Regional Health

Consent to Treatment and Financial Responsibility Agreement

Patient Last Name: ______________________

First Name: ______________________

Date of Birth: ______________________

Patient MRN#: ______________________

1. **Consent for Medical Care.** The Undersigned, whether as patient or as agent, consents to the following:
   a. All initiation of care, consultation, treatment, and procedures to be performed (including emergency treatment or services). The treatment and procedures may include, but are not limited to, laboratory tests, x-ray examinations, injections, medical or surgical treatments or procedures, anesthesia, or other services rendered under the general and special instructions of the patient's provider.
   b. Testing for HIV antibody (AIDS), hepatitis, or bloodborne pathogen should the healthcare worker have an exposure to the patient's blood or other body fluids.
   c. The disposal of any body parts or tissues removed according to Regional Health policy, including the use of de-identified specimens for research purposes.
   d. Transfer and transportation to another facility for further care as instructed by the patient's provider.
   e. Allow the patient's prescription medication history to be obtained from external electronic sources.
2. **General Risks.** The Undersigned, whether as patient or as agent, understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. No guarantees can or have been made regarding the results of examination, procedures, or treatment.
3. **Release of Information.** The Undersigned, whether as patient or as agent, authorizes the following:
   a. Regional Health may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable to pay for all or a portion of the charges. Regional Health's authority shall include but is not limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits by telephone at the time of appointment check-in or during or after the appointment. The entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organizations, worker's compensation carriers, or government or other payors or their agents, such as utilization review, rehabilitation, or auditing agencies.
   b. Release of clinical information to providers and facilities for the purpose of continued health care. The patient or agent understands that healthcare providers participate in Regional Health's Connect Program, and that patient data will be stored in a shared community electronic record. This clinical data may be shared with Regional Health, its affiliates, and other healthcare providers whom are associated with the patient's medical care.
   c. Gives consent to Regional Health and its respective subsidiaries, affiliates, and vendors, to contact the Undersigned at the number provided using any means of communication, including, but not limited to, calls placed to a cellular phone using an automated dialing device and calls using prerecorded messages and/or SMS text messages, regarding any current or future accounts, outstanding balances, or payments owed to Regional Health or its respective subsidiaries and affiliates even if the Undersigned will be charged by his or her service provider(s) for receiving such communications. The Undersigned understands he or she will be provided the option to update communication preferences during the servicing of accounts and will notify Regional Health if he or she wishes to revoke this method of notification.
4. **Notice of Privacy Practices.** The Undersigned, whether as patient or as agent, acknowledges that the law requires that Regional Health maintain the privacy of the patient's Protected Health Information and that Regional Health provide a notice of legal duties and privacy policies with respect to protected health information. By signing below, the Undersigned acknowledges that he or she has received a copy of our Notice of Privacy Practices.
5. **Patient Portion Due at Time of Service.** The Undersigned, whether as patient or as agent, acknowledges all co-payments must be paid at time of service. This arrangement is part of the patient's contract with his or her insurance company. For procedures, the Undersigned will be asked to pay a co-insurance and deductible. Upon request, an estimate of services will be given prior to the service being performed.
6. **Insurance and Claims Submission.** The Undersigned, whether as patient or as agent, understands Regional Health will submit insurance claims to most insurance companies; however, if Regional Health does not participate with the patient's insurance plan, it will be the responsibility of the Undersigned to pay-in-full at time of service. The Undersigned should be aware that some or all of the services may be non-covered by insurers, and many insurance companies require pre-authorization for various procedures. Regional Health will assist in obtaining the necessary pre-authorizations when needed; however, it is the responsibility of the Undersigned to determine if the patient's insurance company requires one. Failure to obtain the necessary pre-authorization or second opinion may result in a reduction or denial of benefits by the insurance company, which would result in the requirement of the Undersigned to pay the full amount due. For employer-requested services, Regional Health will confirm pre-authorization and guarantee of payment prior to the service being rendered.
7. **Assignment of Insurance Benefits.** If the patient's care is covered by insurance, the Undersigned agrees the insurance company is to pay Regional Health directly for the patient's care. Additionally, certain physicians (e.g., anesthesiologists, oncologists, pathologists, and radiologists) may participate in the patient's care at the clinic. These physicians are not employees or agents of Regional Health, and they will bill separately for their care. The person signing this form, whether he or she is the patient or signing for the patient, authorizes direct payment to Regional Health and/or the physicians of any insurance benefits, settlements, or awards otherwise payable for this outpatient service (including emergency services if rendered) at a rate not to exceed the respective charges of Regional Health and/or the physicians. The Undersigned understands he or she is financially-responsible for charges not paid by insurance or any other third-party payor.

Consent to Treatment and Financial Responsibility Agreement

8. **Promise to Pay Account.** The Undersigned agrees that he or she will pay for the care the patient receives. The person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the account charges in accordance with the rates and polices of Regional Health. If the patient is uninsured or has a large deductible, payment arrangements can be made with a Regional Health Patient Financial Counselor. The Undersigned also agrees that Regional Health may assess interest on any unpaid balance at a rate not to exceed the maximum statutory amount per year.

9. **Guarantee of Account.** The Undersigned understands that Regional Health must be paid for the care the patient receives. The Undersigned may expect that someone else is going to pay for the patient's care, as there may be insurance coverage, or the patient may have been injured due to some else's negligence, or there may be other circumstances; however, the Undersigned agrees to be personally-responsible for paying for the care received. Even if the Undersigned believes another party is obligated to pay for the care, he or she still agrees to personally guarantee Regional Health will be paid for the care the patient receives. Therefore, the person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the charges in accordance with the rates and policies of Regional Health. He or she agrees that Regional Health may assess interest on any unpaid balance at a rate not to exceed the maximum statutory allowable interest rate per year.

10. **Minor Patients.** The Undersigned understands that the parent or guardian accompanying a minor is responsible for payment regardless of legal arrangements. An unaccompanied minor will not be seen without a minor consent form signed by the parent or guardian, and the minor must bring his or her co-payment or patient portion due at the time of service.

Patient, Parent, Guardian, Agent Name: (Signature): ______________________ Date: __________ Time: __________

Patient Name: (PRINT) ______________________

If other than the patient,
indicate your relationship to the patient and print your name: ______________________

Witness (1) Name PRINT and SIGN: ______________________ Date: __________ Time: __________

Witness (2) Name PRINT and SIGN: ______________________ Date: __________ Time: __________

(2 witnesses needed for emergent situations in the ED or verbal consents only)