Physicians Pavilion
2232 Wilborn Ave, Suite A
South Boston, VA 24592
(p) 434.572.8977

Consent To Treat

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Halifax Heart Center to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Halifax Heart Center of benefits otherwise payable to me. I hereby authorize release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original. Further, I acknowledge that if I am indebted for past due charges that I am financially responsible for those charges also.

I consent and authorize Halifax Heart Center to collect my personal medical information in order to obtain and maintain on file the information necessary to verify and process electronic prescriptions. The received information can include prescription insurance eligibility, prescription insurance claims history, and prescription insurance formulary files.

I consent and authorize Halifax Heart Center to transmit prescription information to the pharmacy of my choice through a third party intermediary operating under a business associate agreement with the electronic prescription software vendor.

I further consent to these options:	Publish Data to My Halifax Medical Record	YES	NO
	Transmit Data to Immunization Registry	YES	NO
	Receive Immunization Reminders from the Registry	YES	NO
	Should the Immunization Registry Protect Data	YES	NO
	Mail Order Prescriptions Preferred	YES	NO

Preferred Method of Contact: Mail/Letters Phone Call My Halifax Medical Record No Preference

MEDICARE PATIENTS: I authorize Halifax Heart Center to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Halifax Heart Center. In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any healthcare provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the Virginia Health Department and appropriate counseling will be offered. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Email Address: ______________________________

Patient's Signature (or responsible party) ______________________________

Date: ____________________

Revised January 2016