PULLMAN REGIONAL HOSPITAL

CONSENT TO TREATMENT, PROMISSORY NOTE, AND AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS

1. The patient named below has been informed of the nature and purpose of his/her hospitalization, treatment, and procedures and is aware of the risk and medical complications that may occur. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained. The patient voluntarily consents to the hospitalization, care, treatment and procedures, including, but not limited to, anesthesia, x-ray procedures, blood tests, psychological and/or drug and alcohol related diagnoses and procedures, and laboratory tests as the attending physician(s) consider being necessary.
2. Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law.
3. The patient hereby promises to pay for hospital and physician services rendered to the patient registered hereon. I understand that I will receive a bill from Pullman Regional Hospital, and possibly separate bills from individual physicians or other organizations for any services performed. This may include charges from specialists. Should account be left unpaid, account will be referred for collection. The undersigned shall pay all court costs, reasonable attorney's fees and collection expense. It is agreed by the parties involved that Washington has jurisdiction and that venue in any action taken to collect this account will be Whitman County.
4. The patient understands that the physician in attendance, are not employees or agents of the hospital, with the exception of Emergency Department physicians and the Hospitalists, but rather, are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Furthermore, the patient realizes that among those who attend patients at this hospital are sometimes medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care.
5. Medicare Certification and Payment: If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or organizations furnishing the services or authorize them to submit a claim to Medicare and/or Medicaid.
6. The patient, if applicable, has received a copy of the *"Important Message from Medicare"*. [ ] Yes [ ] No
7. The patient, under state and federal law, has the right to make decisions concerning his/her medical care including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives regarding these rights. I have Advance Directives [ ] Yes [ ] No, if Yes, I have provided the hospital with a copy [ ] if No, I would like more information regarding Advance Directives. [ ] I have a Physicians Order for Life Sustaining Treatment (POLST) form, the form is intended for any individual with an advanced life-limiting illness [ ] Yes [ ] No, if Yes, I have provided the hospital with a copy [ ] if No, I would like more information regarding the POLST form. [ ]
8. The patient, if applicable, elects to have a "Birth Announcement" listed in the *Moscow/Pullman Daily News & Whitman County Gazette.* [ ] Yes [ ] No
9. The patient, if applicable, has given consent to Pullman Regional Hospital billing staff to discuss the hospital bill in its entirety with patient's parents or legal guardian. [ ] Yes [ ] No
10. The patient understands that Pullman Regional Hospital is a non-smoking facility.
11. This consent will expire 90 days from end of event. Event described as: ____________________
Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap. The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.
Pullman Regional Hospital keeps a record of the health care services we provide you. You may ask to see and copy that record (copy fees apply). You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Health Information Management. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed, and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on the Pullman Regional Hospital's web site: www.pullmanhospital.org.
By my initials, I acknowledge a copy of the hospital's Notice of Privacy Practices, Patient Rights and Responsibilities have been offered to me, and if applicable, I have been asked about Advance Directives. _____

Patient Name	Medical Record No.	Account Number	Date

Signature of Patient	Date	Signature of Hospital Representative	Date

Patient's Agent or Authorized Representative	Date	Relationship to Patient