Western Washington Medical Group

Acknowledgment of Conditions for Treatment & Financial Disclosures

The undersigned Patient and/or Patient's Representative hereby acknowledges receipt of Western Washington Medical Group's Handout entitled "Notice of Privacy Practices, Conditions for Treatment, Financial Disclosures, Patient's Right Materials" (Rev. 02/21/24), referenced here as the Handout. The Handout will be presented physically at the clinic or you can access here if checking in online.

CONSENT FOR CARE: I agree to care and treatment by Western Washington Medical Group (WWMG) that may include examinations, tests, imaging studies, labs, anesthesia, and medical or surgical treatments provided by both WWMG employed and WWMG affiliated physicians, surgeons and other licensed independent practitioners involved in my care. Care may be delivered via secured audio video platforms or secure, asynchronous internet-enabled platforms. Additional documents and consent forms may be required for specific procedures. I understand I have the right to ask questions about my care at any time, and to be involved in my care decisions.

RISKS OF TREATMENT: NO GUARANTEE OF RESULTS OR CURE:
No promise or guarantee of results or cure has been made to me.
I know there are risks related to surgical, medical, or diagnostic procedure(s). These risks include, but are not limited to the potential for infection, blood clots in veins and lungs, bleeding, allergic reactions, and death.

PHOTOGRAPHS FOR TREATMENT, DIAGNOSIS AND/OR IDENTIFICATION:
For diagnosis and treatment purposes, I allow images such as photographs to be taken and used. This includes video and electronic monitoring or recording methods. These images may be used to add to written information about my illness or injury. Some images are used once and immediately discarded when no longer needed. Others may be kept as part of my medical record, at the option of my treatment providers. Photographs of me may also be taken for identification purposes.

IMAGES OR RECORDINGS OF HEALTH CARE PROVIDERS:
I understand I must obtain the permission of all health care provider(s) and any other individuals present before I can take photographs or video of any members of my care team. I also understand I cannot record conversations by any means without first obtaining the permission of all persons being recorded. At no time may I take photos or recordings of other patients or their information.

NON-EMPLOYED PHYSICIANS & PROVIDERS: I understand there are physicians or other licensed providers who practice at WWMG who are not employed by WWMG. These individuals are independent providers and are not employees or agents of WWMG. These include, but are not limited to: anesthesiologists, radiologists, emergency medicine, pathologists, and hospitalists/internists. I understand these providers use their own independent judgment in their medical care and treatment. WWMG does not control the medical care and treatment given by these providers. I understand that WWMG has provided me with a list of all independent providers or groups who provide care to me, together with their contact information within this handout (Understanding Your Bill section). I understand that I may receive separate bills for services provided by those parties.

FINANCIAL AGREEMENT: I agree to pay WWMG for care at its regular rates and terms applicable to my care and any applicable health insurance coverage I have. I permit WWMG to appeal any denial received from my insurance company. If a third party payor will not pay, I agree to pay for the services given, subject to any applicable contractual or governmental regulations. If a third party caused my injuries, I understand that WWMG may file a medical services lien as permitted under RCW 60.44.010. (This lien attaches only to a portion of the proceeds of any settlement between me and the party that caused me harm.) If my bill is sent to a lawyer or

collection agency, I will pay all reasonable attorneys' fees and costs, together with interest and any amounts otherwise found to be owing. Information about the estimated charges for health services is available upon request. I understand I have the right to request this information.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service. If you are unable to pay your co-pay at time of service there may be an additional $15.00 fee charged to your account. Should the account be referred over to our collection agency the undersigned, or their agent, may be responsible for payments of interest on the unpaid balance of 9% per month from the date of the service, collection fees, reasonable attorney fees and court costs. We charge $35.00 for any NSF checks. (per RCW 62A-3-515 & 520). I agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

AGENTS & CONTRACTORS: Whenever "WWMG" is referenced herein, that term is intended to include its employees, officers, agents, attorneys, first and third party liability and claims agents, third-party claims administrators and collection agencies, as well as their agents or employees, to receive any information that WWMG would otherwise be entitled to receive.

