



1. CONSENT FOR SERVICE

I acknowledge my attending physician is responsible for directing my care and has advised me of the need for services such as nursing care, diagnostic tests, anesthesia, medical or surgical treatments, disposal of removed tissue, services for any newborn if appropriate, and any other necessary medical service. By signing below I give my consent to all such services instructed by my attending physician, his/her assistants or designees. I understand my physician may order an operation or procedure, and give my consent after receiving adequate advice as to the benefits and risks of such operation or procedure. In the event a healthcare worker is exposed to my blood or body fluid in a manner posing a risk for transmission of a blood-borne infection, I give my consent to be tested for infections such as HIV, Hepatitis B and Hepatitis C at no cost to me, so the healthcare worker may be treated promptly. In such situations, I authorize release of applicable information to the healthcare worker and his/her healthcare provider.

2. USE AND DISCLOSURE OF INFORMATION

I have received and read the "Notice of Privacy Practices" and authorize Providence Health and Services (PH&S) to use and disclose information about me and my health to diagnose and treat me, to obtain payment for my care and for PH&S business operations.

3. PH&S TEACHING FACILITIES

I acknowledge PH&S has teaching facilities, and consent to supervised residents and students being involved with my care. I acknowledge I may refuse care by a resident or student at any time, and that such refusal will not result in any reduction of the quality of care provided.

4. NURSING CARE

I acknowledge PH&S offsite hospital facilities do not provide general duty nursing care and release PH&S from all liability for special duty services that may be arranged by me/my legal representative.

5. HEALTH PLAN OBLIGATION

I acknowledge I am individually obligated to pay the full charges of all services rendered to me by PH&S if I belong to a health plan that does not have a contract with PH&S at the time services are provided.

6. ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

Medicare / Medicaid and Other Government Programs: I authorize PH&S to receive direct payments for any benefits to which I may be eligible under Medicare, Medicaid or any other government program, and authorize PH&S to release relevant information about me and my healthcare necessary to receive payment under the applicable government program(s). I understand and accept my responsibility to pay any deductible and/or co-insurance under such program(s).

Medicare Notice: I understand I may receive a bill from PH&S for self-administered drugs not covered by Medicare Part A, B and C, and may request an itemized statement containing the national drug codes necessary for me to bill my Part D carrier.

Insurance / Coverage: I hereby assign to PH&S all insurance company or other healthcare coverage benefits to which I am entitled for services rendered by PH&S, and authorize PH&S to release relevant information about me and my healthcare to receive such payment. I understand and accept I am responsible for paying any co-payments and/or deductibles required under my insurance plan(s).

7. RIGHT TO REVOKE CONSENT

I acknowledge I have the right to revoke consent to treatment at any time effective immediately, and may also revoke authorization for the release of information about me and my healthcare to relevant government programs and insurance company(s). I understand and accept such revocation must be in writing and is effective only when it is received by the Medical Record Department at PH&S. I understand and accept if my revocation results in denial of payment to PH&S, I am responsible to pay for the care provided by PH&S.

8. FINANCIAL ASSISTANCE AT PROVIDENCE

In keeping with our mission and core values, Providence Health & Services cares for people and their health needs regardless of their ability to pay. We are committed to working with our patients through any financial issues, including finding ways to make medical care more affordable. Providence's hospitals offer financial assistance to eligible patients who do not have the financial ability to pay for their medical bills. If you are having trouble paying for all or some of your health care, we encourage you to talk with a Providence Financial Counselor or someone in our business office about how we can help you.

What Is Covered? For emergency and medically necessary services at Providence hospitals we provide financial assistance to eligible patients on a sliding fee scale basis, with discounts ranging from 30 to 100% based on ability to pay. Financial assistance for other services or at our non-hospital facilities is governed by the policies of the Providence entity providing the care.

