RIDGECREST REGIONAL HOSPITAL

CLINICS

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE AND ASSIGNMENT

HIS AGREEMENT APPLIES TO ALL PATIENTS RECEIVING SERVICES AT REGIONAL HOSPITAL CLINICS -- SOUTHERN ERRA MEDICAL CLINIC, SOUTHERN SIERRA SURGICAL, CHINA LAKE GASTROENTEROLOGY, HEALTHY BONE AND OINT CENTER, SOUTHERN SIERRA SPECIALTY CENTER, RIDGECREST RURAL HEALTH CLINIC, RIDGECREST RGENT CARE CENTER, TRONA RURAL HEALTH CLINIC, AND DESERT OASIS CLINIC.

atient Name: **Birth Date:**

. I consent to the procedures and/or medical services that may be performed during this course of treatment or while I am an outpatient. These may include, but are not limited to, medical or surgical examination, treatment or procedures, including emergency treatment or services if necessary, laboratory tests and procedures, X-ray examinations, telehealth services, anesthesia, photography for medical treatment (using clinic owned camera) or other outpatient hospital and clinic services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital or clinic.

2. I understand that I am under the care and supervision of my attending physician. The hospital or clinic and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital or clinic services provided to me under my physician's general and special instructions.

3. I understand that I am responsible for all charges incurred as a result of such treatment as well as those incurred in collecting for treatment charges. I realize that even though I may have insurance coverage, I am still responsible for payment. If legal action is instituted for payment of such treatment and/or services, I agree to pay reasonable attorney fees and all costs incurred herein.

4. I agree to promptly pay all hospital or clinic bills in accordance with the charges listed in the hospital's or clinic's charge description master and, if applicable, the hospital's or clinic's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's or clinic's charge description master before (or after) I receive services from the hospital or clinic. I understand that physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, may bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

5. I authorize the release of any medical information necessary to process my insurance claim.

6. I irrevocably assign and transfer to the hospital and clinics, all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital or clinic of all insurance and health plan benefits payable for outpatient services. I agree that the insurer or plan's payment to the hospital or clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital or clinic to perfect, confirm, or validate this assignment.

7. I authorize the use of this signature on all of my insurance claims submitted for me by the hospital or clinics.

8. I have read or received the Ridgecrest Regional Hospital Summary Notice of Privacy Practices.

9. No one will be able to pick up prescriptions or test results or call regarding my medical attention unless authorized below.

I authorize _____ Relationship _____

10. I understand prior to delivery of healthcare via telehealth, Ridgecrest Regional Hospital shall inform the patient about the use of telehealth and I shall give my consent either verbally or written for the use of telehealth as an acceptable mode of delivering healthcare services. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audios, video or data communicating. I understand that telehealth also involves the communication of medical information both orally and visually to practitioners located in California or outside of California. I understand that if my treatment is for tele-psych my medical/mental information may be communicated both orally and visually to practitioners in California or outside of California. I understand that I have the right to withhold or withdraw consent at any time. I understand that mental health records shall not be released to me (patient) without written consent. Mental health records shall not be released to the patient or parent if patient is a minor. I agree if the physician agrees to release the records, then all information that may be deemed detrimental to the patients so that they may cause harm to themselves or someone else will be redacted from the records. If a provider disagrees to release records, Ridgecrest Regional Hospital will inform the patient in writing.

11. I have read or received the Ridgecrest Regional Hospital E-Prescription Program and hereby provide informed consent to be enrolled in this program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

12. We participate in an Immunization Registry with California Immunization Registry (CAIR), a statewide, confidential database of patient immunization information. The purpose of CAIR is to consolidate immunization information among health care professionals, assure adequate immunization levels, and avoid unnecessary immunizations. Only you, your doctor, or health care workers who can assist you have access to your immunization information. If you do not want your immunization or tuberculosis (TB) screening test records to be shared with other health care providers, agencies, or schools in the CAIR, fill out and submit "Decline or Start Sharing Information Request Form" to CAIR via fax (888-436-8320). The form is available at the CAIR website (http://cairweb.org/cair-formsl), or you may contact the CAIR Help Desk (800-578-7889 or CAIRHelpDesk@cdhp.ca.gov), or your health care provider for assistance.

13. CONSENT TO MEDICARE AUTHORIZATION (Medicare Patients Only): I request that payment of authorized Medicare benefits be made on my behalf to my provider as listed on this letter for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay my claim. If other insurance is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am responsible to pay for the deductible and coinsurance portions of the charges, and for non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Administrative Contractor.

14. I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

15. **I understand that cellphone audio or video recording of patient care activities is not allowed.**

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR ONE (1) YEAR FROM THIS DATE UNLESS REVOKED IN WRITING

Signature of Patient/Guardian: _____ **Date:** _____

Print Name: _____

Relationship to Patient: _____

Disclaimer: Please be advised that completing preliminary health and insurance information does not establish a physician-patient relationship with our providers. Ridgecrest Regional Hospital will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the provider will accept you as a patient.