Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

Practice Name: _____

Authorization for Treatment

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Bon Secours Health System utilizes an electronic medical record system.
- I understand that Bon Secours Health System utilizes an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my physician prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to my Bon Secours Health System physician from any pharmacy or drug monitoring agency.

Payment Arrangements

- I agree to accept financial responsibility for the payment of the costs of health care services provided to me and my dependent(s) by or on behalf of Bon Secours Health System.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan).
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services provided by Bon Secours Health System which are not covered by my insurance.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a $20 charge for any check returned by my bank.
- I understand that any past due amount owed on my account may be referred to a collection agency, and that I will be responsible for all collection charges and associated legal fees, in addition to the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

This Authorization for Treatment is a legal document and no modifications may be made to it without the written approval of an authorized Bon Secours Health System employee. By signing below, I acknowledge that I have read, understand and agree to the above terms.

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date	Time