ROANOKE VALLEY HEALTH
VITAL REGISTRATION INFORMATION

Thank you for choosing one of the Roanoke Valley Health Services medical clinics! We are committed to providing you with the highest quality healthcare. The information provided on these pages is vital to our relationship. We trust that you will read it carefully, and ask for clarification on any subject, if needed.

PAYMENT:
Please understand that the payment of your bill is a necessary part of your treatment and care. We appreciate your attention to our payment terms. Payment for service is due on the date of the service. If you are unable to pay, you may be asked to reschedule your appointment. We believe that a good relationship is based on open communication and understanding. Our Provider Billing Office staff is willing and available to discuss billing matters with you at any time. Please ask for additional information.

INSURANCE:
Before starting medical services and treatment, we will require all of your insurance information, including a current insurance identification card and a government issued photo ID. We do this for your own protection to be sure that you, and only you, are accessing care and records under your name and ID.
Your insurance coverage is a contract between you and your insurance company, and you are responsible for understanding the coverage and terms of your insurance. (For example: please discuss your non-covered services, out-of-network benefits, policy limits and other details, with your insurance company.) You are required to pay all insurance co-payments, deductible amounts and co-insurance at the time of your visit. All co-payments will be collected at check-in when you arrive for your appointment. If you are unable to pay your co-payments, deductibles and/or other outstanding balances, you may be asked to reschedule your appointment. Additionally, you are responsible for making timely payments on your account. All patient balances are due within 30 days of our statement billing date, regardless of the status of your insurance claims.

WORKER'S COMPENSATION:
We cannot file health insurance claims for Worker's Compensation or on-the-job accidents or injuries in any of our clinics EXCEPT for Halifax Works. If your visit has something to do with your job, please let our receptionist know. If you seek worker's compensation treatment in any of our other clinics, and choose not to notify our staff, then you are responsible for payment of all charges.

AUTOMOBILE ACCIDENTS AND OTHER LIABILITY CLAIMS:
We cannot file health insurance claims for auto accidents or other accidents where another party is at fault. If you have a third-party claim, you are responsible for payment of all charges; and must seek reimbursement from the third party's insurance on your own.

AGREEMENT TO PAYMENT POLICY:
I agree to keep my account current, paying all applicable charges, which are not paid in full by insurance. If amounts due to this Roanoke Valley Health Services clinic are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due in addition to the amounts in default.

By signing this form, I acknowledge that I received a copy of this paperwork outlining my obligation to pay my account, and that I understand and agree to the payment terms.

<u>Payment May be Made by:</u>

- Cash, check, VISA, MasterCard and Discover at the reception area in each of our clinics, when making a payment on a bill for that clinic
- Via telephone by calling the Physician Billing Office at 252-535-8861 for payments on bills for any RVHS clinic

IMPORTANT NOTE: Checks that are returned by the bank for non-payment will be assessed a $35.00 returned check fee.

MISSED APPOINTMENT FEE:
When patients do not keep scheduled appointments, it is not only dangerous to their health; but it prevents other patients from using that time slot, and is very costly to our medical practice. Unless scheduled appointments are canceled at least 24-hours in advance, our office will charge a $25.00 fee for each missed appointment. The missed appointment fee will not be submitted to your insurance, **AND** you will need to pay the $25.00 fee prior to scheduling another appointment with our practice. Patients who miss three scheduled appointments within one year, will be dismissed from our medical practices, and will need to find healthcare

elsewhere. Thank you for understanding that it is important to your health to keep your scheduled appointments, AND it is important to our practice that you let us know in advance when you will be unable to keep your appointments.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits, be made on my behalf to this Roanoke Valley Health Services clinic for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity, and its agents, any information needed to determine these benefits payable for related services.

AUTHORIZATION FOR MEDICAL TREATMENT:
I hereby certify that I (we) the undersigned consent to and authorize such medical treatment and/or routine diagnostic procedures as the physician or physician extender considers medically necessary. I understand that, absent emergency or extraordinary circumstances, no substantial procedures will be performed upon me unless and until I have had an opportunity to discuss them with the physician or other health professional to my satisfaction. I understand that I am under the care of the physician or physician extender and that the assigned Roanoke Valley Health Services clinic is not liable for following instructions of said physicians or physician extenders.

AUTHORIZATION TO RELEASE INFORMATION PAYMENT FOR SERVICES FOR MEDICAL TREATMENT:
I hereby authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers for the purpose of payment of insurance claims. I further authorize any other individual or entity that has provided health care to me to release to Roanoke Valley Health Services clinics any and all of my medical record information (whether in printed or electronic form) needed to provide me with informed care. I may revoke my consent for the release of this information, in writing, at any time; except to the extent that action has been taken in reliance on the consent.

MEDICARE-MEDICAID PATIENT CERTIFICATION (PAYMENT REQUEST AND AUTHORIZATION TO RELEASE INFORMATION):
I hereby certify that the information given by me in applying for applying for payment under Titles XVIII and/or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf. I authorize release of all records by RVHS clinics required to act on this request. I understand that I can revoke this authorization at any time if RVHS clinics are notified in writing.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES:
I hereby acknowledge that I have received and had the opportunity to ask questions concerning the Notice of Privacy Practices.

AUTHORIZATION TO RELEASE/DISCUSS MEDICAL INFORMATION:
I hereby give authorization for the providers and staff of the Roanoke Valley Health Services clinics to discuss my medical information and treatment plans with the person(s) listed below:
[Please indicate the person(s) and their relationship(s) to you.]

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that this includes confidential information regarding my past and present medical history, diagnoses, treatment plans and any and all pertinent medical information. I understand that this authorization will remain in effect for one year from the date of signing, unless written withdrawal of this authorization is provided by me. I understand that the person(s) listed will be asked to provide photo identification for proof of identity.

LIVING WILL AND ADVANCE DIRECTIVES:
I hereby acknowledge that I have received information and had the opportunity to ask questions concerning living wills and advance directives.

NORTH CAROLINA HEALTH INFORMATION EXCHANGE:
I hereby acknowledge that I have received information and had the opportunity to ask questions concerning Roanoke Valley Health Services clinics' participation in the North Carolina Health Information Exchange. I understand that I can choose not to participate, or 'opt-out,' by calling the toll free number on the brochure.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE ABOVE CONSENT, RELEASE, AND ASSIGNMENT OF BENEFITS.

_____	_____	_____
Patient's Name (Printed)	Date of Birth	Chart/Account #
_____	_____	
Patient's Signature	Date	
_____	_____	
Responsible Party (if minor)	Relationship to patient	
_____		
Witness's Name (Printed)		
_____		
Witness's Signature		