PULLMAN REGIONAL HOSPITAL

CONSENT TO TREATMENT, PROMISSORY NOTE, AND AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS

- The patient named below has been informed of the nature and purpose of his/her hospitalization, treatment, and procedures and is aware of the risk and medical complications that may occur. The patient understands and acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The patient voluntarily consents to the hospitalization, care, treatment and procedures, including, but not limited to, anesthesia, x-ray procedures, blood tests psychological and/or drug and alcohol related diagnoses and procedures, and laboratory tests as the attending physician(s consider being necessary.
- Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law.
- The patient understands that the physician in attendance are not employees or agents of the hospital, with the exception of Emergency Department physicians and the Hospitalists, but rather, are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Furthermore, the patient realizes that among those who attend patients at this hospital are sometimes medical, nursing, and other health care personnel in training who unless requested otherwise, may be present during patient care.
- In the event that a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of an infectious disease, I understand that my blood will be tested for infectious diseases, including HIV, Hepatitis B, Hepatitis C to allow the healthcare worker to be treated promptly. I consent to this testing, including HIV testing and I authorize disclosure of the results to any exposed healthcare worker and any treating provider. I further understand that any positive results may be reported as required by law. I understand that any testing resulting from healthcare worker exposure will be performed at no cost to me.
- Screening or treatment will not be delayed by your refusal to pay. I understand that I may receive a bill from Pullman Regional Hospital, and possibly separate bills from individual physicians or other organizations for any services performed. This may include charges from specialists. Should the account be left unpaid, the account will be referred for collection. The undersigned shall pay all court costs, reasonable attorney fees and collection expense. Pursuant to RCW 60.44.020 and 1503-S.SL, patient is hereby notified that Pullman Regional Hospital at its discretion may utilize the practice of filing hospital liens as authorized under Washington law. It is agreed by the parties involved that Washington has jurisdiction and that venue in any action taken to collect this account may be in Whitman County, Washington, Superior Court or Whitman County, Washington, District Court, at the option of Pullman Regional Hospital.
- Medicare Certification and Payment: If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or organizations furnishing the services or authorize them to submit a claim to Medicare and/or Medicaid.
- The patient understands that for reasons of the health and safety, Pullman Regional Hospital is a non-smoking facility. The patient further understands that children under their care should be continuously monitored and supervised at all times while in the facility.

This consent will expire 90 days from end of event. Event described as: _____

Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap. The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.

Pullman Regional Hospital keeps a record of the health care services we provide you. You may request your protected health information (PHI) or get more information about it by contacting Health Information Management. (Copy fees apply). You may also ask to correct or amend your protected health information (PHI). We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed, and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on the Pullman Regional Hospital's web site: www.pullmanhospital.org. **By my initials, I acknowledge a copy of the hospital's Notice of Privacy Practices, Patient Rights and Responsibilities, Financial Assistance Summary have been offered to me, and if applicable, I have been asked about Advance Directives.** _____

Patient Name	Medical Record No.	Account Number	Date / TIME
Signature of Patient	Date / TIME	Signature of Hospital Representative	Date / TIME
Patient's Agent or Authorized Representative	Date	Relationship to Patient	

The health and billing records we create and store are the property of Pullman Regional Hospital.

The protected health information in it, however, generally belongs to you.

We are required to:

- Keep your protected health information private.
- Have this Notice available for you.
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our campus or our website.

When would we use your information to contact you?

- For patient satisfaction surveys
- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Health Information Management Contact
To obtain a copy of your medical record or for questions on medical record disclosures, please contact our Health Information Management Department during normal business hours at: ***835 SE Bishop Bvld, Suite 401; Pullman, WA 99163 or call 509-336-7410***

To ask for help or to file a complaint:
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

HIPAA Coordinator 509-336-7576
Corporate Compliance Hotline 509-336-7686

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint attention ***HIPAA Coordinator at 835 SE Bishop Blvd; Pullman, WA 99163.*** You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

If you file a complaint to Pullman Regional Hospital or outside entities, we will not retaliate against you.

PULLMAN REGIONAL HOSPITAL

03/2018

NOTICE OF PRIVACY PRACTICES

PULLMAN REGIONAL HOSPITAL

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

You Have the Right To...

- Request, receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. We are not required to grant the request in all situations.
- Request that you be allowed to see and get a copy of your protected health information from our Health Information Management Department.
- Have us review a denial of access to your health information.
- Ask us to change your health information that is inaccurate or incomplete. You must give us this request in writing. Documentation will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information.
- Ask that your health information be given to you by another confidential means of communication or sent to another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations:

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team to be used by members of our health care team.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral.

For payment:

- We request payment from your health insurance plan. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.
- We bill you or your guarantor if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose your information to conduct or arrange for services, including:
  - o Accounting, legal, risk management, and insurance services; and
  - o Audit functions, including fraud and abuse detection and compliance programs

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- Required by law: We must make any disclosure required by state, federal, or local law.
- Notification of family and others: We may release health information about you to a friend or family member who is involved in your medical care. We will only do this if you agree, or do not object, and will only share with them the information they need in order to help you. If asked, we may tell your family or friends your status and that you are in a hospital.
- Public health and safety purposes: As permitted or required by law, we may disclose protected health information:
  - o To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- To public health or legal authorities:
  - o To report vital statistics such as births or deaths.
  - o Coroners, medical examiners, and funeral directors
  - o Organ-procurement organizations
  - o Workplace injury or illness
  - o Lawsuits and disputes.

For clarification about any of the permitted disclosures or your rights, please utilize the contact information on the back of this pamphlet.