CONSENT TO TREATMENT, PROMISSORY NOTE, AND AUTHORIZATION TO PAY MEDICAL AND SURGICAL BENEFITS

The patient named below has been informed of the nature and purpose of their hospitalization, treatment, and procedures and is aware of the risk and medical complications that may occur. The patient understands and acknowledges that no guarantee or assurance has been made as to the result that may be obtained. The patient voluntarily consents to the hospitalization, care, treatment and procedures, including, but not limited to, anesthesia, x–ray procedures, blood tests, psychological and/or drug and alcohol related diagnoses and procedures, and laboratory tests as the attending physician(s) consider to be necessary.

USE AND DISCLOSE OF INFORMATION ABOUT THE PATIENT: Whitman Hospital and Medical Center (WHMC) will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law, and explained in the "Notice of Privacy Practices." You have the right to receive and review the "Notice of Privacy Practices" prior to signing this document.

FINANCIAL RESPONSIBILITY: The patient hereby promises to pay for hospital and physician services rendered to the patient registered hereon. The patient understands that they will receive a bill from WHMC and possibly separate bills from individual physicians for any services performed. This may include charges from specialists. Should an account be left unpaid, the account will be referred for collections: the undersigned shall pay all court costs, reasonable attorney's fees and collection expense. Pursuant to RCW 19.16.500 a 50% collection fee will be added to the balance of the patient's account if referred to a collection agency.

CHARITY CARE: The patient has read and understands the charity care guidelines of the hospital and option to receive charity care.

STUDENT PERMISSION: The patient gives permission for WHMC to discuss the hospital bill with their parents. However, the patient realizes that, being at least age 18, they continue to hold responsibility for their own accounts. The patient also realizes if this bill is discussed with parents, the parents will be aware of the nature of the hospital services.

☐ **Yes** ☐ **No**

INSURANCE PREAUTHORIZATION: Many insurance companies require their patients to preauthorize treatment of all non–emergency admissions. The patient or family is responsible for notifying their insurance if this is a requirement. The patient acknowledges this responsibility and understands they also hold responsibility for any penalties due to a failure to comply with their insurance company's stipulations.

MEDICARE/MEDICAID CERTIFICATION AND PAYMENT: If the patient is applying for payment under Medicare or Medicaid, the patient certifies that the information they provide is correct.

MEDICATIONS: The patient understands that the medication, which they may receive from WHMC, is considered only enough medication to help until a pharmacy is available. It has been explained to the patient that their health insurance may not cover the costs of the medications dispensed and the patient may be billed for the medications by the hospital.

☒ **The patient acknowledges copies of WHMC's *"Patient Rights & Responsibilities"* and *"Notice of Privacy Practices"* have been offered for review.**

☒ **The patient acknowledges a copy of the *"Credit and Collection Policy"* brochure has been offered for review.**

☒ **The patient, if applicable, has received a copy of the *"Important Message from Medicare".***

☐ **I, the patient or authorized representative, request that WHMC bill me privately, and not bill or share any information with my insurance company for this visit.**

ATTENDING PHYSICIANS: The patient understands that H.Graeme French, MD is an employee of WHMC and that other physicians in attendance are not employees or agents of WHMC, but rather, are independent contractors who have been granted the privilege of using WHMC facilities, for the care and treatment of their patients. Further, the patient realizes that among those who attend patients at this hospital, there may be medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care. Still or motion pictures and closed circuit television monitoring of patient care are property of the physician and/or WHMC and may be used for educational purposes unless the patient expressly requests otherwise. The patient understands that there is not a physician on site 24/7. They are on–call 24/7.

ACCT:

WHITMAN HOSPITAL and MEDICAL CENTER
1200 W. Fairview – Colfax, Washington 99111–9579

MR:

ROOM: **BED:** **DOB:**

ADMIT: **AGE:** M D **SEX:**

PERSONAL VALUABLES: The patient acknowledges WHMC is not liable for the loss or damage to the patient's personal property unless deposited within the hospital safe for safekeeping.

MISCELLANEOUS:

- This contract will be governed by the laws of the State of Washington and the venue of any action brought between the parties hereunder shall be in the Superior Court for Whitman County, Washington.
- The patient, under state and federal law, has the right to make decisions concerning their medical care including the right to accept or refuse medical or surgical treatment and the right to formulate Advanced Directives regarding these rights.
- The patient understands that WHMC is a non–smoking facility.
- The patient requests the hospital authorities dispose of any tissue removed from during their treatment at WHMC.

Whitman Hospital and Medical Center does not discriminate on the basis of age, sex preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap.

The patient or authorized representative has read this form and is satisfied with their understanding of its content and significance.

______________________________	6–1–2016 12:55:56 PM
Patient Name	Date

______________________________	______________________________
Signature of Patient or Patient's Agent Or Authorized Representative	Signature of Hospital Representative *(Witness Required ONLY when Hardcopy Consent)*

(v.12/11/14)

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