Conditions Of Admission/Registration

CONSENT FOR TREATMENT
I have a condition requiring emergency, inpatient or outpatient health care, and I voluntarily consent to such care, including diagnostic procedures, laboratory testing, toxicology screening and medical treatment by my physician and hospital personnel. I acknowledge that no guarantees have been made to me as a result of such care.

HIV, SYPHILIS, HEPATITIS TESTING
I understand that Virginia Code § 32.1-45.1 provides that in the event of any health care provider's exposure to my blood and/or body fluids, I shall be deemed to have consented to laboratory testing for human immunodeficiency virus (HIV) or hepatitis B or C viruses, with release of the test results to the person(s) exposed.

RESPONSIBILITY FOR VALUABLES
I waive any cause of action that I now have or may have in the future against Bon Secours Health System, Inc., their officers, agents or employees arising from the loss of or damage to any personal property.

ASSIGNMENT OF INSURANCE BENEFITS/FINANCIAL AGREEMENT
I assign and direct all insurance benefits available to me, be paid directly to the hospital and hospital-based physicians, and agree to be financially responsible for any required co-payments or deductibles and all other charges not covered by my insurance plan. I understand that financial assistance applications are available to me should I be uninsured or otherwise anticipate difficulty concerning payment of all or part of my bill for health care services rendered by Bon Secours Health System Inc., their hospitals and hospital-based physicians. I understand that I am responsible for any services not covered by my insurance benefits as well as any unpaid balance plus the reasonable costs of collections, including any attorney fees or court costs associated with attempts to collect the unpaid portion of my bill.

PHARMACY LIMITED POWER OF ATTORNEY
If you cannot afford your medication, or if your medication is not covered by your insurance plan, Bon Secours Health System Inc. may be able to obtain reimbursement for some of your medications through Patient Assistance Programs sponsored by drug manufacturers. To qualify for these programs, it may be necessary to provide information regarding your financial status, illness, and/or treatment to the drug manufacturer sponsoring the program(s). All information associated with the patient assistance programs will remain confidential and will only be provided to drug manufacturers in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law.

My signature on this form authorizes Bon Secours Health System Inc., their hospitals, and hospital personnel to complete any necessary application forms. I release any claim to the medication I may receive as a result of my participation in the patient assistance programs and give my permission for any medication to be repackaged. This authorization shall remain in full force from the date signed until I cancel it or no longer belong to the patient assistance programs.

_____ _____

Patient Signature **Signature of Patient Representative**

RECORDKEEPING
I understand that medical records will be retained for five years after the date of the last visit or for five years following a patient's death. In the case of a minor, the medical record will be retained for 10 years after the last visit or for five years after age 18, whichever comes later.

CONSENT TO PHOTOGRAPHY FOR IDENTIFICATION PURPOSES

I hereby consent to have my photograph taken at any Bon Secours Health System Inc. affiliated hospital. I understand that the images from such photography will be included in my electronic medical record and are considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such images will be used for identification purposes only. The images will not be further used or disclosed without my written authorization except as may be required by law.

CONSENT TO RECEIVE TELEPHONE CALLS

PLEASE CAREFULLY READ THE FOLLOWING INFORMATION ABOUT HOW WE MAY USE YOUR PHONE NUMBER(S). IT AFFECTS YOUR LEGAL RIGHTS.

CONSENT

I hereby consent Bon Secours Health System, Inc., including its employees, agents, assigns, affiliates, or independent contractors (including but not limited to debt collection agencies), to contact me by voice call, at the phone number(s) associated with my account. I understand that by giving this consent, BSHSI may contact me about any and all matters related to me, my medical care, my account, appointments, billing issues, and the repayment or collection of amounts due. I understand that these calls may be placed using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the phone number(s)provided are for a cellular telephone or other service that charges me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

RELEASE

In consideration for BSHSI's provision of products and/or services and my request to receive calls or messages at the phone number(s) provided, I hereby release BSHSI from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

I HAVE READ THE ABOVE AND ALL MY QUESTIONS HAVE BEEN ANSWERED

I have received information on the following topics: Conditions of Admission/Registration, Good Help Commitment, Sign Language, Patient Rights and Responsibilities, Pain Control, Virginia Prescription Drug Monitoring Program, Advance Directives. Tobacco-Free Campus, How You Can Prevent A Fall, How You Can Prevent Medical Errors, CarePages.com, Discharge Instructions, and Billing Information.

I certify that I have read and received a copy of the foregoing information and certify that I am the patient or person duly authorized by the patient or Virginia law to execute this Conditions of Admission/Registration and accept its terms.

_____ _____

Signed (patient or patient representative) **Relationship to Patient**

Initials: **Patient unable to sign. Reason:**

_____ _____

Bon Secours Virginia Health System

Bon Secours Health System, Inc.