MEDICAL SERVICES CONTRACT

I hereby authorize Health West, P.C./Rozana A. Itskovich, M.D., to render services to me and/or my child. I authorize payment directly to Health West, P.C. for the benefit otherwise payable to me under the terms of my insurance. Health West, P.C. may, but is not required to (with the exception of Medicare), file a claim with any and all policies of insurance. If the insurance company payment is not timely, I understand that it is my responsibility to pay any outstanding balance and pursue recovery of expenses with the insurance company. *I understand that I am financially responsible for all the charges arising for the medical diagnosis and treatment*.

I understand that health information in my and/or my child's medical record may be released in accordance with Health West, P.C. *Notice of Privacy Practices*, a copy of which has been provided to me.

I hereby grant Health West, P.C. an irrevocable lien on any and all Medpay insurance I may have or may otherwise be a beneficiary to. In the event that my (or my child's) illness or injury has arisen out of an occurrence for which a third party is, or may be, responsible, I hereby grant Health West, P.C. an irrevocable lien on any recovery against said third party in an amount equal to the total of all sums due plus contract interest and attorney fees if the bill has been turned over to an attorney for collection. I acknowledge that there has been no representation or agreement by Health West, P.C. that it will withhold collection against me pending settlement of such a claim.

If the physician determines that I need a medical supply such as medication, a brace or appliance to treat my problem, I understand that I have the option to obtain it from Health West, P.C. or from an outside supplier. If I choose to obtain the supply from Health West, P.C., a claim will be filed with my insurance company on my behalf. *If an insurance payment is not received within 30 days, I understand that I will be responsible for payment in full immediately.*

If this contract or any debt owed to Health West, P.C. is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees up to thirty-five percent (35%) of the total indebtedness and all court costs incurred by Health West, P.C. If this indebtedness is not paid in full within sixty (60) days, I agree to pay a service charge of one and one-half percent (l ½ %) per month, eighteen percent (18%) per annum.

Patient acknowledges that Doctor has determined that he/she is in the profession of providing quality medical care, not testifying as a witness in legal proceedings. Doctor has further determined that Patient and all of Doctor's other patients are best served by Doctor's express policy to decline, to the full extent permitted by law, to provide testimony as a witness in any type of legal proceedings. In the event that Doctor is compelled to testify he/she may, at his/her option, appear only as a witness to fact and, accordingly, interpret what is in the patient's records for the court. He/She, at his/her option may not wish to offer any expert opinion. Patient consents to and agrees to abide by this policy. Patient further acknowledges that in the event Doctor is compelled to testify in connection with any such legal process, patient agrees to be responsible for payment of the fee prior *to* the Doctor's testimony.

Date _____ 20___ Patient/Guarantor Signature _____

Health West, P.C.

Written Acknowledgment Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected' health 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, _____ (*please print patient name*)

have received a copy of the Health West, P.C. Notice of Privacy Practices.

I have had an-opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Health West, P.C. if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____ 200___
Patient Signature Date

_____ _____ _____ 200___
Authorized Representative of Patient Relationship to Patient Date

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NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A Virginia law was enacted in 1989 that allows Health Care providers to test their patients for HIV antibodies when a Health Care Worker is exposed to the body fluids of a patient in a way which may transmit human immunodeficiency virus (HIV), the virus which causes AIDS. Because of this law, in the event of such exposure, you will be deemed to have consented to such testing. Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies. The testing will be explained to you and you will be given the opportunity to ask any questions you might have.

You will be provided with the test results and appropriate counseling. These results, if positive, are required to be reported to the Virginia Department of Health

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing."

Patient's Signature (or responsible party) _____ Date _____20___