

Conditions of Registration

CONSENT TO TREAT

I consent to the medical procedures that may be performed at the Foundation. These procedures may include, but are not limited to, laboratory procedures, X-ray examinations, digital images for care and treatment purposes and medical or surgical treatment or procedures deemed necessary and performed by and under special instructions of my physician. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of failure to resolve the condition under treatment, injury or even death. I acknowledge that no warranties or guarantees have been made to me regarding the results of examination or treatment.

RELATIONSHIP BETWEEN FOUNDATION AND CLINICIANS

I am advised that all physicians and surgeons furnishing services to me/the patient, are independent contractors and are not employees or agents of the Foundation. Furthermore, the Nurse Practitioner and Physician's Assistant may be independent contractors and may not be employees or agents of the Foundation. I understand that I/the patient am under the care and supervision of my/the patient's attending physician, and it is the responsibility of Foundation staff to carry out his/her instructions. I understand that it is the responsibility of my/the patient's physician, surgeon, or authorized healthcare to obtain my informed consent for surgical or complex medical treatment, special diagnostic or therapeutic procedures, investigational treatment or procedures, and/or other specialized services.

CONSENT TO PHOTOGRAPH

I consent to the taking of photographs, videotapes, digital or other images of me and/or my medical or surgical condition or treatment, and the use of the images, for purposes of my diagnosis or treatment or the Foundation's operations, including peer review and education or training programs conducted by Foundation.

FINANCIAL AGREEMENT

Please review this Financial Agreement carefully. This is a legal agreement that affects your rights and obligations. The Foundation provides advice and counseling for patients who request assistance in understanding their financial obligations for Foundation services, including deductibles, copayments, coinsurance, cost shares, and other amount that are may be your responsibility to pay, as well as government health care program eligibility, and financial assistance (e.g., charity care, uninsured discounts) and installment payment programs. **If you have any questions at all regarding your financial liability for Foundation services, please contact a Patient Financial Services Counselor.**

FOUNDATION CHARGES: The Foundation's charges for services and items provided during your/ patient's care are established in accordance with Foundation's list of usual and customary charges. These charges are subject to change from time to time. If you would like to review the charges, or an estimate of the Foundation's total charges for the medical care, please contact Patient Financial Services Counselor.

BENEFITS REVIEW: The Foundation provides advice and counseling for patients who request assistance in understanding insurance, government healthcare eligibility, financial assistance, uninsured discounts, and installment programs. Please contact Patient Financial Services Counselor if you need assistance in understanding your financial obligations for Foundation services.

HEALTH PLANS: The Foundation maintains a list of commercial health plans (e.g., HMO, PPO, Medicare Advantage) it has contracts with. A list of these plans is available upon request from a Patient Financial Services Counselor. Please ask to see the Counselor if you have any questions about whether your plan is contracted with Foundation, or if you need any help in understanding your financial obligations outlined below:

- If the Foundation **currently has a contract** with my/patient's **commercial health plan** that covers my/patient's medical care at the Foundation, I hereby authorize Foundation to submit a claim to the commercial health plan for medical care and items Foundation provides, and, at the Foundation's option, to take legal steps to obtain payment from the commercial health plan for all medical care and items on my behalf. I understand and agree that I am responsible to pay directly to the Foundation any deductible, co-payment, cost share, and coinsurance as determined by my health care benefit plan, as well as all charges for services and items that my health plan determines are not covered by my health care benefit plan.
- If the Foundation **does not have a contract** with my/patient's **commercial health plan** that covers my/patient's medical care at the Foundation, I hereby authorize Foundation to submit a claim to the commercial health plan for medical care and items Foundation provides, and, at the Foundation's option, to take legal steps to obtain payment from the commercial health plan for all medical care and items on my behalf. I understand and agree that my health plan may determine that it is not responsible to pay for my care, and, in that case, **I am responsible to pay for my care at the Foundation**, in the amount of the Foundation's total charges for my/patient's medical care, calculated in accordance with the Foundation's charge list in effect at the time of care, unless Foundation and I enter into a different agreement. I understand and agree that I am responsible to pay directly to the Foundation any deductible, co-payment, cost share, and coinsurance as determined by my health care benefit plan, as well as all charges for services and items that my health plan determines are not covered by my health care benefit plan.
- If the Foundation **currently has a contract** with my/patient's **Medicare Advantage health plan** that covers my/patient's medical care at the Foundation, I hereby authorize Foundation to submit a claim to the commercial health plan for medical care and items Foundation provides, and, at the Foundation's option, to take legal steps to obtain payment from the commercial health plan for all medical care and items on my behalf. I understand and agree that I am responsible to pay directly to the Foundation any deductible, co-payment, cost share, and coinsurance as determined by my health care benefit plan, as well as all charges for services and items that my health plan determines are not covered by my health care benefit plan.
- If the Foundation **does not have a contract** with patient's **Medicare Advantage health plan** that covers my/patient's medical care at the Foundation, I understand and agree that patient will be responsible to pay up to 100% of the amount Medicare would pay for my care.
- Please seek the assistance of a Patient Financial Services Counselor to determine whether financial assistance or payment plans apply.

