Patient Name:_____

DOB:_____

RADFORD UNIV STUDENT HEALTH PHYSICIAN PRACTICE FINANCIAL AGREEMENT AND GENERAL CONSENT

All references within this document to "Carilion Clinic" shall refer to Carilion Clinic and its affiliates.

1. CONSENT TO TREATMENT: I give permission to the employees, doctors, nurses, and staff at Carilion Clinic to perform medical treatments, procedures, tests, and evaluations that they think are needed. This could include but is not limited to tests, imaging, procedures, labs, telehealth services, electronic consults, consultations between providers, MyChart messaging, and emergency care. I agree that treatment may include taking photographs, video or audio recordings.

2. NO GUARANTEE: I acknowledge that no guarantees have been made about the results of any medical treatments, procedures, tests, or evaluations. I understand that treatment carries risks including, but not limited to, infections.

3. TEACHING FACILITY: I am aware that Carilion Clinic is a teaching facility and that certain patient services may be performed or observed by students or trainees in the health profession under the supervision of employees of Carilion or other health care providers. I hereby authorize and consent to students, trainees, or residents, performing or observing certain patient services, including medical treatment, examinations and diagnostic procedures. I understand that at any time I can decline to have a student, trainee or resident physician participate in my care and treatment by advising my healthcare provider; however, medical education facilities may not be able to continue to provide my care if I refuse to see a resident physician.

4. DEEMED CONSENT FOR BLOOD TESTING: : I understand that, under Virginia law, whenever any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, is directly exposed to my body fluids in a manner (such as through an accidental needle stick) that may, according to CDC guidelines, transmit HIV, Hepatitis B or C viruses, I consent to testing for HIV, Hepatitis B or C viruses.I consent to the release of my test results to the person who was exposed. Patients who test positive will be given the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, soreness and/or bruising at the puncture site. The results of this test will become part of my confidential medical record.

5. ASSIGNMENT OF PAYMENT: I understand that Carilion Clinic is not liable or responsible for the loss, damage, or theft of any valuables, money, medications, jewelry, computers, tablets, cell phones, glasses, hearing aids, dentures, prosthetic devices, documents, garments, items, or other personal property regardless of the value or size of the item unless the item is formally transferred to the care, custody and control of Carilion Clinic for safekeeping. I will receive a receipt for any item(s) transferred to the care, custody, and control of Carilion Clinic for safekeeping. Without a receipt, Carilion Clinic shall not be liable for any loss, damage or theft of personal property. I assume the risk of loss, damage, or theft of any personal property not transferred to the care, custody and control of Carilion Clinic for safekeeping and agree to hold Carilion Clinic harmless from any and all liability which may result from the loss, damage, or theft of any such personal property.

6. ARTIFICIAL INTELLIGENCE (AI): Carilion Clinic may use AI tools to assist my healthcare providers. These tools may include, but are not limited to, software that assists decision-making, records information, or helps prepare documentation for my healthcare providers to review and approve. Any data used or recorded by AI tools will be kept in accordance with federal and state privacy requirements..

7. CONSENT TO TELEPHONE CALLS AND TEXT MESSAGING: I expressly consent to receive on my cellular phone or other phone number(s) that are listed on any of the forms completed related to my care, now or in the future, text messages, telephone calls, or other communications for any purpose related to my medical care, current or upcoming services offered by an authorized caller, or my account. I understand that these communications may be made using live, artificial or pre-recorded voice messages, automatic telephone dialing systems, text message systems, emails or any other computer-aided technologies. I understand
that these communications may come from Carilion Clinic or any of its affiliates, agents, and/or business associates, including but not limited to third-party billing agencies or other third parties acting on behalf of Carilion Clinic. I understand that data charges may apply and that this consent is not required in order to receive services or treatment from Carilion Clinic. If I change my number, I agree to notify Carilion Clinic immediately. I understand texts carry risks. They may be sent in unencrypted form and could be viewed by others who have access to my device or if I do not update my phone number with Carilion Clinic. I accept these risks. I understand that I may opt out from calls or texts by following the instructions in the message.

8. CONSENT FOR EMAIL COMMUNICATIONS: I agree to use email to communicate with Carilion Clinic about appointments, products, service reviews, billing, and other information related to my care. I understand that emails carry risks. They may be sent in unencrypted form and may be viewed by others. I accept these risks. If I change my email address, I will notify Carilion Clinic. I can opt out from emails by following instructions in the email.

