PATIENT CONSENT AND FINANCIAL AGREEMENT

Kalispell, Montana

LOGAN HEALTH

Patient Name: _____ Patient DOB:_____

Please Print

Welcome to Logan Health. Thank you for choosing us for your care and treatment. Logan Health is an integrated health system that includes a number of organizations and Healthcare Services providers. Your consent covers services provided at all Logan Health entities.

Please review this Agreement carefully. Except in cases of emergency care, we must have a signed and dated Patient Consent and Financial Agreement before Healthcare Services (defined below) can be provided to you. If you have any questions about this Agreement, our Logan Health staff will be happy to answer your questions before you sign.

If, at a later date, you have additional questions about your medical bills or need to make corrections to the information you have provided to Logan Health, please contact the Logan Health Patient Accounting office by calling (406) 756-4408, Monday through Friday, except holidays, from 8:00 a.m. through 5:00 p.m.

CONSENT FOR TREATMENT AND CARE

You hereby consent to any Healthcare Services (as defined below in this paragraph) provided by Logan Health and Healthcare Services providers who are independent from Logan Health but who are authorized to provide Healthcare Services to you as a Logan Health patient. These independent, non-Logan Health-employed providers include, but are not limited to physician and other medical and allied health professional staff members of Glacier Regional Pathology, Ltd.; Clinical Pathology Associates, LLC; Northern Rockies Anesthesia Consultants, PLLC; Northwest Imaging, PC; Silvertip Emergency Physicians, PC (collectively, "Logan Health Affiliated Providers") and outside reference laboratories. You understand and agree that resident physicians and other Healthcare Services education students may participate in or be observers of the Healthcare Services you receive at Logan Health. These residents and students will be supervised by qualified instructors and Logan Health staff. You can decline care by supervised resident physicians and Healthcare Services education students by discussing it with your provider(s) prior to care being rendered. Your Healthcare Services may be provided in person or via telehealth technology and may include, but are not limited to, hospital inpatient, outpatient, and/or emergency services; physician office services; diagnostic procedures; transportation; nursing care; and other Healthcare Services and products. You acknowledge that no guarantees have been made regarding the outcome of these Healthcare Services. If you are not able to sign this Agreement personally, then the consent for your care and treatment: (1) may be given by your representative(s) who are legally authorized to make decisions and sign this Agreement on your behalf, or (2) shall be implied in cases of emergency.

REPORTING OF IMMUNIZATION RECORDS

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS data to other public health agencies as well as to your/your child's healthcare providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release IIS data to schools in order to comply with immunization requirements. You can always choose to opt out at a later time and/or have your/your child's immunization record removed at any time by contacting your county's health department. You understand that any such revocation will not be effective as to uses and/or disclosures already made prior to opting out.

THIS IS NOT A CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO DPHHS IIS. If you are OPTING OUT and do not wish for your/your child's immunization data to be provided to DPPHS, check the box, sign and date in the area below.

☐ **OPT OUT** OF THE DPHHS IMMUNIZATION INFORMATION SYSTEM

_____ _____

Name of Patient Date Signature of Patient/Parent, Authorized Representative or Guardian, if applicable

FINANCIAL AGREEMENT

AGREEMENT TO PAY CHARGES AND BILLING STATEMENTS – In consideration of the Healthcare Services provided to you, you and/or any individuals who are directly responsible for your medical bills, such as a parent or guardian, (collectively, "Guarantors") agree to pay Logan Health's billed charges related to those Healthcare Services ("Charges"), minus any contractual reductions from the Charges agreed to by Logan Health with your Health Plan Payor (if applicable) and any other reductions to which you may be entitled, such as under the Logan Health financial assistance policy. You understand and agree that: (1) any Logan Health Affiliated Providers that provide Healthcare Services to you in connection with your care and treatment at Logan Health may have separate billing and collection practices that result in one or more separate bills for which Guarantors are responsible to pay; (2) the terms of this Agreement prevail over any conflicting terms and conditions in any other contract or plan to which you claim to be a party or a beneficiary; (3) it is possible that your Health Plan will determine that Healthcare Services provided to you are not Covered Services and that you will be responsible for paying for those Healthcare Services; and (4) the terms of this Agreement are governed by the laws of the State of Montana.