MEDICARE: WWMG's insurance and patient billing processes are consistent with the requirements established by CMS. If I am a Medicare participant, I understand that I need to pay for services that are not covered by the Medicare Program. This may include, but is not limited to, cosmetic surgery, dental care, take-home and "over the counter" medications, private duty nurses, services not medically needed, personal items, services covered by car or liability insurance, or where a third party is otherwise responsible for any accident or injury leading to my need for care, as well as any services not otherwise covered by Medicare.

CO-INSURANCE: There may be a co-insurance for care given related to my Medicare or other insurance benefits.

ASSIGNMENT OF BENEFITS; PERMISSION TO ALLOW WWMG TO DETERMINE, APPLY AND OBTAIN BENEFITS INFORMATION AND PAYMENT: I permit payment from insurance or other third-party payor's to go to WWMG directly. I permit WWMG, in WWMG's sole judgment, to determine, apply for and obtain benefits, and get paid from, any and/or all available payor sources until my bill is paid in full. I understand and agree that, to the extent necessary to receive payment or reimbursement for services provided at WWMG, I authorize WWMG to access any applicable accident reports, industrial injury (workers compensation) reports and/or police, fire or other first responder reports or investigations related to my treatment or injury, as well as any records of any claims, lawsuits, insurance claims or investigations that pertain to my medical care and treatment, or the circumstances leading to same, together with any applicable consumer and/or credit reports pertaining to me. I further authorize any applicable Federal, State or Local government or administrative agency to fully and completely release any and all of my records and/or incident information they have about me, pertaining to my care or the circumstances leading to my need for care, upon request by WWMG..

PHONE, EMAIL, TEXT MESSAGING AUTHORIZATIONS: I grant permission and consent to WWMG to contact me using any e-mail addresses or phone numbers associated with me, including wireless (cell) numbers, for any purpose related to my care, including the availability of services at WWMG. I also represent that I am the owner or a customary user of the phone number(s) provided and have authority to grant the permission and consent to contact described herein. This consent and permission includes (1) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (2) to send me text messages or emails using any e-mail addresses or cellular device numbers; (3) to send me paperless billing by e-mail or text notifications; (4) to use pre-recorded/artificial voice messages and (5) use of an automatic dialing device (an "autodialer") in connection with any of these communications. I understand that I am not required to accept messages in these formats as a condition of receiving services at WWMG. I understand that I have the option

to “opt out” of receiving such emails or text messages, which I may exercise at any time by following the opt out option contained in the message, or notifying WWMG in writing to discontinue such communications using those pathways. I understand that opt out processes may take up to ten (10) business days to go into effect. Unless I have opted out, communications may continue after the expiration of this consent form.

EMAIL CONTAINING PROTECTED HEALTH INFORMATION; MYCHART:
I understand that exchanging e-mail, text or other written communications with my health care provider(s) or other members of my care team can result in protected health information being disclosed to unauthorized persons, and that WWMG cannot control who views such information when sent in unencrypted form. I understand that WWMG offers “MyChart” to all patients, which provides a fully encrypted and protected pathway for communicating with most of its providers, although not all WWMG providers choose to utilize MyChart. If I initiate or respond to communications using unencrypted pathways, I assume the risk that my information may be compromised, and I authorize WWMG and its providers to communicate with me using that process, unless or until I choose to opt out of such communications pathways by notifying WWMG in writing, allowing up to ten business days to implement any change in my communications pathways.

HEALTH CARE ADVANCE DIRECTIVE / LIVING WILL: I understand a health care directive, also called a Living Will, lets me choose if I want life-sustaining and other treatments in certain situations, and also lets me choose someone to make decisions on my behalf, if necessary. I understand that I have the right to create a Health Care Directive.

