## Conditions of Registration

1. **Medical and Procedural Consent:** I consent to the procedures that may be performed during my clinical visit. These may include office visits, non-complex blood tests or laboratory procedures, x-ray examinations, nursing, telehealth, e-visits and other services provided to me under the direction of my clinic provider. I understand that the practice of medicine is not an exact science and that my treatment may involve risks. I acknowledge that no guarantees have been made to me as a result of my examination or treatment in this clinic.
2. **Release of Information:** I have received a copy of the Notice of Privacy Practices (NPP), which describes when the clinic may use or disclose my information for treatment and payment. The NPP is incorporated into these Conditions of Registration and Financial Agreement by this reference. This notice is only provided the first time I receive services from the clinic and is otherwise available upon request. My legal rights relating to this information allows me to file a complaint if I believe my rights have been violated.
3. **Financial Agreement:** I accept financial responsibility for all services during my care. I am aware that my service may be offered at both a hospital based clinic and a non-hospital based clinic, and that I should check with my health insurance company about locations that may cost less. For any questions that I may have now or in the future, I can contact the staff in this clinic. I agree to promptly pay all bills for services during my care. Should the account be referred to an attorney or agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate. I hereby authorize the clinic and/or its agent(s) to request credit information from various credit reporting bureaus for the collection of my account including, but not limited to, collection of delinquent accounts, the evaluation of requests for financial assistance, and routine credit scoring.
4. **Financial Assistance:** I have been informed of Adventist Health's Financial Assistance policy. I understand more information about the policy can be found at facility registration area(s), the website AdventistHealth.org, by calling (844) 827-5047, or by writing Adventist Health ATTN: Financial Assistance PO Box 619122, Roseville, CA 95661.
5. **Assignment of Insurance Benefits:** I assign and authorize direct payment to the clinic of all insurance plan benefits that are payable for care. With this authorization, all parties agree that the insurance company's payment to the clinic shall satisfy the insurance company's obligations related to care. I further understand that I am financially responsible for charges not paid according to this assignment.
6. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective

date of such coverage. I also authorize my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim(s).

7. **Nondiscrimination:** I am informed that the clinic does not discriminate based on age, race, ethnicity, color, ancestry, religion, culture, language, physical or mental disabilities, socioeconomic status, sex, sexual orientation, and gender identity or expression. Additionally, I understand that room assignments are made based on gender identity.
8. **Personal Valuables:** I understand that I am responsible for all personal belongings. Adventist Health is not responsible for replacing lost or misplaced items.
9. **Legal Relationship between Clinic, Physicians and Mid-Level Providers:** Physicians and surgeons, including, but not limited to, primary care physicians, other clinic physicians, radiologists, pathologists, specialists, surgeons, and some nurse practitioners, physician assistants and midwives providing services to me are NOT employees of Adventist Health and have been granted the privilege of using the clinic for the care and treatment of their patients. Physicians may bill separately for their services. I understand that I am under the care and supervision of my attending physician. The clinic and its staff are responsible to carry out his/her instructions. My physician is responsible for obtaining my informed consent, when required, for specific medical treatment, special diagnostic or therapeutic procedures, or clinic services rendered to me under his/her general or special instructions. Notice to Consumer: physician assistants are licensed and regulated by the Physician Assistant Committee (916) 561-8780 www.pac.ca.gov. Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov.
10. **Photography:** I consent to the taking of photographs, videotapes, digital or other images, and surveillance monitoring for purposes of my diagnosis, treatment, or for the clinic's operations, including peer review, education or training programs conducted by the clinic. My consent will be requested for non-treatment photography such as marketing or external purposes.
11. **Consent to Telephone Calls for Financial Communications:** If the telephone number I have provided to the hospital is a wireless telephone number, I hereby consent to receive auto-dialed and/or pre-recorded calls, including debt collection calls, from or on behalf of the hospital at this number in the course of routine business communications.

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the financial Agreement and Assignment of Insurance Benefits.

I have read the above, received a copy, and am the patient OR I am the patient's legal representative OR I have been authorized by the patient to sign on his/her behalf.

Patient/Patient Representative Signature:

X Date:

Time: _____

_____
Printed Name

☐ I am the patient

☐ I am the patient's legal representative

☐ I have been authorized by the patient to sign on the patient's behalf

If you are not the patient, please identify your relationship to the patient:

☐ Spouse ☐ Legal Guardian ☐ Healthcare Power of Attorney

☐ Parent ☐ Guarantor ☐ Other (please specify)

Witness Signature and Title: (required for patients unable to sign or without a representative)

X Date:

Time: _____

_____
Printed Name

Interpreter Signature:

Interpreter Printed Name:

Language used for translation of document:

Date: Time: