SKAGIT REGIONAL HEALTH
SKAGIT VALLEY HOSPITAL
SKAGIT REGIONAL CLINICS
CASCADE SKAGIT HEALTH ALLIANCE

CONSENT FOR TREATMENT

The undersigned hereby consents for treatment such as x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, or Hospital services as may be rendered to, or for the benefit of the patient under the general and special instructions of the patient's doctor or doctors, their assignees or designees.

I understand that my care is under the control of my attending physicians, and that some doctors and dentists furnishing services to me, including, but not limited to, the radiologist, pathologist, anesthesiologist, and emergency room physicians are independent contractors and are not employees or agents of the Hospital.

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made to me as to the result of treatment, services, or examination in the Hospital.

CONTINUING MEDICAL EDUCATION: I understand that Skagit Valley Hospital allows students of various health care specialties to observe and/or participate in the care provided for its patients. I understand that this may include surgical procedures, x-ray procedures, examinations of tissue, photography, and other aspects of my care. I further understand that at all times these activities will be performed under the supervision and with the approval of my health care provider at a level deemed appropriate by them. I consent to the observation and participation of health care students in the medical care provided for me while I am a patient at Skagit Valley Hospital.

NOTICE: We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at our medical records department. (You may be charged for copies of medical records.)

PERSONAL VALUABLES: It is understood that the Hospital shall not be liable for the loss or damage of patient valuables unless placed in the care of the Hospital for safe keeping.

CONSENT TO RELEASE INFORMATION: "I hereby authorize and direct Skagit Valley Hospital to disclose all or any part of my medical record to any company or agency that may be responsible for payment of all or part of my hospital charges, including my insurance company, third party payer, employer, or managed care program, Medical/Medicaid program administrators, as may be necessary to determine benefits entitlement, continued stay review, case management and to obtain reimbursement for healthcare services provided to me. I understand that the information released may include records in these subject areas: HIV/AIDS; sexually transmitted disease; mental health problems/mental health treatment; and drug or alcohol abuse problems/treatment. I hereby release Skagit Valley Hospital from all legal responsibility or liability that may arise from the disclosure of any part or all of my medical record as provided in this paragraph." Certain conditions such as, HIV, tuberculosis, viral meningitis and other diseases must be reported to the Health Department.

FINANCIAL AGREEMENT: The undersigned agrees, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individual obligates himself/herself, and if married obligates his/her marital community, to pay the account of the Hospital in accordance with its regular rates and terms. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorneys' fees and collection expenses. All delinquent accounts bear interest at the rate of 1 % per month (12 % per annum). The undersigned further hereby authorizes Hospital to make inquiry to those parties he/she has identified for reference purposes to confirm patient's insurance coverage and/or financial responsibility and capacity to pay any charges which may accrue on behalf of the patient.

Billing provided by the radiologist, oncologist, pathologist, anesthesiologist, psychiatrist, therapist, or psychologist I understand that I will be billed separately by their respective office or billing agent. I also understand that my insurance carrier may provide separate and different benefit consideration for the above services than for those services billed by Skagit Valley Hospital.

You are hereby authorized to contact me at any telephone numbers, including pagers and cell phone numbers provided by me, or otherwise obtained by you, using an automatic telephone dialing system and to leave prerecorded messages on these devices.

FINANCIAL ASSISTANCE: Skagit Valley Hospital provides charity care. Charges for persons meeting medical indigence criteria as outlined in WAC 261-14-017 may be waived or reduced. Please contact the Financial Counselor at: (360) 814-2287 for more information.

FOR MEDICARE PATIENTS ONLY: The undersigned certifies that the information given by him/her in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes Skagit Valley Hospital and its medical staff to release to Social Security Administration or its intermediary, any and all information needed for this or a related Medicare claim, and requests that payment of authorized unpaid charges for certain in Hospital physician's services for whom the Hospital is authorized to bill. The undersigned understands that he/she is responsible for any health insurance deductibles and coinsurance.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to Hospital benefits of any type whatsoever arising out of any policy insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to Skagit Valley Hospital for application on patient's bill, and it is agreed that the Hospital may receipt for any such payment, and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, leaving the undersigned and/or patient being- responsible for charges not covered by this assignment.

IMMUNIZATIONS: Immunization(s) will be offered if indicated. Screening cultures for MRSA (Methicillin Resistant Staphylococcus Aureus) will be obtained if admitted to the critical care unit.

CERTIFICATION BY RESPONSIBLE PARTY: The undersigned certifies that he/she has read and understands the foregoing, has received a copy thereof, and is the Patient, or is duly authorized as the patient's legal agent to execute the above and accept its terms.

Witness _____ Patient _____

Date: _____ Other Responsible Person _____

Time: _____ Relationship, and why signing for patient _____

S3544
03/29/2012

CONSENT FOR TREATMENT