MITCHELL/WHITTAKER/WU (Loudun Medical Group)

Patient Application and Consent for Health Care

Patient Name:_____ Date of Birth:_____ ID#_____

PATIENT CONSENT FOR GENERAL PRIMARY CARE

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Mitchell/Whittaker/Wu(LMG) to examine and/or treat me and/or my dependent, as named above.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

MWW/LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any MWW/LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a MWW/LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from MWW/LMG or until I withdraw it

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date Signed**

_____ _____

Relationship (if signature is not of Patient) **Signature of Person Obtaining Consent**

PAYMENT FOR SERVICES

You will be responsible for paying for those services you or your dependent receive which are not covered by insurance.

I understand that I am responsible for paying the bill.

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date Signed**

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the Loudoun Medical Group.

RECORD KEEPING

I understand that medical records will be retained for ten years after the date of the last visit or for five years following patient's death. In the case of a minor, the record will be retained ten years after the last visit or for five years after age 18, whichever comes later. I authorize MWW/LMG to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to MWW/LMG on my behalf.

I understand that this consent will remain in effect as long as my dependent or I receive care from MWW/LMG or until I withdraw it.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information, or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date Signed**

_____ _____

Relationship (if signature is not of Patient) **Signature of Person Obtaining Consent**