Consent for Treatment and Financial Responsibility

Medical and Surgical Consent:
I consent to procedures or treatments that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to emergency treatment, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services provided to me under the general or special instructions of my physician or other medical staff healthcare professional. I understand that diagnostic, treatment, or surgical procedures involving material risks will be explained to me, and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and benefits, and then further consent or decline. I understand that photographs or digital images may be recorded to document my care and I consent to this, understanding these images become part of my medical record and will have the same privacy protections as my protected health information.
In the event a healthcare worker is exposed to my blood or body fluid in a manner posing a risk for transmission of a blood-borne infection, I give my consent to be tested for infections such as HIV, Hepatitis B and Hepatitis C at no cost to me, so the healthcare worker may be treated promptly. In such situations I authorize release of applicable information to the healthcare worker and his/her healthcare provider.
I understand that some physicians and healthcare providers providing services to me, including radiologists, pathologists, emergency physicians, anesthesiologists and others are not employees of Olympic Medical Center (OMC). They have been granted privileges to use the medical center for care and treatment of patients, but they are not employees, representatives or agents of the medical center. They are independent practitioners. These providers may bill separately for their services.

Use and Disclosure of Information:
I have received and read the "Notice of Privacy Practices" and authorize OMC to use and disclose information about me and my health to diagnose and treat me, to obtain payment for my care, and for OMC business operations. I will be included in the hospital directory, which allows OMC to relay my location and general condition, if asked for by name and my religious affiliation to clergy viewing the directory. If I do not want to be included in this directory, I will notify a hospital representative. If I opt out of this directory, I understand that my presence here will not be disclosed to family members, my clergy, neighbors, friends, or others inquiring about me while I am a patient.

Patient Rights and Responsibilities:
I acknowledge that I have received and read the "Patient Rights and Responsibilities" information provided by OMC.

Teaching Facilities:
I acknowledge OMC is a teaching medical center and I consent to supervised residents and students being involved with my care. I acknowledge I may refuse care by a resident or student at any time, and that such refusal will not result in any reduction of the quality of care provided.

Safe Environment:
I acknowledge that weapons or other dangerous objects and illegal drugs are not permitted while I am being cared for as a patient. I accept the rights of OMC to search individuals and rooms upon reasonable cause and to remove any such items.

Personal Valuables:
I understand that OMC is not responsible for my personal belongings and valuables brought into an OMC facility, and agree to send such items home with my family or other responsible party, if possible. I accept full responsibility and hold OMC harmless for any loss, theft or damage for personal belongings or valuables retained at OMC.

Non-Smoking Facilities:
I have been made aware that this is a smoke free campus and that smoking is not allowed on Olympic Medical Center properties. If I choose to leave the premises to smoke, I take full responsibility for the consequences of my actions.

Assignment of Benefits/Release of Information:

Insurance:
I consent to assign to OMC all insurance company coverage benefits to which I am entitled for services rendered by OMC, and authorize OMC to release relevant information about me and my healthcare necessary to receive such payment. I understand and accept I am responsible for paying any co-payments and/or deductibles required under my insurance plan(s).

Medicare / Medicaid and Other Government Programs:
I authorize OMC to receive direct payments for any benefits to which I may be eligible under Medicare, Medicaid or any other government program, and authorize OMC to release relevant information about me and my healthcare necessary to receive payment under the applicable government program(s). I understand and accept my responsibility to pay any deductible and/or co-insurance under such programs(s).

Medicare Notice:
I understand I may receive a bill from OMC for self-administered drugs not covered by Medicare Part A, B, and C, and may request an itemized statement containing the national drug codes necessary for me to bill my Part D carrier.

Financial Assistance:
I understand OMC offers financial assistance programs to qualifying individuals, and prompt pay discounts. I understand that I may request further information on these.

Financial Responsibility:
I understand and accept that OMC will bill the charge master rates in effect when services are provided; that I may request a price estimate for such services; that I agree to pay for such services; and that I acknowledge and accept my personal responsibility for payment in full for billed charges even where OMC has been assigned benefits from government programs and insurance companies. I acknowledge failure to meet my financial obligations to OMC will result in the referral of account(s) to professional collection agencies. Should my account be placed for outside collections, I agree to pay reasonable costs and legal fees as set by the court.

Authorization:
I have read, or have had explained to me, the above Conditions of Admission. I understand the contents of this Conditions of Admission document. I am the Patient, the Patient's legal representative, or am otherwise authorized by the Patient to sign for the above and accept its terms.

Signature of Patient or
Patient's Authorized Representative: _____

Date Signed: _____ **Time Signed:** _____

Patient Name (Printed): _____

Patient Date of Birth: _____

Patient Label	**Olympic Medical Center (OMC)** includes our hospitals, clinics, outpatient services, home and community services, retail pharmacies, and skilled nursing facilities.