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## TERMS AND CONDITIONS OF SERVICE

**HEALTH CARE CONSENT:** Patient care provided at WFPG is directed by attending staff providers. I understand that there may be risks and alternative to a proposed treatment. I have the right to ask for detailed explanations of all aspects of my care and treatment. I consent to services rendered and provided under the instructions of attending staff physicians or other WFPG health care providers who may be assisting in my care, as well as volunteer or courtesy physicians or other providers who may be associated for the purpose of consulting.

**TEACHING INSTITUTION:** WFPG is a teaching institution we are affiliated with OHSU. I agree that persons who are students, resident physicians and post-graduate fellows or others involved in graduate medical education programs may participate in my care as a part of the educational programs of the institutions. I may be contacted by various health care providers or clinical researchers at OHSU for voluntary participation in clinical research projects; however, I have the right to refuse to participate without jeopardizing future care in any way at WFPG.

### CONSENT FOR RETENTION OF GENETIC INFORMATION

I understand and consent that genetic information received or created in the course of the delivery of health care at WFPG will be entered into the routine medical record and maintained by WFPG.

### CONSENT FOR RELEASE OF INFORMATION

**RELEASE OF INFORMATION TO PRIMARY CARE PROVIDER, REFERRING PROVIDERS, INSURERS AND PROFESSIONAL REVIEW ORGANIZATIONS:** I understand and consent that health information received or created in the course of the delivery of health care at WFPG will be used or released for treatment, payment and health care operations as described in the WFPG Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available upon request.

**SOCIAL SECURITY NUMBERS:** WFPG collects administrative and nonmedical patient data including social security numbers for the purpose of patient identification, compliance with federal and state agency reporting requirements, billing to insurance carriers and collection needs, as authorized by ORS 351.070 or 353.050. Disclosure of the social security number information is voluntary. I have provided this information and authorize WFPG to use this information for the purpose stated above.

### STATEMENT OF FINANCIAL RESPONSIBILITY

**FINANCIAL AGREEMENT:** The undersigned, jointly and severally, in consideration of services to be rendered to patient, agrees to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and cost on appeal. The undersigned assigns to each provider of service all insurance benefits available for the professional and institutional services rendered. The assignment is irrevocable, and the undersigned authorizes carriers of such benefits to make payment directly to WFPG. Payments received from insurers will be applied to the patient's account balance obligation. The undersigned agrees to promptly pay any charges not immediately (within 30 days) covered by insurance(s).

**SOCIAL SECURITY PROGRAMS:** I certify that the information given by me in applying for payment under Titles V, XVIII or XIX of the Social Security Act is correct. Should benefits be required to be terminated by Peer Review Organization, I understand I will be notified and I will become responsible for payment of non-covered hospital care if I elect to remain in the hospital. I request that payment of authorized benefits be made on my behalf directly to the provider.

### OTHER

**PATIENT CARE:** I agree that the above consent for treatment, consent for release of information and agreement of financial responsibility apply to services provided at WFPG.

### I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date