Dignity Health®

PATIENT NAME: _____

DOB: _____

MRN: _____

New Patient Financial Consent

Dignity Health is contracted with various health insurance plans, including but not limited to Medicare, Medicaid, and other commercial insurance plans. If your insurance plan is contracted with Dignity Health, Dignity Health will file a claim on your behalf for the services you receive. If your health insurance is not contracted with Dignity Health, you are responsible to pay in full at the time service is rendered.

You should have an agreement with your insurance regarding your financial responsibility for medical treatment. It is important that you understand your insurance coverage. You are liable for any out of pocket expenses including but not limited to deductibles, co-insurances, co-pay's and/or services not covered by your insurance plan. Some insurance plans also require a prior-authorization for a referral. Dignity Health will help obtain your prior authorization for referral, however you are responsible to ensure the required authorization is provided in advance. Payment for cosmetic services are due in full at the time of service.

Depending on your insurance coverage at the time of your visit to the Dignity Health practice, you may be required to make a deposit on your account before seeing your clinician. Deposits will be applied toward charges incurred but may not fully cover the services you receive. There may be additional charges if you receive an x-ray, supplies, or if more complex services are required for treatment.

In some instances Dignity Health cannot bill your insurance carrier. This includes cases involving auto accidents or insurance liens. However, Dignity Health can provide all of the information necessary to submit a claim to your insurance should one of these instances apply.

It is your responsibility to ensure that all services rendered by Dignity Health on your behalf are paid in full within thirty (30) days of the statement date. Please note that, with the exception of errors, Dignity Health does not change the reason for your services (billing codes) once they have been submitted to your insurance company.

Please understand that you are ultimately responsible for the payment of the medical bill. If it becomes necessary for Dignity Health to collect payment, you understand that you will be responsible for legal costs, including attorney's fees.

You are consenting that payments from authorized Medicare, Medicaid, Government and any other insurance or third-party benefits can be made on your behalf, and/or on behalf of all members covered under your insurance plan, directly to Dignity Health for services provided.

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Consent to Treat

You (or you as personal representative on behalf of your dependent/minor, as a parent or authorized adult) consent to health care, including routine diagnostic procedures and other health services provided by Dignity Health, and its duly authorized agents and staff.

You understand that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made regarding the results of treatments, examinations or other health services rendered by Dignity Health.

Telecom Agreement

By signing this form, you agree that Dignity Health (its affiliates, and those acting on its/their behalf) may call or text. The types of calls or texts you may receive include those concerning the patient's care, payments, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide, or Dignity Health obtains, even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying your home phone number, mobile phone number, email address, and any other personal contact information, you authorize your health care clinician to employ a third-party automated outreach and messaging system to use your personal information, the name of your care clinician, the time and place of your scheduled appointment(s), and other limited information, for the purpose of notifying you of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other health care related function. You also authorize your healthcare clinician to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding your healthcare events. You consent to the receiving, when necessary, multiple messages per day from your healthcare clinician. You consent to allow detailed messages to be left on your voice mail, answering system, or with another individual, if you are unavailable at the number provided.

Dignity Health respects your privacy and will not share your contact information other than for the purposes outlined above.

Late Patient/No Show Policy

Our goal at Dignity Health is to maximize the time your clinician spends with you and minimize your wait time. In order to do so, Dignity Health has a standardized policy for no shows, cancellations, and late arrivals.

You understand that you can request a copy of the late patient/no show policy which includes discharging you from the office after a number of these incidents.

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Medication Refills

Please contact your preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within 3 business days.

Patient Rights and Responsibilities

You understand that you can request a copy of the patient rights and responsibilities brochure.

Joint Notice of Privacy Practices for Health Information (NPP)

Effective April 14, 2003, the law requires that Dignity Health give every patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such.

Consent

_____	_____
Patient Name	Date
_____	_____
Patient/Guarantor/Responsible Party Signature	Guarantor/Responsible Party Name *(If signed by someone other than patient)*

For Official Use

Dignity Health has provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

_____

_____

Dignity Health has attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of Dignity Health Representative _____ Date _____

Print Name _____ Department _____