

I, THE UNDERSIGNED, HEREBY CONSENT (AGREE) TO RECEIVE MEDICAL CARE FROM THE PRACTITIONER(S) RESPONSIBLE FOR MY DIAGNOSIS AND TREATMENT. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I may ask questions about my medical care and make my wishes known to my practitioners and/or staff. I will participate in my care and foster a safe environment for myself, staff, and other patients within Swedish Medical Center (SMC). I understand that my care is under the direction of my attending physicians, who may be independent contractors and not employees or agents of SMC. SMC is not liable for the acts or omissions of such independent contractors. I acknowledge that SMC is a teaching hospital and that teachers, trainees, residents and students may observe or participate in my care. I understand that photographs and video recordings of my treatment may be taken if they may be useful as a component of my treatment.

IN CASE OF AN EMERGENCY I WILL RECEIVE CARDIOPULMONARY RESUSCITATION (CPR). The policy of SMC is to provide emergent medical care to all individuals unless we have a Physician Order that directs us otherwise. SMC provides emergent care through a code team or by calling 911.

SMC IS NOT RESPONSIBLE FOR MY PERSONAL ITEMS. SMC offers temporary safekeeping for essential personal items (i.e., glasses, dentures, hearing aids, or other assistive devices). Luggage or purses brought into a SMC facility may be subject to search in an effort to keep staff and visitors safe. SMC shall not be liable for the loss or damage to any personal item including money or articles of value.

THE FOLLOWING ITEMS AND BEHAVIOR ARE NOT PERMITTED ON SMC PROPERTY:

Weapons: I agree to turn over all weapons to Security and I understand that if I am suspected of possessing a weapon, SMC has the right to search me and/or my belongings and seize such items.

Illegal Drugs: Substance abuse is prohibited in all areas of SMC and I agree to turn over any and all illegal substances. I understand that if I am suspected of possessing an illegal substance or illegal contraband, SMC has the right to search me and/or my belongings and seize such items, and I consent to such search and seizure.

Tobacco: SMC is a smoke-free facility on all campuses and in all clinics. I understand that I will not be allowed to leave the building to smoke or chew tobacco during my treatment or service. I understand help and resources are available to me to avoid tobacco withdrawal.

SMC MAY GIVE INFORMATION TO MY HEALTH INSURANCE COMPANY FOR PAYMENT. To the extent required to assure payment, SMC will disclose any pertinent medical information to a designated representative, corporation, governmental agency or third party payor. Examples of such entities may include insurance companies, workers compensation carriers, the Social Security Administration, or a Department of Health and Human Services. Communication to these entities may include details to support appropriateness of treatment, medical necessity, and financial reimbursement. I understand that disclosures supporting treatment, payment, or operations may extend

to, but are not limited to, all aspects of my care, including data related to treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions, unless expressly limited by me in writing. I understand that limiting disclosure may prevent my insurer from paying for my medical care, making me responsible for the cost of my treatment.

IT IS MY RESPONSIBILITY TO PAY MY BILL OR TO MAKE ARRANGEMENTS TO HAVE MY BILL PAID:

Private Pay: As a patient (or a patient's agent), I agree to be financially responsible to SMC for charges not paid by insurance. I understand this amount is due upon billing.

Insurance Coverage: I certify that the information provided regarding my insurance policy and eligibility is correct to the best of my knowledge. I hereby authorize SMC to receive reimbursement directly from my insurance company. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within 30 days of invoice. I understand that SMC will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all noncovered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

Financial Assistance: As a part of our strong commitment to ensuring access to medical care, SMC offers financial assistance for medically necessary services in our hospitals. I understand I may still qualify for financial assistance even if I have medical insurance. Eligibility is determined based on federal poverty guidelines, family size, and other criteria. I may apply for potential financial assistance prior to service, at the time of service, or at any point in the billing process up to the resolution of the account. This assistance does not cover services such as care from my doctor, dental care, eyeglasses, lab tests, or prescription drugs. I understand that financial assistance applications are available at any registration area or after I have received a bill from SMC.

I UNDERSTAND THAT IN ADDITION TO MY SMC BILL, I WILL RECEIVE A SEPARATE BILL(S) FROM PHYSICIANS AND/OR CARE PROVIDERS INVOLVED IN MY DIAGNOSIS AND TREATMENT. Because every health insurance plan is different, I understand that SMC is unable to ensure that all physicians and/or care providers are preferred providers under my insurance plan, and that I may be responsible for out-of-network rates.

I HAVE BEEN OFFERED A COPY OF THE NOTICE OF HEALTH INFORMATION PRACTICES AND UNDERSTAND THAT IT IS ALSO AVAILABLE UPON REQUEST. The Notice of Health Information Practices describes how information about me may be used and disclosed and how I can get access to this information. I have a right to receive a paper copy of this notice, available in all patient registration areas. Swedish will not use or disclose health information except as indicated in this notice. This notice describes examples of disclosures for treatment, payment or health operations. It also includes other uses and disclosures and information about special authorizations and my rights.

I have read the above and understand the content. **Changes to this form are not permitted,** and questions about this form will be addressed by appropriate administrative or clinical staff. If I bring any prohibited items or engage in behavior that is not permitted on Swedish property, I may be asked to sign a behavioral agreement. Repeated violations may result in additional restrictions and/or transfer or discharge.

Date: _____ Time: _____

Witness: _____

Unable to obtain signature Reason: _____

Patient _____

Patient's Agent or Representative _____

Relationship _____



SWEDISH

SEATTLE, WASHINGTON

Form 60337 Stock Rev. 7/13/11 FV