The Chronic Pelvic Pain Center of Northern Virginia

8100 Boone Blvd | Suite 710 |Tysons Corner, VA 22182 | Phone: 703.448.6070

Universal Consent

THE CHRONIC PELVIC PAIN CENTER OF NORTHERN VIRGINIA

Patient name: _____ DOB: _____ Date: _____

CONSENT FOR TREATMENT (Please initial) _____
I hereby consent to the administration and performance of all tests and treatments by members of the medical staff and personnel of The Chronic Pelvic Pain Center of Northern Virginia (CPPC), which, in the judgment of the physician(s) and/or nurse practitioner(s), may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. I authorize CPPC to request and receive information, including my medical record, from my treating physician(s), nurse practitioner(s), or agents. I also authorize CPPC to test my blood for hepatitis and/or the AIDS virus if, in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING (Please initial) _____
CPPC is required by *§ 32.1-45.1 of the Code of Virginia (1950)*, as amended, to give you the following notice:

1. If any CPPC health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, 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. Under Va. Code $ 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a CPPC health care professional or staff in a way that may transmit disease, that person's 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 and that person the result of the test.

MISSED APPOINTMENTS (Please initial) _____**Scheduled time with the provider is extremely valuable. If you find it necessary to cancel or reschedule your appointment, please contact our front office as soon as possible. For scheduled office visit appointments, we require at least 24 hours or a business day notice to avoid a cancellation fee of $150.00.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES (Please initial) _____
I acknowledge that I have received CPPC's Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by CPPC and informs me of my rights with respect to my protected health information. For more information, please contact the Patient Advocate Office at (703) 448-6070.

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I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME (PLEASE PRINT)	DATE

_____	_____	_____
PATIENT/LEGAL GUARDIAN SIGNATURE	PERSON GIVING CONSENT AND RELATIONSHIP TO PATIENT	WITNESS — CPPC EMPLOYEE

The patient, _____, is a minor, or is unable to sign above because: _____