BAYVIEW
PHYSICIANS GROUP

CONSENT FOR TREATMENT

I, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as any testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director.

No Guarantee of Results
I understand that no guarantee or assurance has been made as to the results which may be obtained from the exam, testing, or treatment.

Release of Medical Information
I hereby authorize the release of any medical records to any company insuring the patient named above and assign all benefits from said insurance to Bayview Physician Services, PC. In the case of a work related injury or illness, I hereby authorize Bayview Physician Services, PC to release any information obtained by Bayview Physician Services, PC to any employer or prospective employer when the medical exam, testing, or treatment is in accordance with the provisions of, and under the conditions prescribed by the Workers' Compensation Act, any state of federal mandated exams, or company policy which requires a medical examination.

I agree that Bayview Physician Services, PC. may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Bloodborne Pathogen Exposure
As established in Virginia Law (Virginia Code Section 32.1-45.1) acknowledge that if a caregiver is exposed to my blood or body fluids in the course of my treatment, my blood will be tested for the Human Immunodeficiency Virus (HIV) antibody and the results will be released to me.

Electronic Communications
As a service to our patients, we will send you electronic appointment reminders and possibly other important electronic messages. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not provide your information to any other entity.

Payment
I understand that payment is due when services are rendered unless other arrangements have been made in advance. I understand that my medical insurance carrier will be billed as a courtesy, if requested. I understand and agree that I am responsible for all co-pays (if applicable) and all balances due. I understand and agree to pay all reasonable attorney fees and collection fees, as well as any court cost incurred by the practice(s) in the collection of any monies due by myself or my dependents.

In case of a work related injury or illness, employer requested medical services are usually paid by the employer of their insurance company. I understand that I will be responsible for services provided by Bayview Physician Services, PC if arrangements have not been made, or arrangements have been negated for any reason.