

Conditions to Registration and Acceptance as a Patient of Prime Care Family Practice

Patient Name: _____

Consent to Medical Care: the undersigned requests and authorized the physicians and other health care providers of Prime Care Family Practice and their professional staff to perform any medical diagnostic procedures and medical surgical care which in their professional judgement is deemed necessary to diagnosis and/or treat the condition(s) that have brought about my seeking medical services at the offices of Prime Care Family Practice. I understand that the practice of medicine is not an exact science, that there are risks and benefits associated with receiving medical treatment and I acknowledge that no guarantees are made to me concerning the results of the medical examinations and treatments I receive by the providers and professional staff.

Release of Medical Records: The undersigned hereby authorizes Prime Care Family Practice to disclose all or any part of the contents of the medical record of the patient named to such insurance companies, organizations or agencies that may be concerned with the payment of medical services provided to the patient. This authorization is given with full knowledge that such a disclosure may contain information which may result in a denial of insurance benefits or otherwise may not serve the interest of the registered patient.

Assignment of Benefits: I hereby request and authorize that all insurance benefits due for the medical services rendered to the registered patient be paid directly to Prime Care Family Practice. The undersigned, whether signing as the patient or as representative for the patient, accepts responsibility for and agrees to pay for any health insurance co-payments, deductibles and co-insurance required under the terms of the insurance policies.

Deemed Consent: The undersigned acknowledges that the requested patient is informed of the provisions of Section 32.1-45 of the Code of Virginia 1950, that provide if any patient/health care provider is exposed to the bloody/body fluids of a health care provider/patient under the control or direction of Vital Care FP, LLC in a manner which may transit Human Immunodeficiency Virus, Hepatitis B or C viruses, then the patient/health care provider shall be deemed to have consented to testing for HIV, Hepatitis B or C, and to the release of such test results as provided by law.

Consent to Obtain External Prescription History: I authorize Prime Care Family Practice and its providers to view my external prescription history via Surescripts (or any other) prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here at it may include prescriptions history for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

Consent to Contact Via Email: To the extent that our medical records software allows it, we may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare. I authorize Prime Care Family Practice to use the email address I provided to contact me regarding my healthcare. I consent that protected health information may be transmitted to me via this email address.

Patient/Guardian Signature: _____ **Date:** _____