Sutter Pacific
Medical Foundation
A Sutter Health Affiliate
With You. For Life.

Conditions of Registration

PATIENT NAME:_____
MRN#_____ _____

CONSENT TO TREAT

I consent to the medical procedures that may be performed at the Foundation. These procedures may include, but are not limited to, laboratory procedures, X-ray examinations and medical or surgical treatment or procedures deemed necessary and performed by and under special instructions of my physician. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of failure to resolve the condition under treatment, injury or even death. I acknowledge that no warranties or guarantees have been made to me regarding the results of examination or treatment.

FINANCIAL AGREEMENT

I agree to promptly pay all Foundation bills in accordance with the regular rates and terms of the Foundation, including charity care and discount payment policies, if applicable. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts will bear interest at the legal rate, unless prohibited by law.

Patient Initials: _____

ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to the Foundation of all insurance benefits payable for these outpatient services. I agree that the insurance company's payment to the Foundation pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

HEALTH PLAN OBLIGATION

This Foundation maintains a list of health plans with which it contracts. A list of these plans is available upon request from the Business office. The Foundation has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the Foundation if I belong to a plan that does not appear on the above mentioned list. It is my responsibility to determine if the Foundation contracts with my health plan.

SIGNATURES

I confirm that I have read the preceding information and have received a copy of this form. Any questions that I may have had have been answered fully and to my satisfaction. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____Time _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print Name:_____
(legal representative)

Witness Signature: _____
(Witnesses only required for telephone consent, physical inability to sign, or signature by mark.")

Witness Print Name:_____

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FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Date: _____Time _____ AM / PM

Signature: _____
(legal representative/interpreter)

Print Name:_____
(legal representative/interpreter)

Address: _____

_____

Phone Number: _____

Witness Signature: _____
(Witnesses only required for telephone consent, physical inability to sign, or signature by mark.")

Witness Print Name: _____

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ALL SIGNATORS