Conditions of Registration (Oregon Only)

1. Medical Treatment and Surgical Consent: I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, telehealth, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

2. Nursing Care: Nurses are hospital employees and they provide general nursing care and care ordered by the physician(s). If I want private duty nursing care, I (or my legal representative) agree to make such arrangements.

Patient initials: _____

3. Legal Relationship Between Hospital and Physician: Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, cardiologist and surgeon, are NOT employees of the hospital and have been granted the privilege of using the hospital for the care and treatment of their patients. Physicians may bill separately for their services. I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible to carry out his/her instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to me under his/her general or special instructions.

4. Photography: I consent to the taking of photographs, videotapes, digital or other images, and surveillance monitoring for purposes of my diagnosis, treatment, or for the hospital's operations, including peer review, education or training programs conducted by the hospital. My consent will be requested for non-treatment photography such as marketing or external purposes.

5. Maternity Consent for Newborns: If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Registration shall apply to the newborn infant(s).

6. Release of Information: I have received a copy of the Notice of Privacy Practices (NPP), which describes when the hospital may use or disclose my information for treatment, payment and health care operations. The NPP is incorporated into these Conditions of Registration and Financial Agreement by this reference. This notice is only provided the first time I receive services from the hospital and is otherwise available upon request.

7. Personal Valuables: As a patient, I am encouraged to leave valuable personal items at home. While the hospital maintains a safe for small personal items of unusual value, it is not responsible for these items. Hospital liability for any personal property deposited with the hospital for safekeeping is limited to $300.

8. Teaching Program: If the hospital conducts teaching programs, students will be allowed to participate in my care, unless I (or my legal representative) notify the hospital to the contrary in writing.

I have read the above, received a copy, and am the patient OR I am the patient's legal representative OR I have been authorized by the patient to sign on the patient's behalf.

Date: _____ Time: _____ Signature: _____

If signed by other than patient, indicate relationship: _____

Witness: _____

Interpreter Signature: _____ Language: _____

Interpreter Name: _____ Telephone Number: (____) ____ - _____
(Printed)

Patient initials: _____

9. Financial Agreement: I accept financial responsibility for all services during this episode of care. I understand that I can expect to receive separate bills from physicians and specialty services.

I agree to promptly pay all hospital bills, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate.

If your account is overpaid, a refund will automatically be issued. If the amount of the credit is less than $5.00, you agree that the Hospital will assess a service fee equal to the credit balance to avoid the administrative costs associated with processing a refund.

I hereby authorize the hospital and/or their agent(s) to request credit information from various credit reporting bureaus for the collection of my account including, but not limited to, collection of delinquent accounts, the evaluation of requests for financial assistance, and routine credit scoring.

10. Assignment of Insurance Benefits: I assign and authorize direct payment to the hospital of all insurance and plan benefits that are payable for this episode of care. With this authorization, all parties agree that the insurance company's payment to the hospital shall satisfy the insurance company's obligations related to this episode of care. I further understand that I am financially responsible for charges not paid according to this assignment.

11. Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Medicare Part B, including but not limited to the effective date of such coverage. I also authorize the hospital and my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim(s).

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement and Assignment of Insurance Benefits.

Date: _____ Time: _____ Signature: _____

If signed by other than patient, indicate relationship: _____

Witness: _____

Interpreter Signature: Language:

Interpreter Name: _____ Telephone Number: (____) ____ - _____
(Printed)