

Urogynecology and Pelvic Surgery Center provides services without regard to race, religion, national origin, or disability.

With my signature below I hereby acknowledge and authorize the following:

1. **Consent** for treatment, administration of medications and performance of any procedures that may be considered necessary or advisable.
2. **Assignment of insurance benefits** to Urogynecology and Pelvic Surgery Center. This is to include Medicare and worker's compensation benefits. In doing so I authorize release of any information necessary to process the claim.
3. **Financial responsibility.** The undersigned agrees, in consideration of services rendered by Urogynecology and Pelvic Surgery Center, to be responsible for payment in full including any collection or attorney's fee related to my not paying the bill when due. Payment is due immediately upon receipt of the bill.
4. Acknowledge that according to Virginia State law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency Virus (HIV), Hepatitis B or Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, be directly exposed to my body fluids in connection with rendering care to me as a patient, in a manner which may, according to the current guidelines of the center for Disease Control, transmit HIV, Hepatitis B or Hepatitis C viruses to such healthcare provider. Test results may be released to the person exposed.

Urogynecology and Pelvic Surgery Center will submit your claim if we participate with your current insurance plan. You will be responsible for any co-payments, deductibles, or non-covered services at time of service. **If we do not participate with your health plan or you do not have insurance, payment in full is required at the time of the visit for all services. A \$25.00 service charge will be charged for all returned checks.**

With my signature I also acknowledge reading and being given a copy of the NOTICE OF PRIVACY PRACTICES.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Relationship to Patient: _____