FINANCIAL ASSISTANCE – Logan Health has a Financial Assistance policy available to patients who qualify. If you are interested in learning more, please ask our staff for a copy of the policy. The Financial Assistance Policy is available on the Logan Healthwebsite under the heading "Pay Bill."

PATIENTS WITH OUT-OF-NETWORK INSURANCE/OTHER HEALTH PLAN PAYOR/HEALTH SHARE PRODUCT – You understand and agree that except when prohibited by applicable law, Logan Health may collect its charges from guarantors when Logan Health does not have a written contractual agreement with an insurance company, other health plan Payor or health share product outlining an agreed upon rate of payment for the Healthcare Services provided (called "out-of- network"). You understand and agree that when receiving Healthcare Services from Logan Health on an out-of-network basis, Guarantors may also be required to make payment at the time of service.

PAYMENT – Guarantors may make payment to Logan Health: (1) at the time Healthcare Services are provided to you; (2) in accordance with billing statements received from Logan Health; or (3) in accordance with a payment arrangement schedule that is agreed upon by both Logan Health and Guarantor(s). If Guarantors fail tomake any scheduled payment when due, you understand and agree that: (1) Logan Health may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible for all costs associated with collection of the owed charges, including reasonable attorney's fees. You acknowledge and agree that payments to Logan Health Affiliated Providers must be made to them in accordance with their payment rules. No partial payment of the amount owed by Guarantors to Logan Health (whether the payment says it is in full payment or not) will be treated as full payment without a specific separate written agreement between Guarantors and Logan Health that is signed by both parties. Logan Health may also assign past due accounts to third party collection agencies.

THIRD PARTY LIABILITY – In the event that any third party is or could be liable for part or all of the charges for the Healthcare Services provided to you (such as due to an automobile accident), you acknowledge that Guarantors remain responsible for the portion of the Charges that you are responsible to pay, but Logan Health is also legally authorized to bill for and recover from that third party the full charges for the Healthcare Services. Logan Health may do this whether or not Logan Health has also submitted a bill for the services to any federal, state, or private healthcare insurance/health benefits plans (collectively a "Health Plan Payor") covering you. Guarantors will not be responsible for any amounts in excess of the portion of the charges that you are responsible to pay, but Logan Health may recover from the third party an amount that permits Logan Health to receive up to the full charges for the Healthcare Services provided. Guarantors also acknowledge that Logan Health may submit a Healthcare Provider/ Facility Lien, as allowed by Montana Code Annotated Title 71, Chapter 3, Part 11, to the third party. To the extent any medical care I receive under this Care Agreement is rendered in connection with a vehicle accident, I hereby designate Logan Health and/or its representatives, designees or agents as my representative for purposes of requesting and securing copies of any accident reports under 61-7-114(2)(b), MCA.

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OVERPAYMENTS – **Please let us know if your address changes so that we can contact you in the event that your account is overpaid and you are entitled to a refund in accordance with this paragraph.** ***If your account is overpaid by less than $15.00,*** you agree that the amount is too small to refund and that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us, or (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. ***If your account is overpaid by $15.00 to $49.99,*** we will attempt to contact you and provide you with a refund of the overpayment amount. If, after one year, we have not been able to contact you, you agree that we may take either of the following actions in the following order: (1) apply the overpayment amount to any other outstanding accounts that you have with us or, (2) if you do not have any other outstanding accounts with us, we may write off the overpayment amount. ***If your account is overpaid by $50.00 or more,*** we will attempt to contact you and provide you with a refund of the overpayment amount. If, after three years, we have not been able to contact you, then pursuant to Montana's Unclaimed Property Act, we will send the overpayment amount, minus a statutorily allowed dormancy charge of $10 per year, to the Montana Department of Revenue.

