Consent to Treatment, Promissory Note, & Authorization to Pay Medical

Pullman Regional Hospital does not discriminate on the basis of race, color, sex, national origin, disability, religion, age, sexual orientation, gender identity, or source of payment

The patient named below has been informed of the nature and purpose of their office visit, hospitalization, treatment, 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 office visit, hospitalization, care, treatment and procedures, including, but not limited to, residency, 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.

Medicare/Medicaid 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/Medicaid.

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 such as Imaging and pathology. 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.

We May Call or Send Text Messages to Your Phone Number(s) Provided and Send Email Communications to Your Email Addresses Provided. You acknowledge that you are the owner of the phone numbers (whether associated with a mobile, cell or landline) and email addresses that you provide to us. If you are not the owner, you represent that you are authorized by the respective owner(s) to authorize the use of those phone numbers and email addresses as described below, on the owner's behalf.

You authorize us and any third-party, such as our independent contractors, business associates, agents, and/or affiliates, who we may authorize, to: (1) call you at any of the numbers that you provide to us, using an automatic telephone dialing system and/or using a recorded message upon being answered, or another similar method such as an artificial or pre-recorded voice; (2) text messages to you at any of the numbers that you provide to us; and/or (3) send email communications to you at any of

the email addresses that you provide to us; for any of the following purposes: confirming appointments, providing registration or clinical instructions, communicating about post-service follow up, telemarketing, billing, advertisements, advising you of special offers, events and services, communicating about your account, insurance and payments, and collecting debts that you owe to us.

You do not have to give us permission to call, text or email you. Giving us permission to call, text or email you is not required in order to receive services or purchase any property or goods. You have the right to opt out of these types of communications.

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.

I understand that repeated failure to attend scheduled appointments without prior notice may result in cancellation of future appointment. There will be a no-show fee assessed for all no-show appointments and late cancellations in accordance with the specific clinic's policy. A fee is applied based upon the visit you missed. In addition, Pullman Regional Hospital reserves the right to terminate the provider-patient relationship due to excessive no shows.

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.

The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.

Patient Name: _____ Medical Record No: _____

Signature: _____ Date: _____Time: _____
(Patient, Parent, Guardian, or legal authorized signature)

Printed name & Relation of signed on behalf of the patient: _____

Signature of Staff Representative: _____