

VIRGINIA DEPARTMENT OF HEALTH
Patient Application and Consent for Health Care

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

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 0 % 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.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

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

RECORD KEEPING

I understand that medical records will be retained for six 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 six years after the last visit or until the client reaches the age of majority, or until emancipation, and at a minimum six years after the last medical encounter, 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, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH 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