UW Medicine
VALLEY
MEDICAL CENTER

FINANCIAL AGREEMENT & CONSENT FOR DISCLOSURE

By signing below, I agree:

1. That Harborview Medical Center and Clinics (HMC), Northwest Hospital & Medical Center and Clinics (NWH), University of Washington Medical Center and Clinics (UWMC), Valley Medical Center and Clinics (**VMC**), UW Medicine Neighborhood Clinics (UWNC), UW Medicine Sports Medicine Clinic (UW Sports Med), Hall Health Primary Care Center (HHPCC), and University of Washington Physicians (UWP) (collectively known as "UW Medicine"), University of Washington School of Dentistry (SOD), Children's University Medical Group (CUMG) and Seattle Cancer Care Alliance (SCCA) may share any financial information I provide to facilitate payment.
2. To pay UW Medicine, **VMC**, SOD, CUMG and/or SCCA for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
3. To notify UW Medicine, **VMC**, SOD, CUMG and/or SCCA of changes to my insurance coverage and/or address.
4. That UW Medicine, **VMC**, SOD, CUMG and/or SCCA may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
5. To notify UW Medicine, **VMC**, SOD, CUMG, and/or SCCA if I am not able to pay my balance due within 30 days of receipt.
6. To apply to other financial programs that I may qualify for as requested by UW Medicine, **VMC**, SOD, CUMG and/or SCCA, should I be unable to pay my account.
7. That any lawsuit for collection of my account may be brought in King County, Washington.
8. To receiving information related to treatment, payment or health care operations, including receiving autodialed and prerecorded message calls and/or text messages, at any number I have provided or, if not current, to any number I am reasonably found to be associated with.
9. That UW Medicine and **VMC** may, at its discretion, disclose to appropriate parties my medical records or information from my records for treatment, payment and health care operation purposes.

I understand that:

- Each UW Medicine entity, **VMC**, SOD, CUMG, and/or SCCA bill separately for their services.
- Patients who receive outpatient services at UWMC or HMC sites and some **VMC** sites generally receive two bills: one bill from the physician or other provider (for the costs of the professional services) and one bill from the hospital (for the facility costs, i.e. building, equipment, supplies, staff time). 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 have. Sometimes patients will pay more for certain outpatient services and procedures at hospital-based outpatient locations. The amount will depend on my insurance. I may review my insurance benefits or contact my insurer to learn what my policy will pay and what out-of-pocket expenses I may need to pay. At my request, clinic or hospital staff will provide me with an estimate of the billed charges for outpatient services I am likely to receive.
- UW Medicine and **VMC** 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: to make determination of available financial assistance, assistance in managing the payment process, or if I report that my identity has been stolen.
- As part of our billing and collection practices, we reserve the right to file liens to obtain payment for outstanding balances owed to VMC.
- You may receive additional bills from physicians who provided care as a result of your visit in our clinic, outpatient department or hospital. Some of those providers may be contracted with VMC while others are independent healthcare providers in private practice. For example: Valley Anesthesia Associates, Associated Emergency Providers, Incyte Diagnostics (Pathology), Vantage Radiology and Diagnostics, LabCorp (Laboratory) Providers.

Patient Label

UW Medicine
VALLEY
MEDICAL CENTER

FINANCIAL AGREEMENT & CONSENT FOR DISCLOSURE

- VMC must bill according to the type of visit and care provided during your appointment. Office visits that combine both preventive and problem focused care will be billed separately and may have additional out of pocket expenses such as a co-pay or deductible.
- Payment of co-pays will be required at check in. Please know the amount of your co-pay and come prepared to pay it. Patients that are not prepared to pay on the day of service will be asked to reschedule to another time unless a medical emergency exists or be charged a $30 billing fee.
- We accept payment by check, Visa, and MasterCard or on our website at http://www.valleymed.org/Patients-and-Visitors/MyChart-Online-Billing-Notice/ Cash is no longer accepted at our clinic locations for security reasons. We will provide a receipt for all payments. Please retain this receipt for your records.
- If you have no insurance coverage or elect not to use your insurance for the visit, a deposit is expected at the time of service. A 40% discount will be applied to your visit when this good faith payment is made at the time of service with the exception of cosmetic and experimental procedures. Remember that services provided by outside entities will not be included (see ancillary services above).

  Deposit amounts are as follows: Primary & Urgent Care Clinics: $125.00
  Specialty Care Clinics: $140.00
- In the event that I am undersigning as an agent for the patient, I personally assume liability for the patient responsibility amount.

Statement to Permit Payment of Medicare or Insurance Benefits to Provider

I request payment of authorized Medicare or insurance benefits for any services furnished to me by UW Medicine, **VMC**, SOD, CUMG, and/or SCCA. I authorize any holder of medical and other information about me to release to Medicare [and its agents] or other insurance providers any information needed to determine these benefits for related services.

Signature (Patient or Person Authorized to Give Authorization)	Date

If Signed by Person Other than Patient, Check Relationship to Patient:

☐ 1. Guardian ☐ 2. Durable Power of Attorney for Health Care ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/legal custodian ☐ 2. Court-authorized person for child ☐ 3. Parent(s)

Patient Label