Conditions of Registration

Please review this Agreement carefully. This is a legal Agreement that affects your legal rights and obligations.

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 treatment or surgical procedures performed by or 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 outcome of any examination or care.

RELATIONSHIP BETWEEN FOUNDATION AND CLINICIANS

I am advised that all physicians and surgeons at the Foundation perform medical and surgical services in accordance with their own professional judgment and licensure, and not at the direction of the Foundation. I understand that I am under the care and supervision of my attending physician, and it is the responsibility of Foundation staff to carry out their instructions.

CONSENT TO DIGITAL IMAGING FOR IDENTIFICATION PURPOSES

I consent to the Foundation capturing digital images of me for identification and security purposes.

INFORMED CONSENT FOR SERVICES

I understand that an attending physician, surgeon, or authorized healthcare professional is responsible for obtaining my informed consent for special diagnostic or therapeutic procedures, complex medical treatment (including investigational procedures), surgery, and/or other specialized services.

FINANCIAL AGREEMENT

The Foundation provides financial counseling to assist you in understanding your financial obligations for Foundation services, including deductibles, copayments, coinsurance, cost shares, and other amounts that may be your responsibility to pay, as well as government health care program eligibility, financial assistance (e.g., charity care, uninsured discounts), and installment payment programs. **If you have any questions regarding your financial liability for Foundation services, please visit sutterhealth.org or speak with a Patient Advocate by calling 866-681-0736**.

FOUNDATION CHARGES: The Foundation's charges for healthcare services and items are established in accordance with the 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 receive an estimate of the Foundation's total charges for your medical care, please visit sutterhealth.org or contact us at 866-681-0736.

HEALTH PLANS: The Foundation maintains a list of commercial health plans (e.g., HMO, PPO, Medicare Advantage) it has contracts with that is available upon request by visiting sutterhealth.org or calling us at 866-681-0736. Please contact a Patient Advocate if you have any questions about whether your health plan is contracted with the Foundation, or if you need help in understanding your financial obligations outlined below:

- If the Foundation **currently has a contract** with my **commercial health plan** or **Medicare Advantage health plan** that covers my medical care at the Foundation, I hereby authorize the Foundation to submit a claim to the commercial health plan or Medicare Advantage health plan for healthcare services and items the Foundation provides, and, at the Foundation's option, to take legal steps to obtain payment from the commercial health plan or Medicare Advantage health plan for all such services 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 the health plan determines are not covered by the health care benefit plan.

- If the Foundation **does <u>not</u> have a contract** with my **commercial health plan** that covers my medical care at the Foundation, I hereby authorize the Foundation to submit a claim to the commercial health plan for healthcare services and items the Foundation provides, and, at the Foundation's option, to take legal steps to obtain payment from the commercial health plan for all healthcare services and items on my behalf. I understand and agree that the health plan may determine that it is not responsible to pay for my care, and, in that case, **I am responsible to pay for the healthcare services and items provided by the Foundation**, in the amount of the total of the Foundation's usual and customary charges for my healthcare services and items, calculated in accordance with the Foundation's charge list in effect at the time of care, unless the Foundation and I enter into a different written agreement. I understand and agree that I am responsible to pay directly to the Foundation the difference between the total of the Foundation's usual and customary charges for my healthcare services and items, less the amounts paid by my health care benefit plan.
- If the Foundation **does <u>not</u> have a contract** with my **Medicare Advantage health plan** that covers my medical care at the Foundation, I understand and agree that I will be responsible to pay up to 100% of the amount Medicare would pay for the care.

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(s) 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, during, or after the Foundation provides a healthcare service or item to me that one or more healthcare service or item is not a covered benefit under my health care benefit plan. If the health plan determines that a healthcare service or item provided by the Foundation to me is not a covered benefit under my health care benefit plan, I hereby authorize the Foundation to pursue payment from me for the non-covered service or item of amounts up to the total of the Foundation's usual and customary charges, calculated in accordance with the Foundation's charge list in effect at the time of care. I may be eligible for a discount for a non-covered healthcare 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 care benefit plan for the Foundation's medical care, and I irrevocably assign to the Foundation the benefits under my health care benefit plan for the Foundation's healthcare services and items. At its sole discretion, the Foundation may at its option and without notice to me, accept this assignment of my benefits. I understand that if the Foundation elects to accept assignment of benefits, I shall remain responsible to pay the amount due on the account, provided that the Foundation shall apply any amount paid by such health care benefit 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.

OTHER SOURCES OF PAYMENT: Nothing in this Financial 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 my health plan issues a payment that is less than the full amount due for the healthcare services 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 the total of the Foundation's usual and customary charges, calculated in accordance with the Foundation's charge list in effect at the time of care, 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 the Foundation's healthcare services and items may be reduced or even eliminated under this policy. I also understand that Patient Advocates 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 healthcare services and items; and establish a reasonable payment plan should I desire one.

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.

COMMUNICATION METHODS

I understand that I will receive communication through automated emails, voice mails, written and/or electronic statements, text messages, autodialed calls and pre-recorded messages for appointment, billing and health-related purposes. I understand that these communications could result in charges to me by my mobile service provider, and are not encrypted. Further, I agree the Foundation, Sutter Health or its affiliates and agents may use the wireless number(s) and/or residential lines that I have provided (or will provide) to send informational messages regarding my care, and billing for such care. I understand that I may modify my communication preferences, either through My Health Online (MHO) account or by contacting Sutter Health directly.

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 I conduct myself 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. If I am not the patient, I understand and agree that any references to "I", "my", or "myself" are deemed to include the patient.

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 WHO SIGN THE DOCUMENT