Patient Name: Date of Birth:

CONSENT TO SERVICES AND CARE

Consent for Treatment:
I will allow Shenandoah Community Health Clinic (Clinic) to treat the patient. I will provide, when asked, any and all information for any illness or injury, medical history, prescriptions or treatment, and copies of all medical records. I understand that the Clinic provides services without regard to race, creed, color, or national origin.

Financial Agreement:
I authorize direct payment to the Clinic for any health care received. I will allow the Clinic to file claims on my behalf. I understand that I am responsible for services not paid by my insurance plan and that I may apply for discounted services where fees are based on my family's income and subsidized by grants and donations. I understand that I may incur fees for services from outside entities like hospitals and specialty practices and that charitable assistance programs may be available to make these services more affordable.

Notice of Deemed Consent for Infections Disease Testing:
By my signature, I understand that I have been informed of Virginia state code 32.1-45.1 regarding blood testing. In the event that a health care provider or employee is exposed to the patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and Hepatitis and to the disclosure of the test results to that health care employee.

I agree that this permission will be valid until taken away in writing or replaced by one at a later date. A photocopy of the agreement will be considered effective and as valid as the original.

Patient/Guardian Signature:_____ Date: __ __/ __ __/ __ __ __ __

Print Name:_____ Relationship to Patient: _____

CONTACT INFORMATION

Tell us the best phone number to reach you during the day: _____

Tell us the best phone number to leave messages or appointment reminders: _____

Can the Clinic leave extended messages on the message phone number above? ☐ Yes ☐ No

Please list all individuals with whom we may discuss your medical care (HIPPA). THESE INDIVIDUALS WILL ALSO BE YOUR EMERGENCY CONTACTS. We will not discuss your health care with anyone NOT listed below.

NAME (First and Last)	Primary Phone	Relationship to Patient

FOR OFFICE USE ONLY

Entered By: _____ **Scanned By:**_____ **Date:**