LEESBURG MEDICAL CLINIC, PLLC

Patient/Dependent Authorization and Consent for Health Care Treatment

Authorization for Services and Information Release

I hereby authorize physicians, nurse practitioners, nurses, and other clinical staff of Leesburg Medical Clinic, PLLC to examine and/or treat me and/or my dependent(s).

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(name of dependent, if applicable)

I certify that the information that I provided is true and complete according to the best of my knowledge. Further, I authorize the staff of Leesburg Medical Clinic, PLLC to release medical information to any of my physicians, other providers, or my insurance companies that may be pertinent to my case or that of my dependents(s) named above.

Payment for Services

I certify that a full explanation of services and charges has been given to me. I hereby authorize payment directly to Leesburg Medical Clinic, PLLC of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I understand that I must report any income changes and that I will lose Sliding Fee Scale rights if I do not. I also understand that my Sliding Fee Scale status will be revised periodically.

Notice of Deemed Consent for HIV, Hepatitis B or C Testing

As a healthcare provider, we are required by 32 1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit diseases, 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.
2. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit diseases, that person's blood will be tested for infection 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.

The information above has been explained to me and I understand it.

_____ _____

Signature of Patient Date signed

_____ _____ _____

Signature of Parent, Legal Guardian Relationship Date Signed