AUTHORIZATION FOR

TREATMENT / FINANCIAL RESPONSIBILTY STATEMENT

Patient Name:

Patient Date of Birth:

AUTHORIZATION FOR TREATMENT: I authorize the Physician(s) or his/her designee(s), in charge of my or the patient's (named above) care to administer any treatment including medication(s) or vaccine(s) as deemed necessary or advisable in the diagnosis and treatment of any conditions related to me or the patient. This authorization is valid and in effect until such time I withdraw it in writing or in person.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS

MEDICARE / MEDICAID AND OTHER GOVERNMENT PROGRAMS: If I qualify for benefits under Medicare, Medicaid or any other government program, I authorize these program(s) to make payment directly to Providence for my care. I also authorize Providence to release all relevant information about me and my health care necessary to receive payment to the applicable government program(s). I am responsible to pay deductible and/or co-insurance under such program(s).

INSURANCE: If I qualify for benefits from any insurance company(s), I assign those benefits to Providence to pay for care provided. I also authorize Providence to release all relevant information about me and my health care to the company(s) necessary to receive payment. I am responsible to pay any co-payments and/or deductible required under your insurance plan (s).

PAYMENT TERMS: Providence has agreed to accept assignment of benefits from governmental health care programs and certain insurance companies. I remain personally responsible for payment in full for billed charges, unless otherwise required by law.

EXPRESS CARE CLINIC LOCATIONS: Providence Express Care services are set at a basic low rate. Providence's usual discount policy does not apply to Express Care services.

FINANCIAL ASSISTANCE: If I am unable to meet the financial requirements for the services rendered, I am aware that I may apply for financial assistance or establish a payment plan by contacting a Providence financial representative.

RIGHT TO REVOKE AUTHORIZATION: I have the right to cancel my assignment or my authorization for Providence to release information about me and my health to government programs and insurance company(s). My revocation must be in writing and will be effective when it is received by Providence.

USE AND DISCLOSURE OF INFORMATION: The manner in which Providence Physician Services may use information about me is explained in the "Notice of Privacy Practices."

FINANCIAL RESPONSIBILITY STATEMENT: I accept financial responsibility for all treatment provided. The balance is due 30 days from the date of billing. If I need financial assistance or wish to establish a payment plan I can contact a Providence Health & Services financial representative, Should this account be assigned to an attorney or collection agency, I will be obligated to pay associated costs. I request direct payment of benefits to Providence Health & Services for any clinical services rendered.

- I understand Providence Health & Services will make inquiries regarding insurance coverage and my financial responsibility from third party payors or financial references. In addition, I approve these payors and/or references to release information to Providence Health & Services.
- I understand 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, sexual orientation or gender identity.
- I have read, or have had explained to me, the above Authorization for Treatment and Financial Responsibility Statement. I understand the contents and by signing; I agree to be legally bound by this document.
- By signing this document via electronic signature pad, I certify that I am of lawful age and legally competent to consent.

Patient/Personal Representative Signature:

Physician Authorization for Treatment