9. RESEARCH PARTICIPATION: Carilion Clinic routinely conducts research studies to learn about new treatments and ways to prevent health problems. I understand that Carilion Clinic may contact me and invite me to participate in research. If I do not wish to be contacted about

research, I may contact 540-224-6744 or email optoutresearch@carilionclinic.org at any time. Carilion Clinic will then use reasonable efforts to avoid contacting me about research. I understand this will not prevent my healthcare team from discussing research with me.

10. **AUTHORIZATION FOR RELEASE, DISCLOSURE, AND USE OF PATIENT INFORMATION** (including **protected health information):** I understand that Carilion Clinic uses an electronic medical record. I authorize Carilion Clinic to obtain my health information from other doctors, providers, and places where I have received care in the past, present, and future. I authorize the release of my health information to doctors, providers,and places involved in my treatment. This includes places where I am discharged, transferred, or arrive for treatment in the past, present, or future. This also includes other healthcare providers, affiliates of Carilion Clinic or business partners for the purposes of treatment, payment, healthcare operations, billing, healthcare management, discharge planning, quality assurance, bill collection, defense of litigation or anticipated litigation.This also includes any insurance company, review organization or other entity in any way responsible for payment or review of services provided by Carilion Clinic. I authorize use of my information to determine if I have insurance coverage or other benefits. I agree that Carilion Clinic may bill discovered coverage according to the scope of this consent.

I consent to the use, release, and disclosure of my protected health information for any and all of the above reasons. I understand that my health information may be transmitted in an electronic or paper format or verbally. I authorize Carilion Clinic to access and use my patient prescription information from any healthcare provider or benefits manager, including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment, and healthcare operations. Carilion Clinic is not required to agree to such a request.

11. HEALTH INFORMATION EXCHANGE (HIE) GENERAL CONSENT: To improve the coordination of my care,
I authorize Carilion Clinic to electronically release my protected health information to other healthcare providers involved in my care and treatment who participate in local, state, national and/or international Health Information Exchanges (HIE). This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases, HIV test results, reproductive healthcare, developmental disabilities and genetic testing results. If I do not wish to participate in Carilion Clinic's HIE, I may contact the Health Information Management Department at 540-981-7145 or email medicalrecords@carilionclinic.org to opt out.

12. ASSIGNMENT OF PAYMENT: In consideration of medical services to be provided to me or at my request,I hereby assign to Carilion Clinic all of my benefits, interests, and title in recovery of any type whatsoever receivable by me or on my behalf arising out of any policy or plan of insurance, trust, fund, healthcare sharing ministry, or any entity otherwise providing benefits, coverage, indemnification, or monies of any type to me (or any third party responsible for me) for all charges for the items and services provided to me by Carilion Clinic; this assignment is further inclusive of coverage through a state or federal healthcare program, liability- based coverage including but not limited to personal injury, general liability, automobile liability inclusive of uninsured motorist coverage or med-pay, workers' compensation, or any other plan or policy for medical benefits stemming from my employment or the employment of my spouse, parent, or guardian, inclusive of self-funded employer group plans, multiple employer welfare arrangements, collective, union, or any other employment-related entity or association, or from any settlement or judgment that comes from any related incident that caused the medical treatment (hereinafter collectively "Coverage Source"). I authorize directed payment of any benefits or monies be made directly to Carilion Clinic on my behalf for any services furnished to me as a patient inclusive of payment for physician services, from any Coverage Source, inclusive of those related to a settlement, judgment, or lien. Pursuant to this assignment, I recognize and understand that,if Carilion Clinic has a contractual relationship with my Coverage Source, Carilion Clinic will bill my Coverage Source and accept payment in accordance with that contractual agreement.

If Carilion Clinic does not have a contractual relationship with my Coverage Source, I acknowledge and understand that Carilion Clinic may, to the extent permissible by law, choose not to accept assignment and/or not to bill my Coverage Source directly. Without a contractual relationship I may be responsible for all service charges, regardless of any representations made by my Coverage Source, and it will be my responsibility to seek reimbursement from my Coverage Source. If I have any questions as to whether my Coverage Source has a contractual relationship with Carilion Clinic, I may direct those questions to Carilion Clinic Billing Customer Service.

13. REFERRAL/AUTHORIZATION AND NON-COVERED SERVICES: I understand that my insurance, HMO, or health benefit plan may require a referral and/or authorization prior to the delivery of this service. I also understand that my insurance, HMO or health benefit plan may deny payment for failure to obtain a referral and/ or authorization, failure to properly identify my/the plan or coverage, receipt of services that are not covered or for which the patient is not eligible under the plan or coverage at the time the services are rendered, or a determination under the plan or coverage that the services were not medically necessary. I acknowledge and agree that, in the event payment for these services is denied based on the provisions of my insurance, HMO or health benefit plan, I am fully personally responsible for payment of charges for these services and will be billed directly.