MEDICARE AND MEDI-CAL: The Foundation is a Medicare and Medi-Cal provider. I understand that I am responsible to pay directly to the Foundation any cost share or co-payment due from me under these programs, as well as any charges for treatment or services or item not covered by these programs that I have requested and agreed, in advance, to be provided.

NON-COVERED SERVICES: I understand that even if I am an eligible member of a health plan, the plan may determine prior to, concurrent with, or after Foundation provides a service or item to me that one or more service or item is not a covered benefit under my health care benefit plan. If my health plan determines that a service or item provided by the Foundation to me is not a covered benefit under my health care benefit plan, I hereby authorize Foundation to pursue payment from me for the non-covered service or item of amounts up to Foundation's charges, calculated in accordance with the Foundation's usual and customary charges. I may be eligible for a discount for a non-covered service or item under the Foundation's Financial Assistance policy.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment to the Foundation of any benefits under my health benefit policy for the Foundation's medical care, and I irrevocably assign to the Foundation the benefits under my health benefit policy for the Foundation's medical care. At its sole discretion, Foundation may at its option and without notice to me, accept this assignment of my benefits. I understand that if Foundation elects to accept assignment of benefits, I shall remain responsible to pay the amount due on the account, provided that Foundation shall apply any amount paid by such health plan to the balance owed. I agree to cooperate with the Foundation in its efforts to collect from my health plan(s) and other insurance carriers.

INTEREST ON DELINQUENT PATIENT ACCOUNTS: I understand and agree that, if permitted by law, delinquent accounts shall bear interest at the legal rate.

MEDICARE/MEDICAID/MEDI-CAL: The Foundation is a Medicare and Medi-Cal provider. I understand that I am responsible to pay directly to the Foundation any cost share or co-payment due from me under these programs, as well as any charges for treatment or services or item not covered by these programs that I have requested and agreed, in advance, to be provided.

OTHER SOURCES OF PAYMENT: Nothing in this agreement shall preclude the Foundation from seeking reimbursement from other responsible third parties (e.g., health plans, auto and liability insurers, third party administrators, and government healthcare programs) for any amounts that may be due from them.

RIGHT TO REFUSE PARTIAL PAYMENT AS PAYMENT IN FULL: If you or your health plan issues a payment that is less than the full amount due for the medical care and items provided, and states that Foundation must accept the payment as payment in full, Foundation reserves the right to refuse such payment as payment in full and will pursue the entire amount due from the legally responsible party or parties.

SELF PAY: If I do not have coverage from a third party source for the medical care and items the Foundation provides to me, I agree to pay all of the individual charges calculated in accordance with the Foundation's usual and customary charges for the services and items provided to me, less the Foundation's uninsured discount, unless I qualify for charity care or other financial assistance under the Foundation's Financial Assistance Policy. I understand that the Foundation maintains a Financial Assistance policy and that, depending on my financial condition, the cost of my Foundation care may be reduced or even eliminated under this policy. I also understand that Patient Financial Services Counselors are available to: help me understand whether I qualify for government health care programs, charity care, and uninsured discounts; answer any questions I may have about this financial agreement; estimate my financial responsibility for the Foundation's services and items; and establish a reasonable payment plan should I desire one. I understand that, if permitted by law, delinquent accounts shall bear interest at the legal rate.

NOTICE THAT THE FOUNDATION VERIFIES FINANCIAL INFORMATION: The Foundation may use outside agencies that verify the information I have provided, including my income and credit information. The Foundation uses this information to assist it with identifying potential sources of payment for my healthcare services, obtaining payment for healthcare services, and assessing my eligibility for Financial Assistance.

CONSENT TO COMMUNICATION

I consent to receive communication, including but not limited to billing information, in any manner, including automated emails, voice mails, written and/or electronic statements, text messages, autodialed calls and pre-recorded messages. I understand that these communications could result in charges to me. Further, I acknowledge that if I provided a cell/mobile phone number to the Facility, I have already given consent to receive non-marketing informational messages regarding my care and billing for such care.

KEEPING PATIENTS SAFE

The Foundation has adopted a zero tolerance policy for violence in our Foundation. As such, we are committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. It is the expectation of the Foundation that you conduct yourself in a respectful, non-violent and non-abusive manner.

Patient Initials: _____

SIGNATURES

I confirm that I have read the preceding information and have received a copy of this form. Any questions that I may have had have been answered fully and to my satisfaction. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time _____ AM / PM

Signature: _____
(*patient/legal representative*)

If signed by someone other than patient, indicate relationship: _____

Print Name: _____
(*legal representative*)

Witness Signature: _____
(*Witnesses only required for telephone consent, physical inability to sign, or signature by mark.*)

Witness Print Name: _____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Date: _____ Time _____ AM / PM

Signature: _____
(legal representative/interpreter)

Print Name: _____
(legal representative/interpreter)

Address: _____

Phone Number: _____

Witness Signature: _____
(Witnesses only required for telephone consent, physical inability to sign, or signature by mark.)

Witness Print Name: _____

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ALL SIGNATORS