Consent for treatment/conditions of admission

Please read and sign the following, which provides your consent and agreement.

CONSENT TO ROUTINE HEALTH CARE SERVICES: I consent to the services to be rendered during this hospitalization or on an outpatient basis at the instruction of my attending physician or his/her associates. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment.

I consent to have my blood tested for HIV and other blood-borne bacteria and viruses in the event a health care worker is exposed to my body fluids that may result in the transmission of blood-borne disease. Neither I nor my insurance company will be billed for these tests.

There may be circumstances under which information must be mandatorily reported. These circumstances include diseases or lab results that require reporting to organizations such as Health Departments or Center for Disease Control and Prevention.

The undersigned hereby authorizes the administration of such medicines, anesthetics, surgical and other procedures, as shall be prescribed or shall be deemed necessary for proper diagnosis or treatment. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and staff to carry out the orders of such physician. It is the responsibility of the patient's physician to obtain the patient's consent, where required, for medical or surgical treatment.

I understand that photographs, video, electronic or audio recordings or films may be created to document my care and/or performance improvement and educational purposes, and I consent to this.

The undersigned hereby authorizes the pathologist to use his/her discretion in the disposal of any tissue or severed member.

Safe environment for patient care: Weapons or other dangerous objects, illegal drugs, and drugs not prescribed by the patient's physician are not permitted in the patient's room. Tuality Healthcare's obligation to provide a safe environment for patient care must override the patient's right to have these items in their possession. Tuality Healthcare reserves the right to search the patient and room and to confiscate such objects upon reasonable cause.

Medical education programs: I understand that this hospital participates in teaching programs. I consent to the observation and participation of nursing, medical and paramedical students in the care I receive while I am a patient in this hospital. I understand that I may not be aware of the student status of specific caregivers.

Important message from Medicare: I have received a copy of "An Important Message from Medicare or Tricare", where applicable.

Responsibility for all personal property: I understand that Tuality Healthcare is not responsible for the safekeeping of money or valuables. I understand there is a safe provided for keeping money or valuables, if requested.

☐ I acknowledge and understand that the Emergency Department has Qualified Medical Personnel on-site 24/7 to perform a medical screening exam to provide necessary and appropriate treatment. I understand the Personnel providing treatment to me may not always be an MD/DO.

☐ I acknowledge and understand that the physician providing care to me, including any Emergency Physicians (Northwest Emergency Physicians Inc.), Anesthesiologists, Radiologists (Medical Imaging Group of Hillsboro LLC) (who interpret x-rays, mammograms, Nuclear Medicine images, or other imaging scans and studies), Hospitalists (Sound Inpatient Physicians Inc.) and Pathologists (who evaluate and review tissue and fluid removal from me), are not hospital employees or agents. I understand the physicians are independent health care providers who have privileges in this hospital.

I or my appointed representatives, have read, fully understand and agree to the above statements. I have received a copy of this information.

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Signature of patient or personal representative date time

Financial Agreement

- I agree to pay for services or goods provided by Tuality Healthcare. I understand I will receive a statement if my account has an outstanding balance;
- I understand if my account is assigned to an attorney or collection agency, I will be obligated to pay associated costs;
- I understand that Tuality Healthcare does not refund credit balances less than $5 (five) dollars.
- I agree, in order for Tuality Healthcare or independent providers (for example: Northwest Emergency Physicians Inc., Sound Inpatient Physicians Inc., Medical Imaging Group of Hillsboro LLC, Anesthesiologists personal corporations and Washington County Pathologists LLC, and their billing companies) to service my accounts; or to collect any amounts that I may owe. Tuality Healthcare or the independent providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Also, they may contact me by sending emails, using the email address that I provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- If payment of the bill creates financial hardship, I understand that it is my responsibility to contact Tuality Healthcare Patient Business Services at 503-681-1000 to inquire about our financial assistance/Charity policy.

Confirmation and assignment of insurance benefits

I understand Tuality Healthcare will make inquiries regarding insurance coverage and my financial responsibility from third party payers or financial references. In addition, I approve of these payers and/or references to release information to Tuality Healthcare.

- Medicare, Medicaid, and all other Payers – I request direct payment of insurance benefits be made on my behalf for any service furnished me by or in Tuality Healthcare.

I hereby authorize Northwest Emergency Physicians Inc., Sound Inpatient Physicians Inc., Medical Imaging Group of Hillsboro LLC, Anesthesiologists personal corporations and Washington County Pathologists LLC, and their billing companies to apply for benefits and receive payment for services rendered at Tuality Community Hospital in Hillsboro or Tuality Forest Grove Hospital in Forest Grove. In making this assignment, I agree that I am financially responsible to the above parties for charges not paid under my insurance policy.

For all services, I request that this authorization apply to the anticipated period of treatment but not to exceed 180 days. A copy may be used in lieu of the original.

☐ PATIENT ADVANCE DIRECTIVES: I have been offered information about Advance Directives and understand that I can receive assistance to complete these documents if I desire.

☐ I have been informed that I may have a copy of my Rights & Responsibilities as a patient, if I request. This document will be given to me once each year, although I may obtain another copy from Tuality at any time.

Medication assistance program

In some cases, the hospital is able to obtain reimbursement for some of your medications from companies that manufacture them. When this occurs, the cost of the medication is removed from the charges on your hospital stay. Most of these programs require your signature on the application forms. So that you do not have to sign this application for each medication, we are requesting that you allow Pharmacy Health Solutions (PHS) representatives to sign these forms on your behalf. I appoint PHS to carry out in my name, the applications required for PHS to obtain replacement of my medications from pharmaceutical manufacturers. This document will be in full force from the date signed.

The undersigned agrees, whether he/she signs as agent or as patient; that in consideration of the services to be rendered to the patient he/she hereby individually obligates themselves to pay the account, as well as obligating the patient. Also Tuality Healthcare may look to either or both for payment.

I or my appointed representatives, have read, fully understand and agree to the above statements. I have received a copy of this information.

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Signature of patient or personal representative date time