Samaritan Health Services

Conditions of Service

Place Patient Label Here

MEDICAL AND SURGICAL CONSENT: I wish to receive examination, treatment, or other healthcare services from Samaritan Health Services (SHS). My practitioner will inform me of recommendations related to my treatment that may include tests, examinations or surgery and I reserve the right to refuse any recommended procedure or treatment. **I am aware that I may be photographed or videotaped to document my treatment or care in my medical record. All such photographs and videotapes are confidential.** IF THE PATIENT IS A MINOR (UNDER 15 YEARS OF AGE) OR LEGALLY INCOMPETENT TO SIGN FOR HIS/HER OWN MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE.

RELEASE OF SPECIALLY PROTECTED INFORMATION: A separate authorization will be required for release of the following information: HIV positive diagnosis, drug/alcohol addiction program records, psychotherapy notes and/or mental health program records.

PHYSICIANS: Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

RELEASE OF INFORMATION: I authorize SHS to release information from my medical records to any insurance carrier or government agency for the purpose of processing my claims for health care services.

OBSERVERS/STUDENTS/RESIDENTS: SHS locations provide clinical experience for various educational programs. I understand that students or health care practitioners may observe or participate in my care as part of the educational programs authorized by this facility.

PERSONAL PROPERTY: I agree that SHS is not responsible for loss or damage to any valuables or personal items (including glasses, dentures, hearing aids, contact lenses, personal electronic devices, and cell phones). I understand that SHS hospitals have accommodations for keeping money, jewelry, documents or other valuables upon request. I understand that any personal property not claimed within 30 days of my discharge will be disposed of according to SHS policy.

FINANCIAL AGREEMENT: I understand that I am financially responsible for charges not covered by insurance. I also understand that I am responsible for paying deductibles, co-insurance and co-pays. I agree to make payment according to SHS credit policies. In order to avoid a finance charge, all charges accrued must be paid in full within 90 days of the first statement's closing date. I also understand that credit balances of less than $10.00 will be refunded by request only and if the refund check in the amount of $20 or less is not cashed, I will forfeit the amount as a service charge (ORS 98.311).

INSURANCE BENEFITS ASSIGNMENT: The information I have supplied is true and accurate to the best of my ability. I direct and assign all insurance companies, health care service plans, and other third party payers to make payment directly to SHS. If my payer denies payment, I allow SHS to appeal payment denial on my behalf.

MEDICARE CERTIFICATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act or Medicaid is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize them to submit a claim to Medicare for payment to me.

CONSENT FOR BLOOD TESTING: I consent to have my blood tested for HIV and Hepatitis antibodies in the event a SHS health care worker or other person has an accidental exposure to my blood and/or body fluids. I understand that I can obtain the results of these tests from my physician who can explain them to me. I understand there will be no cost to me for the testing.

Opt-Out Statement

☐ I DO NOT give permission to have my blood tested for HIV and Hepatitis antibodies in the event a SHS health care worker or other person has an accidental exposure to my blood and/or body fluids.

PATIENT RIGHTS ACKNOWLEDGEMENT: I have reviewed a copy of Patient Rights and Responsibilities and the Notice of Privacy Practices and understand I can obtain a copy upon request.

Patient or Patient's Representative — Relationship to the Patient

Witness — Date/Time

 For electronic signature only