



**PULLMAN
REGIONAL
HOSPITAL**

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

- The patient named below has been informed of the nature and purpose of his/her 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 results 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 being necessary.
- Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law.
- The patient understands that the physician in attendance are not employees or agents of the hospital, with the exception of Emergency Department physicians and the Hospitalists, but rather, are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Furthermore, the patient realizes that among those who attend patients at this hospital are sometimes medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care.
- In the event that a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of an infectious disease, I understand that my blood will be tested for infectious diseases, including HIV, Hepatitis B, Hepatitis C to allow the healthcare worker to be treated promptly. I consent to this testing, including HIV testing and I authorize disclosure of the results to any exposed healthcare worker and any treating provider. I further understand that any positive results may be reported as required by law. I understand that any testing resulting from healthcare worker exposure will be performed at no cost to me.
- Screening or treatment will not be delayed by your refusal to pay. I understand that I may receive a bill from Pullman Regional Hospital, and possibly separate bills from individual physicians or other organizations for any services performed. This may include charges from specialists. Should the account be left unpaid, the account will be referred for collection. The undersigned shall pay all court costs, reasonable attorney fees and collection expense. Pursuant to RCW 60.44.020 and 1503-S.SL, patient is hereby notified that Pullman Regional Hospital at its discretion may utilize the practice of filing hospital liens as authorized under Washington law. It is agreed by the parties involved that Washington has jurisdiction and that venue in any action taken to collect this account may be in Whitman County, Washington, Superior Court or Whitman County, Washington, District Court, at the option of Pullman Regional Hospital.
- Medicare Certification and Payment: If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. 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 and/or Medicaid.
- The patient understands that for reasons of the health and safety, Pullman Regional Hospital is a non-smoking facility. The patient further understands that children under their care should be continuously monitored and supervised at all times while in the facility.

This consent will expire 90 days from end of event. Event described as: _____

Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual 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 that he/she understands its content and significance.

Pullman Regional Hospital keeps a record of the health care services we provide you. You may request your protected health information (PHI) or get more information about it by contacting Health Information Management. (Copy fees apply). You may also ask to correct or amend your protected health information (PHI). 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. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed, and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on the Pullman Regional Hospital's web site: www.pullmanhospital.org. **By my initials, I acknowledge a copy of the hospital's Notice of Privacy Practices, Patient Rights and Responsibilities, Financial Assistance Summary have been offered to me, and if applicable, I have been asked about Advance Directives.**

Patient Name

Medical Record No.

Account Number

Date / TIME

Signature of Patient

Date / TIME

Signature of Hospital Representative

Date / TIME

Patient's Agent or Authorized Representative

Date

Relationship to Patient