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PATIENT FINANCIAL RESPONSIBILITY AND TREATMENT CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Oregon Surgical Wellness (OSW).

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named below) at OSW. I voluntarily consent to all medical treatment and health care-related services that the caregivers at OSW consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations. I understand that OSW may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:

a. Subject to applicable law and the terms and conditions of any applicable contract between OSW and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay OSW for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below.

Or, b. Subject to applicable law and the Oregon Surgical Wellness Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay OSW for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to OSW all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding OSW's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by OSW to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer.

Uses and Disclosures of Health Information: I have received OSW's Notice of Privacy Practices. The Notice of Privacy Practices explains how OSW may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let OSW use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by OSW, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent OSW or provide assistance to OSW for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) health care. I can revoke my consent in writing at any time except to the extent that OSW has already relied on my consent.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

Signature _____

Date _____