

# Conditions of Patient Registration Per Visit

## **Medical Consent**

Patient name: Med record #: Date of birth: *Complete information or attach patient label*.

275082

- I agree to the health care services provided by Legacy. I know that I have a say in the care I receive. I also know that I have a choice of where I receive my care if my doctor refers me for more services.
- I understand that I can refuse services at any time. If my doctors provide me medical care in good faith, I agree they should not be responsible if they did not know that I did not want to receive services.
- If a health care worker is exposed to my blood or body fluids in a way that poses 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 health care worker may be treated promptly. In such situations, I authorize release of applicable information to the health care worker and his/her health care provider.
- I acknowledge that the health care provider(s) treating me may be independent contractors, not employed by Legacy. I specifically acknowledge and understand that certain 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.
- I agree to allow Legacy 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 part of my medical record and that Legacy privacy policies apply.
- I understand that Legacy helps teach students in health care, and students may assist in my care. I also understand, I may refuse such care, and that my request will be considered on a case-by-case basis.
- I agree Legacy is not responsible for my personal belongings and valuables. I agree to send my personal belongings and valuables home with my family or friends.
- I understand that I have rights as a patient and that I will be treated with dignity and respect. I agree that Legacy has offered me a *Patient Rights and Responsibilities* brochure that has details about my rights.

#### INSURANCE AND CONSENT

- I agree to pay for any care I receive at Legacy. I understand that I may also be billed by other doctors and businesses who help in my care.
- I understand Legacy will try to bill my insurance and others who may pay for my care and that my insurance, including Medicare or Medicaid, should pay Legacy directly. If my insurance or other party does not pay, I understand I am responsible for my bill.
- I accept that Legacy may use a third party to assess my ability to pay for my care. This is called an "ability to pay assessment." If my bill is sent to collections, I understand that I may need to pay for all related costs.
- I understand that Legacy Health and contracted business entities may contact me by telephone or any electronic means associated with me, including wireless numbers. I understand that they may leave voicemail messages, text messages and email messages for me and include information allowed by law (including debt collection laws) regarding amounts owed by me or services provided to me. I also understand that prerecorded/artificial voice messages and/or auto-dialer services may be used for communications related to my account.

### PAYMENT ASSISTANCE

- I understand that if a bill for my care is too much for me to pay, Legacy has a financial assistance program that may help me. I can ask for information about this program at any time. I understand that I will need to give Legacy information to prove that I financially qualify for this program. I understand I can also arrange a payment plan.
- I can call customer service at 503-413-4048 or 1-800-495-7076 to learn more about both of these options.

#### PATIENT ACKNOWLEDGEMENT

- I have read and I understand the above information. I have asked questions about anything that is not clear to me, and I understand the answers that I was given. If I cannot read this form or ask questions because I am getting care for an emergency, I understand that I will be given the above information as soon as I am able to receive it.
- I promise that all information that I have given is correct. I have read and I agree to the terms of this form. I promise that I am the patient and accept the terms of this form, or that I am allowed to sign this form and accept the terms on behalf of the patient.

Signature of patient or representative	Relationship	Date
LEGACY USE ONLY Patient is unable to consent/acknowledge because:		
Legacy employee(s):		Date:
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