How to Apply? Any patient may apply to receive financial assistance. A patient seeking financial assistance must provide supporting documentation specified in the application, unless Providence indicates otherwise. The application form may be obtained online, by telephone, or from the website or email address noted below.

Other Assistance:

Coverage assistance: If you are without health insurance, you may be eligible for other government and community programs. We can help you discover whether these programs (including Medicaid and Veterans Affairs benefits) can help cover your medical bills. We also can help you apply for these programs.

Uninsured Discounts: Providence offers a discount for patients who may not have health insurance coverage. Please contact us about our discount program.

Payment plans: After your insurance company processes the bill, any balance for amounts owed by you is due within thirty days. The balance can be paid in any of the following ways: automatic credit card, payment plan, cash, check, online bill pay or credit card. If you need a payment plan, please call the number on your billing statement to make arrangements.

Emergency Care: Providence hospitals with dedicated emergency departments provide care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Contact Us for Financial Assistance Help or Applications

For more information about getting help with your Providence medical bills, please call or visit a financial counselor or billing office at your local Providence facility. We can give you any forms you need and can help you apply for assistance. Patients are strongly encouraged to ask for financial help before receiving medical treatment, if possible. Patients can also apply at any time while receiving treatment and for a period of time following receipt of your initial bill.

If you have questions or would like to receive a financial assistance application form, please contact below:

By telephone: 1-866-747-2455

By Email: CustomerService@Providence.Org

On our website at: www.providence.org

9. FINANCIAL RESPONSIBILITY

I understand and accept: PH&S will bill the Charge Master rates in effect when services are provided; I may request a price estimate for such services; I agree to pay for such services; and I acknowledge and accept my personal responsibility for payment in full for billed charges even where PH&S has been assigned benefits from government programs and insurance companies. I acknowledge failure to meet my financial obligations to PH&S will result in the referral of account(s) to professional collection agencies and consent to PH&S or its designees obtaining a copy of my credit report or any other publicly available data related to my ability to pay. I understand and agree that PH&S, its affiliates, agents or designees may contact me using pre-recorded/artificial voice messages and/or automatic dialing services at any telephone number I provide to PH&S. If I have provided a cellular telephone number as a contact number or email address as a contact, I hereby authorize Providence, along with its employees, agents, and business associates, to contact me

via cellular phone, text message or email to communicate billing and payment information. I also understand I may revoke my consent to receive billing and payment communications in this manner by visiting pay.providence.org and opting out, or by calling 866-747-2455. In the event of any dispute regarding payment, I agree to pay all collection costs including but not limited to interest and attorneys' fees whether or not a case is filed in court. I understand I may receive separate bills from PH&S and/or from treating physicians such as radiologists, pathologists, anesthesiologists and emergency room physicians, and accept my responsibility to pay these in accordance with the payment terms set by those providers. If I am entitled to any personal injury settlement, judgment or other payment I agree to take any and all actions to assign or have paid to PH&S balances owed by me.

10. PERSONAL BELONGINGS AND VALUABLES

I agree that PH&S is not responsible for my personal belongings and valuables brought into a PH&S facility and agree to send such items home with my family or other responsible party if possible. I accept full responsibility and hold PH&S harmless for any loss, theft or damage for personal belongings or valuables retained at a PH&S facility.

11. SAFE ENVIRONMENT

I acknowledge that weapons or other dangerous objects, illegal drugs and medications not prescribed by my healthcare provider are not permitted on PH&S premises, and accept the rights of PH&S to search individuals and rooms upon reasonable cause and to confiscate any such items.

12. PHOTOGRAPHS

I agree to allow PH&S to take, reproduce and use photos, video tape, video monitoring / recording, or audio recording for the purpose of diagnosis, testing, medical evaluation, care or treatment (including invasive procedures), patient safety or medical education, and to preserve clinical information. I understand that this material may be treated as a part of my medical record and that PH&S privacy policies apply.

13. PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received and read the "Patient Rights and Responsibilities" notice provided by PH&S.

