Sutter Health

PATIENT LABEL

CONDITIONS OF REGISTRATION
Sutter Health Medical Foundation Patients

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.

FINANCIAL AGREEMENT

I agree to promptly pay all Foundation bills in accordance with the regular rates and terms of the Foundation, including charity care and discount payment policies, if applicable. Should any account be referred to an attorney or collection agency for collection, I may be responsible for all costs of collecting the money owed, including court costs, collection agency fees, legal notice fees, and attorneys' fees (to the extent allowed by law) and other fees (to the extent allowed by law); and failure to pay when due may subject me to late payment charges and can adversely affect my credit report. All delinquent accounts may bear interest at the legal rate, unless prohibited by law.

Patient Initials: _____

ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to the Foundation of all insurance benefits payable for these outpatient services. I agree that the insurance company's payment to the Foundation pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

Sutter Health

PATIENT LABEL

CONDITIONS OF REGISTRATION
Sutter Health Medical Foundation Patients

HEALTH PLAN OBLIGATION

This Foundation maintains a list of health plans with which it contracts. A list of these plans is available upon request from the Business office. The Foundation has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the Foundation if I belong to a plan that does not appear on the above mentioned list. It is my responsibility to determine if the Foundation contracts with my health plan.

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: _____

Sutter Health

PATIENT LABEL

CONDITIONS OF REGISTRATION
Sutter Health Medical Foundation Patients

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