	**Other**
Edema (hands, ankles, etc)	Painful swallowing	Agitation	
Fainting	Ulcers	Alcohol abuse	
Heart disease	Vomiting	Anxiety	
High blood pressure	**Male Health**	Depression	
Palpitations	Frequent Urination	Drug abuse	
Rheumatic fever	Painful Urination	Insomnia	
Shortness of breath lying flat	Urinary Infections	Relationship problems	

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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:

Shenandoah Urologic Specialists
148 Linden Drive, Ste 103
Winchester, VA 22601
Phone (540) 722-0627
Fax (540) 722-9533

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:*** _____