UW Medicine
VALLEY
MEDICAL CENTER

Valley Medical Center Financial Agreement

OCCUPATIONAL HEALTH SERVICES

By signing below, I agree to the following:

1. I am responsible, prior to or at the point of service, to pay for the patient responsibility amount. Amounts may change based on services provided and I will be responsible to pay any remaining patient responsibility amount upon receipt of a bill.
2. In the event that my workers' compensation claim is denied by the Department of Labor and Industries or by the self-insurance carrier representing my employer, I am responsible for the payment of medical services received.
3. In the event that I am undersigning as an agent for the patient I personally assume liability for the patient responsibility amount.
4. If I am married, the marital community is hereby obligated to pay for the patient responsibility amount.
5. If covered by insurance, it is my responsibility to understand my benefits and present my insurance card. The information on the insurance card will be used a) to notify insurance carriers of inpatient admissions, all surgical and emergency visits the next business day and b) to submit bills according to my plan instructions.
6. If a card or document stating proof of coverage is not provided and the insurance denies payment or if coverage is denied because Valley Medical Center or the Clinic Network are determined to be non-contracted providers, I understand that Valley Medical Center will hold me responsible for payment of my bill.
7. That Valley Medical Center may share any financial information I provide to facilitate payment.
8. To pay Valley Medical Center for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
9. To notify Valley Medical Center of changes to my insurance coverage and/or address.
10. That Valley Medical Center may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
11. To notify Valley Medical Center Customer Service if I am not able to pay my balance due within 30 days of receipt.
12. To apply to other financial programs that I may qualify for as requested by Valley Medical Center should I be unable to pay my account.
13. That any lawsuit for collection of my account may be brought in King County, Washington.

I understand that:

- If I receive outpatient services, from Valley Medical Center Hospital and the Clinic Network, I will generally receive two bills: one bill from the hospital (for the facility costs, i.e. building, equipment, supplies, staff time) and one bill from the physician or other provider (for the costs of the professional services). Each of these bills may incur a co-payment or co-insurance responsibility, depending on my insurance coverage. The exact amount of the co-insurance or co-payment will depend upon the actual services provided and the coverage provisions of any insurance I may have. For many of Valley Medical Center's services, staff will provide me with an estimate of the billed charges for services I am scheduled to receive.
- I may receive additional bills from physicians who provided subsequent care as a result of services received at Valley Medical Center including its clinics and ancillary services. Some of those providers may be contracted with Valley Medical Center while others are independent healthcare providers in private practice. For more information about other providers who may bill, please refer to the "Important Information About Your Bill" brochure or the Clinic Network Financial Policy.
- I understand that some services may not be covered by my insurance or government insurance plan, such as annual physical exams or medical supplies. Details are explained in the "Important Information About Your Bill" brochure and the Clinic Network Financial Policy.
- Payment for services related to an accidental injury such as a motor vehicle accident or work related injury may also be excluded by my insurance plan.
- Valley Medical Center requests and, if I provide it, will use my Social Security Number to facilitate access to any potential federal or state health care benefits, to verify my identity, or to facilitate discharge planning. Providing my Social Security Number is voluntary except when applying for state and federal health care benefits.
- My Consumer Credit report information may be accessed for the following reasons: (1) to make determination of available financial assistance; (2), assistance in managing the payment process, or if; (3), I report that my identity has been stolen.
- Until my accounts are settled, I consent that Valley Medical Center and any agents acting on its behalf, may reach out to me regarding my accounts through various means including but not limited to 1) a cell, landline, or text number(s) that I provide; 2) an email address that I provide, 3) auto-dialer systems, and 4) pre-recorded voicemail messages.

Release of Information: Unless I direct Valley Medical Center not to bill my insurance company and personally pay at the time of service, I hereby authorize Valley Medical Center to disclose all or any part of my record, and any other information in Valley Medical Center's possession, to any person or entity which is or may be liable for all or part of the charges related to my care at Valley Medical Center, including but not limited to workers' compensation carriers, insurance companies, welfare funds or my employer. I hereby release Valley Medical Center from all legal responsibility or liability which may arise from disclosure of my record as provided in this paragraph. Unless I direct Valley Medical Center not to bill my insurance company and personally pay at the time of service, I hereby authorize Valley Medical Center to furnish requested information of excerpts from my record to any insurer, its intermediary or another healthcare facility to provide continuity of care.

Assignment of Insurance Benefits: I hereby assign all benefits otherwise payable to me by my insurance company to Valley Medical Center, for the period of hospitalization and/or for the period of treatment and services, including clinic visits.

Assignment of Agent Financial Responsibility (if other than patient): I hereby assign financial responsibility for the patient responsibility amount to any party agreeing to act as an agent on my behalf for the period, for the period of hospitalization and/or period of treatment and services, including clinic visits.

Medicare Beneficiaries: Statement to Permit Payment of Medicare Benefits to Provider

I request payment of authorized Medicare benefits for any services furnished to me by Valley Medical Center. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I request that authorized benefits be made on my behalf.

I assign payment for the charges of any physician(s) for whom the Valley Medical Center is authorized to bill in conjunction with its services. I understand that I am responsible for any health insurance co-payment, deductible, coinsurance, and/or non-covered services. I will be notified in advance for services Medicare does not consider medically necessary and financial arrangements will be made should I choose to have this procedure done. Medicare may consider some services ordered by my physician not to be medically necessary. I will be notified by you in advance for the cost of these services so that I can work with my doctor to make a choice. Should I choose to have these services, I will work with you to arrange personal payment.

Medicaid Beneficiaries: I understand my Medicaid benefits do not cover certain services and acknowledge I will be responsible for payment of such services, including but not limited to dental care, non-emergent care, circumcision of newborns and dietary counseling, except for diabetes. If I am covered for family planning only, I understand I will be required to pay for all other services.

Financial aid: Valley Medical Center is committed to the provision of medically necessary healthcare services to all persons in need of such services regardless of ability to pay. If I meet the medically indigent criteria as outlined in WAC 246-453, the patient responsibility amount may be waived or reduced in accordance with Valley Medical Center's charity care policy.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)	Date

If signed by person other than patient, relationship to patient:

If Patient unable to sign, reason:

Verbal Obtained? ☐ No ☐ Yes