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

Patient Sticker

PATIENT CONSENT AND FINANCIAL AGREEMENT
SMC INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

TREATMENT/ SERVICE AGREEMENT

1. Consent to Services: I consent to the treatment and procedures to be performed in connection with my inpatient, outpatient and/or emergency treatment at Shoshone Medical Center (SMC). This may include, but is not limited to, routine diagnostic procedures, transportation within the hospital, nursing care and other hospital services provided to me at the general instruction of my physician(s), provider(s) and/or other hospital medical staff. I acknowledge that no guarantees have been made to me regarding the outcome of my care. If I am unable to sign, implied consent for treatment is given.
2. Notice of Privacy Practices: I acknowledge that I have reviewed a copy of the hospital's Notice of Privacy Practices (copy furnished upon request) describing how the hospital 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, when available, and 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. Tobacco Free Campus: I have been informed that SMC is a tobacco free campus; including both the main hospital and all associated clinics. This means that no smoking by anyone is permitted.
5. 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.
6. Contact from SMC and Contracted Business Entities: I understand that SMC and 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.
7. No Liability for Loss of Personal Property: I understand and agree that the hospital maintains a safekeeping of money and valuables. The hospital shall not be liable for the loss or damage to any money, valuables or other articles of unusual value, or any other personal property unless deposited with the hospital for safekeeping.
8. 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.
9. Publication of Directory Information: I understand that unless I opt out, my name will be published in the hospital directory. As a patient, regardless of diagnosis, directory information will be released to visitors or callers. Directory information includes my name, my presence in the hospital, my location, my health condition expressed in general terms and my religious affiliation. I understand that I have the right to decide if I want this information released to my family, friends, visitors, delivery people, media, clergy or the general public. I also understand that I may change my request at any time.

If you DO NOT want this information made available, initial here: _____

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

Patient Sticker

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 a 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 SMC is free to declare the entire balance to be immediately due and payable if I fail to make any scheduled payment when due. I further agree to pay all costs of collection, including reasonable attorney's fees, if the account is not paid in a timely manner.
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, investigational 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. **Pre-Authorization:** I understand that it is my responsibility to obtain pre-authorization prior to a service when it 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.
8. **Important Message** (only applicable to Medicare In-patients): I acknowledge that I have received the "*Important Message from Medicare.*" I understand that acknowledging my receipt does not waive any of my rights to request a review and it does not make me liable for any payment.

Signature 1 (Patient, Guardian, or Witness	Signature 1 (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