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5102 West Village Green Drive
The Grove 2, Suite 109
Midlothian, VA 23112

Virginia Child Neurology Specialists

Patient Name _____ DOB _____

Signer Relationship to Patient:

___ Patient ___ Legal Guardian ____ Health Care Power of Attorney ___ Parent

CONSENT FOR HEALTHCARE SERVICES

1. I authorize and consent to healthcare services/medical treatment provided by Virginia Child Neurology Specialists and its healthcare providers regardless of their location whether it be in person, via phone or via telemedicine.

2. Clinical Photographs or Images and Biological Materials: (i) clinical photographs/images may be taken of me to document routine care for educational, clinical, quality improvement, and safety-related purposes, as well as other reasonable purposes in accordance with the Health Insurance Portability and Accountability Act (HIPAA); **(ii)** clinical photographs/images and biological materials retained following completion of care may be published and used for teaching and/or research purposes as long as I am not individually identified; and (iii) I will not receive compensation for such uses.

3. Videotaping and Video Surveillance: Virginia Child Neurology Specialists may use closed-circuit video surveillance monitoring and videotaping of patient care for educational, clinical, quality improvement, security, and/or safety-related purposes.

4. **Education and Teaching: I**ndividuals, as part of their education and training at their respective schools may observe or participate in the delivery of healthcare services to me; **(ii)** I understand and agree that my patient records may be reviewed by students, residents, and trainees rotating or working with Virginia Child Neurology Specialists.

Initial: _____

RELEASE OF INFORMATION

I certify that I understand the following statements and agree to:

1. Release of Information: As allowed by Federal and State Law, Virginia Child Neurology Specialists, or VACNS (as we will refer to it in the rest of this notice) and its employees may release my health information to insurance companies, Medicare, Medicaid, or any other government or third party payer, fund, entity, or another coverage source (defined below under which I, my spouse, child, or dependent may be a beneficiary or entitled

to monies related to the healthcare provided). I also agree to the release of medical or personal information to any third-party entity engaged by the aforementioned for review of my claim(s), processing of benefits, or review of a denial, underpayment, or dispute for any medical care received, as well as any subsequent or related services. I understand that VACNS will share my health information with healthcare providers, such as my primary care physician and other medical specialists involved in my medical care.

AUTHORIZATION FOR E-PRESCRIBING/PROVIDER ACCESS TO PRESCRIPTION MONITORING PROGRAM

I certify that I have read and fully understand the following statements and agree that:
1. Electronic Prescriptions (e-Prescribing): VACNS uses e-Prescribing for my prescriptions. The use of e-Prescribing means that VACNS's healthcare providers will electronically transmit prescriptions to the pharmacy of my choice and review my pharmacy benefit information and pharmacy prescription history. This authorization shall continue as long as I am a VACNS patient or until I withdraw the authorization in writing.

2. Access to Virginia Prescription Monitoring Program: I understand and agree with prescribing healthcare providers at VACNS to access the information contained in the Virginia Prescription Monitoring Program files on Schedule II, III, and IV prescriptions dispensed to me.

FINANCIAL RESPONSIBILITY AND COLLECTION PRACTICES

In consideration of the healthcare services provided, or to be provided, by VACNS to me, my spouse, my child, or my dependent (collectively "I" or "Patient").

1. Financial Responsibility: (i) I accept full financial responsibility for healthcare services provided to the Patient by VACNS; **(ii)** this financial responsibility includes, without limitation, co-insurance, deductibles, and payment for services that are not any health insurance plan, government agency, workers' compensation, employment-based health plan, liability plan or policy, healthcare sharing ministry, any other party payment source, or responsible third-party. I understand that if my coverage non-contracted source does not remit payment consistent with a purported contract or agreement, I may be responsible for all amounts up to the total billed charges for each instance of care, and **(iii)** VACNS will not make a claim for payment that is more than the total charges of the care or services provided.