HEALTH CARE POWER OF ATTORNEY: I understand I have the right to nominate another person or persons to make health care decisions for me if I cannot make decisions myself. I understand that I can nominate this person using a Durable Power of Attorney for Healthcare (DPOAH) form. The person I nominate is known as a health care agent, attorney in fact, surrogate, or medical decision maker. Though neither form is required for treatment, I understand that providing WWMG a copy of my health care directive and/or power of attorney will help my care team understand my wishes.

MENTAL HEALTH ADVANCE DIRECTIVE/POWER OF ATTORNEY:
I understand that I also have the right to complete a Mental Health Advance Directive to help my care team understand my wishes concerning mental health care and treatment. I also can complete a Mental Health Power of Attorney where I can nominate another person or persons to make mental health care decisions for me.

POLST: I understand that a POLST (Physician Orders for Life Sustaining Treatment) is a medical order that is used to communicate medical care decisions to health care providers and emergency responders. If I have completed a POLST with my doctor, I agree that providers can use this to guide my care plan.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: Western Washington Medical Group has a responsibility to protect the privacy of your health care information. Western Washington Medical Group also has a responsibility to give a Notice of Privacy Practices that describes:

- How your health care info may be used and shared
- How you can obtain your health care info and
- Whom to reach if you have questions, concerns, or complaints

We may change the Notice of Privacy Practices at any time. You may email our Compliance office compliance@wwmedgroup.com to obtain an up-to-date copy of the Notice or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Western Washington Medical Group.

APPOINTMENT POLICY: A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled, that time is lost.

We ask that when you make an appointment you make every effort to keep that appointment. We understand

that emergencies do arise, and we will take that into consideration. If you find that you cannot keep your scheduled appointment, we require two business days' notice so that we may see another patient in need of care.

It is office policy to charge a fee for any missed appointment without a minimum of two business days' notice. This charge is your responsibility and insurance will not pay for missed office visits.

If a patient arrives more than **10 minutes late** for their appointment they may be asked to reschedule to a different time. Occasionally we may still be able to see these patients, only if there is an open appointment slot after theirs or if they call ahead and get provider approval for being later than **10 minutes** for their appointment.

Late/ Late Cancelation/ No-Show Fees are as follows:

- $50 for Primary Care and Imaging Center Appointments/ Office Visits
- $100 for Specialty Care Center Appointments/ Office Visits and Pulmonary Sleep Procedures
- $250 for Surgeries, Endoscopy Center Procedures and In-office Procedures
- Podiatry does not charge late fees.

Definitions are:

- Late = patient arrives 10 minutes or more after scheduled appointment time
- Late Cancelation:
    - <72 hours for a Gateway Surgery or Procedure
    - <48 hours for Endoscopy Center Procedures, In-office Procedures, Appointments, Office Visits, and Imaging

I certify that I have read the appointment policy and agree to abide by this policy.

More information and downloadable forms can be found at https://www.wwmedgroup.com/patient-privacy/.

This consent will remain valid for one year from the date of signature.

Patient or legally approved signature:

Patient Name:@NAME@
DOB: @DOB@ AGE: @AGE@
MRN: @MRN@

Western Washington Medical Group
Marysville Family Medicine

FRIENDS AND FAMILY RELEASE

Patient's name PRINTED	Patient's ACCOUNT NUMBER	Today's date

I give the physicians and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition with person listed below.
The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:
(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)
[ ] HIV (Aids virus) **[ ]** Sexually Transmitted Diseases (STD's)
[ ] Psychiatric disorders/Mental health **[ ]** Alcohol/Substance abuse
[ ] All other Health Information
Other: _____

<u>Patient's Personal Phone Information: NOTE - This is DIFFERENT than the above info.</u>

Please provide us with **YOUR *best, most current*** phone contact information. This information will become part of your permanent medical record *unless/<u>until you change it</u>*. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number: _____ Cell Work Home OK to leave detailed message: Y N

Second phone number: _____ Cell Work Home OK to leave detailed message: Y N

Third phone number: _____ Cell Work Home OK to leave detailed message: Y N

X _____ _____
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

X _____
PRINTED name of person signing