



CONDITIONS OF PATIENT REGISTRATION

MEDICAL CONSENT

- I consent to the provision of health care services at Legacy and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, medical and surgical treatment and related anesthesia. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- I acknowledge that the health care provider(s) treating me may be independent contractors, not employed by Legacy. I specifically acknowledge and understand that the physicians providing care to me, including but not limited to any radiologists, anesthesiologists, pathologists and emergency room physicians involved in my care are independent contractors and not agents or employees of Legacy. I understand such physicians are independent health care providers who have privileges at this hospital.
- If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider(s) during each visit.
- I understand if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required.
- I understand Legacy is a teaching institution and I consent to residents and students being involved with my care. I understand these caregivers are under the supervision of qualified health care instructors and/or hospital personnel at all times. I understand that I will be informed whenever possible of the resident or student status of specific caregivers.
- I understand and agree that genetic information received or created in the course of the delivery of health care at Legacy will be entered into the routine medical record and retained by Legacy.

RESPONSIBILITY FOR PERSONAL PROPERTY: I agree that Legacy is not responsible for my personal items brought into a Legacy facility. I agree to send my valuables home with my family or other responsible party if possible.

FINANCIAL AGREEMENT: I agree to pay for services rendered according to Legacy's rates and terms and the rates and terms of the physicians or organizations furnishing the services. I understand that I am responsible for charges not covered by my insurance or other agency, which may include a deductible and coinsurance. If insurance payment is not received after 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing. If this account is referred to an agency or attorney for collection, I agree to pay attorney's fees and costs as may be allowed by law, whether or not a lawsuit is filed.

In keeping with Legacy Health System's mission to create an environment of caring and an atmosphere of responsible service to the community, it is considered not only necessary but also appropriate to make adjustment to patient care charges under certain circumstances. I understand Legacy will provide a copy of its Financial Assistance (Charity Care) policy to me upon request. **If payment of a bill creates financial hardship**, patients may qualify for free or reduced charge services. Please contact Legacy Patient Business Services for additional information.

ASSIGNMENTS OF INSURANCE BENEFITS: I authorize payment directly to Legacy and/or health care provider(s) of all insurance or health plan benefits.

MEDICARE CERTIFICATION AND PAYMENT REQUEST: If I am applying for payment under Medicare or Medicaid, I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or organizations furnishing the services or authorize them to submit a claim to Medicare for payment for me.

FINANCIAL CERTIFICATION: I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing below.

I have read and fully understand the above information, have asked questions about anything not clear to me, and am satisfied with the answers I have received. I understand that I may revoke my consent or authorization at any time except to the extent that action has been taken in reliance on such consent or authorization.

PATIENT CONSENT AND ACKNOWLEDGEMENT

By initialing below, I (Patient or Authorized Consenter) hereby acknowledge receipt of the following notices:

_____ Patient Rights

_____ Important Message from Medicare

_____ What About My Bill?

In an emergent situation, the consent and notices will be provided as soon as reasonably practicable after the emergency treatment situation.

PATIENT'S SIGNATURE

PRINT PATIENT'S NAME

DATE

AUTHORIZED CONSENTER

Patient is unable to consent because: _____ . I therefore consent for the patient.

AUTHORIZED CONSENTER'S SIGNATURE

PRINT CONSENTER'S NAME

RELATIONSHIP TO PATIENT

DATE

LEGACY USE ONLY

Patient is unable to consent/acknowledge because: _____ .

Document good faith efforts made to obtain: _____ .

Legacy Employee Print Name _____ Date: _____