HAMPTON MENTAL HEALTH ASSOCIATES

Patient Name:	Date of Birth:

CONSENT FOR TREATMENT AND CERTIFICATION OF OBLIGATION FOR PAYMENT OF BALANCES DUE

CONSENT: I hereby request and consent to medical and/or diagnostic treatment by Hampton Mental Health Associates, Inc. (HMHA) and hereby authorize physicians, nurse practitioners, and therapists to treat me or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, and administration of medications. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. Virginia law authorizes health care providers to test patients for HIV and hepatitis B & C antibodies when a health care provider or any person employed by or under the direction and control of a health care provider is exposed to the body fluids of a patient on the basis of deemed consent. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider.

PAYMENT OBLIGATION/BALANCES DUE: I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to HMHA for services rendered. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to HMHA for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. If all charges are not paid when due to HMHA, the undersigned agrees to pay all costs of collection, including collection agency fees.

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me at the time of my next appointment. Co-payments and deductibles are due prior to treatment. I have been informed that a fee of $35 may be applied to my account for any returned checks and a $50 fee for missed appointments not canceled at least 24 hours in advance. RETURNED CHECK FEE is only payable in cash or by money order. For Medical Records Requests, the minimum fee is $15.00, which incorporates a $10.00 handling fee fee and the first 5 pages, then it is .50 per page for every additional page up to 50 pages and .25 per page for all additional pages thereafter. Medical Records take 7-14 days to process. Records take 7-14 days to process.. Forms filled by provider fee is $15-$25. HMHA reserves the right to increase the amount charged for returned checks, missed appointments, and medical records requests. Your signature below agrees to these terms. Please direct all billing inquiries to the HMHA Billing Representative.

- I have been given an opportunity to review the "Patient Financial Policy" and my signature certifies that I agree with its terms.
- I have reviewed and understand the "Court Custody Statement" and its financial terms.

I certify that this form has been fully explained to me and I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws. My signature below indicates my understanding of this form, my agreement with, and my consent.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN	IF PARENT/GUARDIAN, PLEASE PRINT NAME	DATE