

## Conditions of Patient Registration Per Visit

Patient Name: Med Rec #: Date of Birth:

Complete information or attach patient label

## **Medical Consent**

- I consent to the provision of health care services at Legacy Health 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.
- Responsibility for Personal Property: I agree that Legacy Health 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 Health rates and terms and the rates and terms of the physicians or organizations furnishing the services. I understand Legacy will make inquiries regarding insurance coverage and my financial responsibility from third party payors and financial references. I consent to any related asset credit checks, including inquiries with any credit reporting agencies. 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'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.



Conditions of Patient Registration		Patient Name:
Assignments of Insurance Benefits: I au Legacy Health and/or health care provide		Med Rec #: Date of Birth:
plan benefits.	er(s) of all hisurance of health	Complete information or attach patient label
that payment of authorized benefits be n	nade on my behalf. I assign the k	nent under Medicare or Medicaid, I request penefits payable for physician services to the submit a claim to Medicare for payment for
<b>Financial Certification:</b> I certify the infor of the financial agreement. I certify that I accept its terms on behalf of the patient.	am the patient or am otherwise	authorized to execute this document and
	ived. I understand that I may rev	ctions about anything not clear to me, and voke my consent or authorization at any timent or authorization.
Pat	tient Consent and Acknowledg	ement
By initialing below, I (Patient or Authorize What About My Bill? Patient Rights It's OK to Ask	ed Consenter) hereby acknowled	lge receipt of the following notices:
In an emergent situation, the consent and emergency treatment situation.  Patient's Signature	d notices will be provided as soc 	on as reasonably practicable after the
Tatient 3 Signature	Butc	
Print Patient's Name		
	Authorized Consenter	
Patient is unable to consent because:		I therefore consent for the patie
Consenter Signature		
Print Consenter Name	Relationsh	nip to Patient
	Legacy Health Use Only	
Patient is unable to consent/acknowledge	e because:	
Document good faith efforts made to obt	tain:	
Legacy Employee Print Name Date:		
	Page 2 of 2	
275082 (7/13)	Medical Record	275082

275082 (7/13)