PLASTIC SURGERY CENTER OF VIRGINIA
817 Davis Street, Suite 2
Blacksburg, Virginia 24060
Phone: 540-951-8885 Fax: 540-951-8887

STATEMENT OF OFFICE POLICIES AND PROCEDURES

Please read this form in its entirety. Your signature below indicates your agreement to and acceptance of these policies. Should you have questions regarding this form, please ask a member of our office staff.

Dr. Philip Grubbs and his staff strive to provide the highest quality care and service to each patient. In order to achieve this, we need your assistance in the following:

1. If I am more than ten (10) minutes late for an appointment I realize it may be necessary to reschedule my appointment so other patients will not have to wait.

2. If I fail to give a 24 hour notice when cancelling an appointment, I realize I will be charged a $25.00 cancellation fee. This is considered a failed appointment. After two failed appointments I may be referred out to another physician. Dr. Grubbs and his staff will give consideration to unforeseen emergencies.

3. If I do not have health insurance, I realize I am responsible for paying my bill in its entirety on the day of service, unless prior arrangements are made. If I do have health insurance, I realize I am responsible for paying my copayment in its entirety on the day of service.

4. Your Social Security Number and date of birth are necessary to verify medical benefits and submit insurance claims for the purpose of receiving payment from your insurance company. The only other time this information is used is for the purpose of collecting any outstanding balance you may have. Virginia State Law requires we send social security numbers and procedure codes (CPT Codes) to the Virginia Department of Health for patients who undergo cosmetic procedures. Dr. Grubbs and his staff take pride in safeguarding this private information. Your personal information is held in the strictest of confidence and at no time, other than what is indicated in this section, will it be used.

5. If your insurance requires a referral or preauthorization, it is the responsibility of the patient to make sure this is in place prior to treatment being rendered.

RECEIPT OF NOTICE OF INFORMATION PRIVACY PRACTICES

I have received a Notice of Information Privacy Practices, understand its content and have had any questions answered my satisfaction.

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

Should an employee or patient be exposed to blood/body fluid in a way that might allow transmission of infection due to blood borne disease (HIV, Hepatitis B) or other communicable diseases, then I understand that according to Virginia State Law for the safety, health and possible treatment of myself or our employee, samples of blood or body fluid may be tested for evidence of infection.

I also understand that PLASTIC SURGERY CENTER OF VIRGINIA employees and physician(s) are obligated to submit to blood tests for certain infectious diseases (HIV Hepatitis B) if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the hospital or office.

I have read, understood and agree to the above policies and procedures.

_____ _____
Signature of Patient or Patient's Representative DATE

_____ _____
PRINTED NAME CHART NUMBER