

WRITTEN ACKNOWLEDGEMENT

OUR NOTICE OF PRIVACY PRACTICES provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

- I have **received** a copy of Colonial Orthopaedics NOTICE OF PRIVACY PRACTICES and the NOTICE OF PATIENT'S RIGHTS AND RESPONSIBILITIES.
- I have declined a copy of Colonial Orthopaedics NOTICE OF PRIVACY PRACTICES and the NOTICE OF PATIENT'S RIGHTS AND RESPONSIBILITIES.

I understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices or the Notice of Patient's Rights and Responsibilities.

Patient's Signature _____ Date _____

Authorized Patient Representative _____ Date _____

Relationship to Patient _____

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if Colonial Orthopaedics health care provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed health care provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

Patient's Signature _____ Date _____

Witness Date _____ Date _____

PRESCRIPTION REFILL POLICY

1. To request a prescription refill, please call us Monday through Friday, from 9:00 a.m. to 4:00 p.m.
2. Please allow 24 hours for us to process your prescription refill request.
3. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

ADDENDUM Office Policy for Payment of Accounts

Colonial Orthopaedics encourages all patients to make timely payments to keep their account balance in good standing. If you experience financial difficulty, we encourage you to speak with one of our account representatives within the billing department and we will assist you in establishing a payment plan.

Should your account remain unpaid after two months, Colonial Orthopaedics will continue your care for that particular problem but will not be able to schedule any appointment for a new problem until the account is paid in full.

I have read and understand the above.

Patient Name

Patient Signature

Patient Account Number

Date