14. NONDISCRIMINATION POLICY

I acknowledge PH&S prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Notice of Nondiscrimination and Accessibility Rights

Providence Health & Services and its Affiliates (collectively "Providence") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Providence:

- (1) Provides free aids and services to people with disabilities to communicate effectively with us, such as: (a) Qualified sign language interpreters; and (b) Written information in other formats (large print, audio, accessible electronic formats, other formats).
- (2) Provides free language services to people whose primary language is not English, such as: (a) Qualified interpreters; and (b) Information written in other languages.

If you need any of the above services, please contact the appropriate Civil Rights Coordinator below. If you need Telecommunications Relay Services, please call 1-800-833-6384 or 7-1-1. If you believe that Providence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Providence by contacting the Civil Rights Coordinator for your state as listed below:

State/Service	Civil Rights Coordinator
Alaska	Civil Rights Coordinator, 3200 Providence Dr., Anchorage, AK 99508, Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.AK@providence.org
California	Civil Rights Coordinator, 501 S. Buena Vista Street, Burbank, CA 91505; Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.CA@providence.org
Montana	Civil Rights Coordinator, 1801 Lind Ave. SW, Renton, WA 98057; Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.MT@providence.org
Washington	Civil Rights Coordinator, 101 W. 8th Ave., Spokane, WA 99204; Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.WA@providence.org
Oregon	Civil Rights Coordinator, 5933 Win Sivers Dr, Suite 109, Portland, OR 97220; Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.OR@providence.org
Senior Services (all states)	Civil Rights Coordinator, 2811 S. 102nd Street, Suite 220, Tukwila, WA 98168, Tel: 1-844-469-1775; Interpreter Line: 1-888-311-9127; Email: Nondiscrimination.pscs@providence.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, one of the above-noted Civil Rights Coordinators is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電888-311-9127 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho bạn. Gọi số 888-311-9127 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-311-9127 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-311-9127 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-311-9127 (телетайп: 711).

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ կարող են տրամադրվել լեզվական աջակցության անվճար ծառայություններ: Ձանգահարեք 888-311-9127 (հեռատիպ (TTY)՝ 711).

يرجى الانتباه: إذا كنتم تتكلمون اللغة العربية، فأعلموا أن خدمات المساعدة اللغوية متوفرة مجاناً لكم. اتصلوا برقم الهاتف 1-888-311-9127 (أو بخط المبرقة الكاتبة TTY لضعاف السمع والنطق على الرقم 711).

توجه: اگر بہ زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 888-311-9127 تماس بگیرید. (TTY:711)

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。888-311-9127 (TTY:711)まで、お電話にてご連絡ください。

ਧਿਆਨ ਖਿਓਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਿਓ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਖਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-311-9127

(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

სუ ოცნაომაგამომ: მისთვის სერვისების მიწოდება

ინგლისურ ენაზე ოცნაომაგამომისთვის სერვისების მიწოდება 888-311-9127 (TTY: 711) ოცნაომაგამომ

ध्यान द: यदि आप हिंदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध 888-311-9127 (TTY: 711)

है।

पर कॉल कर।

LUS CEEV: Yog tias koj hais lus Hmoob, koj tuaj yeem siv cov kev pab txhais lus pub dawb. Hu rau 888-311-9127 (TTY: 711).

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการความช่วยเหลือทางภาษาได้โดยไม่มีค่าใช้จ่าย โทร 888-311-9127 (TTY: 711)

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY STATEMENT

By signing this document I certify I am of lawful age and legally competent. I accept and agree to be legally bound by the terms and conditions contained herein.

Signature of Patient

Date/Time of Signature

Signature of Patient Representative / Agent

Relationship to Patient

PH&S Representative present when consent for service document executed

Note: If patient is unable to sign, indicate reason(s) for inability to sign

Name of interpreter *(if used to explain document to patient)*

Relationship to Patient



Patient
Identification:

Align Patient ID Here