Shoshone Medical Center
25 Jacobs Gulch
Kellogg, Idaho 83837
(208)784-1221

Patient Sticker

Patient Consent and Financial Agreement
Shoshone Family Medicine, Out-Patient Therapy, and Social Services

TREATMENT/ SERVICE AGREEMENT

1. **Consent to Services:** The reason for requesting services at Shoshone Medical Center (SMC) is that a medical condition requiring care exists. I (*either Patient or Legal Guardian*) consent to the medical care and treatment which SMC Clinic and/or hospital staff consider necessary.
2. **Notice of Privacy Practices:** I acknowledge that I have reviewed a copy of the SMC Notice of Privacy Practices (copy furnished upon request) describing how SMC will use and disclose my personal information and my rights in this regard.
3. **Sharing of Electronic Information:** I acknowledge that SMC may send electronic prescriptions to my pharmacy and when available may download medication history records into my electronic medical record. I acknowledge that SMC may participate in a Health Information Exchange, which is a secure service that allows my information to be available to participating providers where I may receive care.
4. **Patient Rights and Advanced Directives:** I acknowledge that I have been advised of my Patient Rights and of my right to formulate Advanced Directives. I understand that I will be provided written information regarding Patient Rights and Advanced Directives upon request.
5. **Tobacco Free Campus:** I have been informed that SMC is a tobacco free campus; including the main hospital and all associated buildings. This means that no smoking by anyone is permitted.
6. **Refunds/Balances Owing:** I understand that an account that contains a credit or debit balance of $10.00 or less may be adjusted by SMC at any time to zero out the account.
7. **Contact from SMC and Contracted Business Entities:** I understand that SMC and/or contracted business entities may contact me by telephone at any number associated with me, including wireless numbers. I understand that they may leave voicemail and/or SMS messages for me and include information allowed by law (including debt collection laws) regarding amounts owed by me or services provided to me. I also understand that pre-recorded/artificial voice messages and/or auto-dialer services may be used for communications related to my account. I understand that SMC may use the e-mail address, mailing address or phone numbers that I have provided for patient satisfaction surveys.

FINANCIAL AGREEMENT

1. **Assignment of Benefits:** I authorize my health insurance company to make payments directly to SMC and associated physicians for benefits covered by my insurance contract.
2. **Appeal Rights:** I authorize and appoint SMC to act on my behalf and/or on the behalf of my covered child (under 18 years of age) or legal dependent as my authorized representative in requesting an appeal of any denial of payment and/or denial of services by an insurance carrier with whom valid coverage exists for medical services. I further direct that any payment made by an insurance carrier as a result of successful appeal is to be paid directly to SMC.
3. **Promise of Payment:** I understand and agree that even though I have assigned my benefits to the providers, I remain financially responsible for the payment of medical care and treatment provided to me by SMC, my attending physicians or other health care providers. Payment is due upon receipt of the invoice. I understand that SMC is free to declare the entire balance to be immediately due and payable if I fail to make any scheduled payment. I further agree to pay all costs of collection, including reasonable attorney's fees, if the account is not paid in a timely manner.

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4. **Financial Responsibility:** I understand that I am responsible for knowing the limitations of my insurance, health plan and/or other third-party benefits. I agree to be responsible for paying the full amount of all charges for services that are deemed by the insurance company, health plan or third-party payer to be: (i) not covered benefits; (ii) in excess of my plan's limitation(s); or (iii) not medically necessary, investigation or experimental. I understand that I am agreeing to pay for such services and/or procedures in the amount(s) consistent with SMC policies and pricing and I am responsible for complying with any insurance requirements, including but not limited to obtaining pre-authorization. If SMC does not participate with my insurance discounts or write-offs, I understand I will be billed and will be responsible for the amount my insurance does not pay. I have the right to seek treatment with a provider that is in-network with my insurance.
5. **Preauthorization Process:** I understand that it is my responsibility to obtain preauthorization prior to a service when preauthorization is required by my health insurance company.
6. **Release of Information:** I authorize the release of any medical and/or other information necessary to process my claim(s).
7. **Length of Contract:** I understand and agree that the authorization(s) and appointment(s) above will remain valid until such time as I revoke them in writing to SMC and my insurance carrier.

Signature 1 (Patient, Guardian, or Witness)	Signature 2 (Witness) (Required only when patient unable to sign)	Date / Time
_____	_____	_____

□ Patient
□ Parent or Legal Guardian
□ Unable to sign, Severity of Illness
□ Unable to sign, Decreased Mental Capacity
□ Unable to sign, Non - Responsive

_____
Relationship to Patient (if not Parent or Legal Guardian)