14. **PROMISE TO PAY:** I owe and unconditionally agree to pay to Carilion Clinic the full contracted allowable rate or discounted rate as determined by Carilion Clinic policy for the charges for the services rendered to myself, my child, and/or any patient for which I am legally responsible that are not paid on my behalf by a third party.I understand my financial responsibility includes, without limitation, co-insurance, deductibles, and payment for services that are not covered by any Coverage Source. I understand, to the extent permissible by law, that if my Coverage Source is non-contracted or does not remit payment consistent with a contract or reimbursement agreement, that I may be responsible for all amounts up to the total billed charges for each instance of medical care. I understand that the Carilion Clinic bill is due in full upon receipt after any third-party payor resolution.

I understand that separate bills may be generated for some services. Examples include but are not limited to: emergency department, hospital, physician, specialist, diagnostic studies, laboratory, radiology, and/or anesthesia. Additionally, I agree to pay my insurance co-payment, co-insurance, or known out-of-pocket expenses at the time of service. I agree that, if Carilion Clinic must initiate collection efforts to recover amounts owed by me, then, in addition to amounts incurred for the services rendered, I will pay, to the extent permitted by law: (a) any and all costs incurred by Carilion Clinic in pursuing collection, including but not limited to reasonable attorneys' fees; and (b) any court costs or other costs of litigation incurred by Carilion Clinic.

15. MEDICARE LIFETIME SIGNATURE AUTHORIZATION AND ASSIGNMENT: If I am a Medicare or Medicaid beneficiary, I request that payment of authorized Medicare/Medicaid benefits be made on my behalf for any services furnished by Carilion Clinic or in a Carilion Clinic facility, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services, and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to submit claims to Medicare and/or Medicaid for payment. I understand that I am responsible for any deductibles, co-payments, and/or any applicable amount of remaining charges.

16. AUTHORIZED REPRESENTATIVE / DESIGNATED AGENT: I hereby designate Carilion Clinic as my Authorized Representative and/or Designated Agent in all matters arising under a claim for benefits from any Coverage Source for any items and services provided to me and for all related expenses incurred.

17. ABILITIES OF AUTHORIZED REPRESENTATIVE: As my Authorized Representative or Designated Agent, I hereby ascribe all rights and privileges available as by and between me and my Coverage Source as well as all rights, remedies, and privileges afforded to me under state and/or federal law; including but not limited to the ability to pursue and dispute any form of adverse determination or denial related to or arising from the medical care provided to me by Carilion Clinic, its employed physicians, and/or related entities at any stage during my medical care, be it before my care is rendered ("pre-service"), during any admission ("concurrent"), or after any or all medical care has been provided to me ("post-service"). To the fullest extent permissible by law, this shall include but is not limited to all rights to the filing or submission of a reconsideration, grievance, appeal, external appeal, or review by any relevant source including but not limited to an independent review organization, board of trustees, or other review board or entity as established by my plan or policy, or as authorized or directed under state or federal law; review by a state or federal agency and/or committee or panel formed through a state or federal agency, administrative law judge, or attorney adjudicator; and any and all legal claims related to my medical care as against any Coverage Source for monetary, equitable, and/ or declaratory remedies including but not limited to mediation, arbitration, or the filing and pursuit of litigation against a Coverage Source in state, federal, or admiralty court, including those where an employing agency may be named as a party and where I may be named as the plaintiff.

By signing this assignment, designation, and authorization, I certify that I am the patient or the patient's duly authorized representative and/or power of attorney and confirm that I understand and accept the terms of this document. I further confirm that I was provided with the opportunity to ask questions and have them answered prior to voluntarily executing this document.

18. ADDITIONAL PROVISION APPLICABLE FOR MINOR OR OTHER PATIENT FOR WHICH THE UNDERSIGNED IS LEGALLY RESPONSIBLE: I acknowledge and verify that I am the legal guardian, custodian, or otherwise legally responsible for the patient.

19. ACKNOWLEDGEMENT: By signing this form, I certify that the information above and all information supplied as a part of the admission/registration process is correct. I acknowledge that I have received a copy of the Carilion Clinic Patient Rights and Responsibilities document and have received or been given the opportunity to receive a copy of the Carilion Clinic Notice of Privacy Practices and ask questions about the information contained within those documents. I understand that I may also obtain a copy of those documents at any time from Carilion Clinic. I have read this agreement, fully understand its terms, and agree to follow and be bound by them.

Patient Name (please print)	Date	Time
Patient or Parent/Legal Guardian Signature	Date	Time
Witness	Date	Time