PRIVIA
MEDICAL GROUP

Authorization and Consent for Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand that payment of authorized benefits under Medicare, Medicaid, and/or any Insurance Carriers listed, will be made to me or on my behalf to the provider or supplier, for any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia Medical Group, the Health Care Financing Administration, listed insurer and/or agents of the company and/or the listed responsible person(s), any information needed to determine these benefits or the benefit for the related services. In the event that my insurance plan is out of the Privia Medical Group network, or if I am a self-pay patient, assignment of benefits may not apply.

I acknowledge that I have received information regarding my rights to privacy of information under HIPAA regulations, as described in the Notice of Privacy Practices. I acknowledge that if I want my protected health information disclosed, I must make that request to the staff and sign a disclosure release.

Guarantee of Payment & Pre-Certification

In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney, and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plans provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

I acknowledge that I have received the Financial Policy and agree to abide by its terms.

Consent for Treatment

Upon my admission to Privia Medical Group, I voluntarily consent to the rendering of such care as the providers and personnel, in their judgment, deem to be necessary for my health and well-being during my admission to said department.

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (including suturing), cast application/removals and shall also include the carrying out of the orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

I certify that I have read and understand this consent.

Consent to Call

As a component of my care, I understand and agree that Privia Medical Group may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from the medical group.

I understand that I must voluntarily "opt-in" to receive automated text message communications from Privia Medical Group by visiting the Patient Portal, and agreeing to additional Terms and Conditions as set forth by my mobile carrier.

I certify that I have read and understand this consent.

➔ **Signature**: _____ **Date**: _____

To be signed by parent or legal guardian if patient is a minor under the age of 18, or a mentally incompetent patient.