2. Assignment of Benefits/claims: I assign to VACNS and its agents, representatives, business associates, and/or delegees all of my benefits and interests in the recovery of any type whatsoever receivable by me or on my behalf arising out of any policy or plan of insurance, fund, healthcare sharing ministry, or any other entity otherwise provided benefits, coverage, or monies of any type to me (or any third party responsible for me) for the full charges rendered for the services provided to me by VACNS; this assignment is further inclusive of coverage through a state or federal program, all forms of liability-based coverage including but not limited to general liability, personal injury, automobile liability including uninsured/underinsured motorist coverage or med-pay, workers' compensation, or any other plan or policy, fund, or trust for medical benefits or coverage of medical expenses stemming from my employment of my spouse, parent, or guardian, inclusive of self-funded employer group plans, MEWA collective, union or any other employment related entity or association (collectively all forms of coverage listed in this section or any other benefit or monies not listed for the benefit of coverage of medical expenses may hereinafter be referred to as "coverage source").

3. Directed Payment: I expressly authorize directed payment of any benefit(s) or monies to be made directly to VACNS on my behalf for any and all services furnished to me as a patient, including payment for physician services, from any coverage source, inclusive of monies or benefits related to a settlement, judgment, or lien related to healthcare services, inclusive of payment for services related to the injury. I understand and agree

that if payment is directly made to the Patient by any coverage source or third party, it is my obligation to submit that payment to VACNS within fourteen (14) days from receipt of payment using a cashier's check or personal check made payable to Virginia Child Neurology Specialists and sent to 5102 West Village Green Drive, Suite 109, Midlothian, VA, 23112. Please include your full name on the payment.

4. Designation of Authorization Representation and Agent: I authorize and designate
VACNS, its affiliates, assignees, and third-party entities are subject to a Business Associate Agreement with as my Authorized Representative and Designated Agent in all matters arising under a claim for benefits from any coverage source(s) or from any other liable party or entity for any and all medical care provided to me and for all related expenses incurred. I direct and authorize that VACNS use a copy of this assignment and authorization rather than the original.

5. Rights of Authorized Representative, Agent, and Assignee: I hereby ascribe to
VACNS all benefits, rights, and privileges available by and between me and any coverage source or liable party, as well as all rights, remedies, and privileges afforded to me under state and/or federal law, including but not limited to the ability to pursue and dispute any form of adverse determination or denial related to or arising from the medical care, provided to me by VACNS at any stage during my medical care inclusive of physician services, be it before care is rendered (“pre-service”), during any admission (“concurrent”), or after any or all medical care has been provided to me (“post-service”). To the fullest extent permissible by law, this shall include but is not limited to:

(i) submission of claims, filing of any liens, rights to the filing or submission of reconsideration, grievance, appeal, external appeal, or request for review by any relevant source including but not limited to an independent review organization, other review board or entity as established by my plan or policy, or as authorized or directed under state or federal law including but not limited to through those remedies available through the Virginia State Corporation Commission's Bureau of Insurance or any other comparable state entity, or as required for any coverage source subject to the Employee Retirement Income Security Act (ERISA) or equivalent state law for coverage under any state or local government plan;

(ii) review by any state or federal agency, department, entity, committee, panel, or process formed through a state or federal agency or entity including but not limited to external review, review, or hearing before an attorney adjudicator, administrative law judge (inclusive of hearings which may be in person, telephonic, or via video streaming), State Fair Hearing, or any other hearing or review of appeal or dispute as permitted or directed by the Medicare Appeals (OMHA); review by any state Medicaid program (inclusive of review through any Managed Medicaid plan and/or review and remedies available through the state), the Department of Veterans Affairs or other such entity providing healthcare benefits for active or retired military and/or spouse or dependent, or equivalent coverage offered for reserves, national or air guard inclusive of civilian employees and/or civilian employees who may be called to active duty; and

(iii) any and all legal claims related to the Patient’s medical care as against any coverage source or third party for monetary, equitable, injunctive, and/or declaratory remedies or relief, including but not limited to medication, arbitration, or the filing and pursuit of litigation against coverage source(s) or any liable party or entity in any proper court or jurisdiction including but not limited to state, federal, workers compensation, or admiralty court, as well as any quasi-judicial proceeding, including those where a coverage source or employing agency or entity may be named as a party and where I may be named as a plaintiff.

6. Consent to Direct Contact by VACNS: As my authorized representative and designated agent, I convey to VACNS and its employees the right to directly contact and communicate with my coverage source(s) and/or any liable party via any reasonable medium or instrumentality. If my coverage source is funded or provided through my employer, or the employer of my spouse, parent, or guardian, I expressly consent and authorize VACNS and its employees to directly contact an employer, union, or association that sponsors a plan as well as any union representative, board of trustees, patient advocacy unit, committee, or any other entity by or through my coverage source(s) for purpose of oversight or administration of benefits, determinations, payments, or

recoupments of payments. I further authorize VACNS to directly contact any third-party administrator, designated decision maker, pricer, claims processor, or adjudicator affiliated with or engaged by the plan, policy, fund, trust, employer, union, attorney, or any other affiliated entity of my coverage source(s) or liable third party.

