3100

PROVIDENCE
Health & Services

CONSENT FOR SERVICES
ENGLISH VERSION

PATIENT IMPRINT

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: I consent to assign to PH&S all insurance company 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 75 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.

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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 **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 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. In the event of any dispute regarding payment, I agree to pay all collection costs 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.

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