



AUTHORIZATION FOR TREATMENT / FINANCIAL RESPONSIBILITY STATEMENT

Patient Name:

Patient Date of Birth:

AUTHORIZATION FOR TREATMENT: I authorize the Provider(s) or their designee(s), in charge of my or the patient's 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. I authorize the Physician(s) or their designee(s), in charge of my or the patient's care to use communications technology-based services ("CTBS") for treatment and billing of care or consultation with other professionals about the care of 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 for paying 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 for paying any co-payments and/or deductible required under your insurance plan(s). I understand, to check with my insurance to confirm my coverage and anticipated out-of-pocket costs.

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 of 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.

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

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 way Providence Physician Services may use information about me is explained in the "Notice of Privacy Practices."

PHOTOGRAPHS: I agree to allow Providence 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 Providence privacy policies apply.

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 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 for any clinical services rendered.

- I understand Providence 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.
- I understand Providence (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.

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

Patient/Personal Representative Signature:

By signing this document via electronic signature pad, I certify that I am of lawful age and legally competent to consent to this authorization for treatment.

Signature of Patient

Date of Signature

Signature of Patient Representative / Agent

Relationship to Patient

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

Relationship to Patient