7. Patient Acknowledgement of cooperation: (i) I understand and affirm my obligation to VACNS to assist in all reasonable requests in obtaining any and all documentation deemed necessary or required for VACNS to provide medical care as well for the submission, processing, or dispute of payment, denial, or adverse benefit determination related a claim submitted for services and care provided by VACNS. This includes, but is not limited to signing documents/forms upon request and in a timely manner, obtaining health records from previous healthcare providers, clinics, and/or hospitals.

(ii) I understand that although VACNS may assist me in doing so, I am solely responsible for compliance with the provisions of any coverage source, third-party administrator, payor, or party including verifying coverage and obtaining any required pre-admission certification/authorization or notification. I agree to cooperate fully with VACNS in billing my coverage source(s) or any other liable third party, including promptly responding to requests for information from VACNS or from any coverage source or a third party; and

8. Consent to Contact - **Telephone Consumer Protection Act: (i)** I expressly consent to receive on my cellular phone or other phone numbers that are listed on any of the forms completed related to my care now or in the future, text messages, telephone calls, voicemails, or other communications for any purpose related to my current or prospective medical care, current or upcoming services offered by an authorized called, or related to my account(s). I understand that these communications may be made using live, artificial, or pre-recorded voice messages, automatic telephone dialing systems, text message systems, e-mails, or any other computer-aided or assisted technologies,

(ii) I understand that these communications may come from VACNS or any of its third-party entities subject to a Business Associates Agreement, including but not limited to third-party billing agencies, account management companies, or contractors retained by VACNS;

(iii) I understand that data charges may apply and that this consent is not required in order to receive services or treatment from VACNS or its related entities or affiliates. I understand I may revoke this consent at any time;

(iv) I understand and agree that should any phone number or contact detail associated with my account(s) change, I must immediately contact VACNS and inform them of all changes by calling 804-322-7800 or submitting them via the patient portal. I understand that should I fail to immediately inform VACNS of any change, communication related to a Patient's account(s) may be sent to an incorrect contact number or address and result in delays that will likely adversely affect the patient.

ADVANCED DIRECTIVE

VACNS encourages all patients to complete Advance Care Planning documents ("ACP"), such as a living will, healthcare power of attorney, and Durable Do Not Resuscitate Order ("DNR"). ACP allows you to state your medical treatment preferences and select a person to make your health care decisions in case you are unable to do so.

___I understand and agree that I have been asked whether I have an ACP by initialing below.

Please select one of the applicable statements and then initial:

_____I have completed an ACP and have requested to supply a copy to VACNS.
_____ I have not completed an ACP. If I choose to complete an ACP I will contact appropriate legal counsel to do this.

Initial:_____

COORDINATION OF BENEFITS

1. Coordination of Benefits: I hereby certify and attest that the information provided regarding the ordering of responsibility and all other information provided regarding the coordination of benefits is accurate and current to the best of my knowledge. **I wish for all coverage sources (including any liability carrier) under which I may be a beneficiary to accept this attestation from my Third-Party Designees in place of independent completion of any coordination of benefits form**.

2. Subsequent Services: This authorization and designation includes any and all subsequent services rendered by VACNS.

Initial: _____

ACKNOWLEDGEMENT OF UNDERSTANDING

I, the undersigned, as a patient or the parent, guardian, spouse, or agent of the patient, hereby certify I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions that have been answered to my satisfaction.

I understand and agree that this document is valid and will remain in effect until the full and final settlement of my account including any and all disputes including those which occur post-payment.

Guarantor (other than patient): I understand that by signing below, I agree to accept personal financial responsibility for healthcare service by VACNS to the patient identified above.

Signature: _____

Relationship to patient: _____

Date: _____

ACKNOWLEDGMENT OF NOTICE OF NO SURPRISES ACT

I acknowledge that I have received and reviewed a copy of Virginia Child Neurology Specialists's No Surprises Act and Good Faith Estimate forms.

Patient Name: _____

Signature: _____ Date: _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

_____