



TERMS AND CONDITIONS OF SERVICE

CONSENT FOR TREATMENT

HEALTH CARE CONSENT: I request and agree to receive all services provided by the health care professionals authorized to care for me at OHSU. I understand that these services may include:

- Services provided under the supervision, direction or instruction of attending physicians and other authorized health care professionals.
- Routine procedures used for diagnosis.
- Additional or related treatments and procedures my OHSU providers determine are necessary and in my best interest.

I also understand:

- There may be risks and alternatives to a particular treatment or procedure my health care provider recommends or prescribes.
- My health care provider may need to explain and discuss with me certain treatments or procedures. He or she also may need to ask for my consent before performing them.
- It is important for me to ask questions or ask for more information about the care or treatment I may receive at OHSU.

I understand the practice of medicine, surgery and dentistry is not an exact science. I have not received any promises or guarantees about the results I may expect from my care at OHSU.

TEACHING/RESEARCH: OHSU is an academic research center and all human research undergoes an ethical review process. I understand that OHSU health care providers or clinical researchers may contact me to ask me if I would like to volunteer to take part in educational or clinical research projects that require consent.

I understand that OHSU is a teaching institution, and that attending staff providers direct the care provided at OHSU. As part of OHSU's education programs and activities, students, resident physicians, post-graduate fellows or others involved in undergraduate and graduate health care education programs may watch and/or take part in the care or procedures I receive at OHSU.

I understand I can refuse to participate in education programs and activities, and my refusal will not affect my care at OHSU.

STATEMENT OF FINANCIAL RESPONSIBILITY

FINANCIAL AGREEMENT: If I have health insurance, I understand that the terms of my health insurance or health benefit plan(s) may reduce, limit or control what I am required to pay OHSU for the services I receive at OHSU. Whether or not I have health insurance, I agree to be financially responsible and pay for the services provided to me by OHSU if the services are not covered or fully paid for by insurance and the law allows OHSU to collect from me the amount owing. I also agree to pay OHSU's reasonable costs for collecting payments if I do not pay on time the amounts I am responsible for paying. These collection costs may include reasonable attorney fees whether or not legal action has been filed or appealed.

ASSIGNMENT: I assign to OHSU and/or OHSU Medical Group the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, physicians and other services I receive at OHSU. I understand this assignment is final.



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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

STATEMENT OF FINANCIAL RESPONSIBILITY CONTINUED

I authorize my health insurance and health plans to make payments directly to OHSU, OHSU Hospital, Faculty Practice Plan, Faculty Dental Practice, or other related professional billing services. I understand the payments from my health insurance or plan for services provided to me at OHSU will be applied to my patient account balance and total financial responsibility. I agree to pay within 30 days following OHSU's notification any charges I owe which are not covered and paid by insurance(s).

SOCIAL SECURITY PROGRAMS: I certify the information I gave when I applied for Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act) is correct. If these benefits end, I understand I will receive a notice and I will then be responsible for paying for hospital care if I choose to stay in the hospital and/or continue to receive services. I request that payment of authorized benefits be made on my behalf directly to the provider. If I have not signed up for any Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act), I agree that if/when I do sign up for such benefits, I agree I will provide accurate information and that this paragraph shall apply to me upon my application for Medicare and/or Medicaid benefits.

OTHER

SOCIAL SECURITY NUMBERS: I understand that OHSU collects administrative and nonmedical patient information including Social Security numbers to identify patients, comply with federal and state reporting requirements, bill insurance carriers, and collect payments, as authorized by ORS 351.070 and 353.050. I understand I do not have to give OHSU my Social Security number. If I provide this information, I authorize OHSU to use it for the purposes listed above.

CLAIMS: I understand that each person is responsible to be informed about laws that affect him or her. I also understand, however, that OHSU wishes to alert me to a limitation in the law that relates to OHSU: Because OHSU is a public body, Oregon law may limit the dollar amount that a person may recover from OHSU or its caregivers for a claim relating to care at OHSU, and the time within which a person may bring a claim. If I have any questions about this, I understand that I am free to ask or seek advice from any independent person or source.

TELEPHONE COMMUNICATION: By signing this document, I expressly give OHSU, its affiliates, agents, and contractors consent to contact me using an auto dialer, prerecorded message, live operator, or other means at any telephone number or any contact information for any other communication device that I provide for treatment, payment, or other health care operations purposes, as those terms are defined in 45 CFR 164.501, as long as such contact complies with applicable law.

The following information is specific to the OHSU Hospitals

PERSONAL BELONGINGS: I agree OHSU is not liable for losing or damaging any personal property I bring into OHSU or onto OHSU property.

RECEIPT OF "AN IMPORTANT MESSAGE FROM MEDICARE". Yes No

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

Patient

Date/Time

Parent, Guardian, Responsible Party,
Legal Representative (if applicable)

Date/Time

Witness

Date/Time