NOTICES OF NON-COVERAGE

If it is determined at any time, prior to or during your hospital stay, that your medical services and/or inpatient hospitalization are considered not medically necessary, not being delivered in the appropriate setting, or are deemed to be custodial in nature, a Hospital Issued Notice of Non-coverage (HINN) or Medicare Waiver/Advanced Beneficiary Notice (ABN) will be delivered to you. The notification will explain any services you may be financially responsible for, the estimated costs associated with those services, as well as your rights to request an expedited review by the QIO.

AUTHORIZATION

Without waiver or limitation of the above Financial Agreement, you hereby: (1) authorize Logan Health, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and other responsible third party providing coverage for, or who may be otherwise liable for, payment of any of the charges for the Healthcare Services provided to you ("Responsible Third Parties"); and (2) direct those Health Plan Payors and Responsible Third Parties to which Logan Health submits a claim for payment to make payment(s) directly to Logan Health. You understand and agree that Logan Health: (1) is not required to submit a claim for payment to anyone other than Guarantors; but (2) may choose to submit a claim to one or more of your Health Plan Payors and Responsible Third Parties. This authorization is limited only to the rights, on your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and Responsible Third Parties. It does not entitle Logan Health to any other rights or bind Logan Health to any responsibilities that you may have under any Health Plan Payor agreements, third party liability agreements or policies or any other theories of coverage or liability. You hereby consent also to Logan Health providing notice of this authorization to your Health Plan Payors and other Responsible Third Parties.

APPOINTMENT OF Logan Health (Logan Health) AS AUTHORIZED REPRESENTATIVE

I understand that Logan Health may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint Logan Health to act on my behalf and/or on behalf of my covered child/ dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to Logan Health. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to Logan Health.

RELEASE OF INFORMATION

You acknowledge that Logan Health and Logan Health Affiliated Providers are authorized by law to release medical and account information necessary for the purposes of treatment, payment, and healthcare operations. This information may be released to Health Plan Payors, liability insurance companies, billing companies, collection agencies, attending/consulting healthcare providers, governmental programs or medical review organizations and otherwise as permitted or required by law.

HEALTH INFORMATION EXCHANGE

Logan Health may share information that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIEs) in which we participate. For example, information about your past medical care and current medical conditions and medications may be available to us or to your non-Logan Health primary care physician or hospital, if they participate in the HIE. Exchange of health information may provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.
If you are OPTING OUT and do not wish for your/your child's PHI to be released to the HIE, check the box, sign and date in the area below.

☐ **OPT OUT OF THE HEALTH INFORMATION EXCHANGE**

_____ _____

Name of Patient Date Signature of Patient/Parent, Authorized Representative or Guardian, if applicable

CONSENT TO CONTACT

You agree that, in order for Logan Health and/or Logan Health Affiliated Providers to request your feedback about the Healthcare Services provided to you, to service your account, or to collect any amounts you may owe, Logan Health, Logan Health Affiliated Providers and their business associates, including without limitation any independent contractors, account management companies or collection agencies, may contact you by telephone, SMS text message or email at any cellular or residential telephone number or email address provided during your registration process. These methods of contact may include auto-dialed, prerecorded and/or artificial voice message calls or texts as permitted by law.

PERSONAL VALUABLES

You acknowledge that Logan Health maintains a safe for securing money and/or other valuables. Logan Health shall not be liable for the loss of or damage to your money, valuables, articles of unusual value, or any other personal property if not deposited with Logan Health for storage in Logan Health's safe.

BY SIGNING BELOW, YOU CONFIRM THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, (2) HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS AGREEMENT AND (3) HAVE RECEIVED AND REVIEWED AND, IF NEEDED, COMPLETED THE FOLLOWING:

- **FEDERAL TRUTH IN LENDING ACT NOTIFICATION**
- **PATIENT BILL OF RIGHTS & RESPONSIBILITIES**
- **Logan Health JOINT NOTICE OF PRIVACY PRACTICES**
- **ADVANCE DIRECTIVE** – You have been advised of your right to formulate and execute an Advance Directive and have been provided with written information regarding the same.
- **AN "IMPORTANT MESSAGE FROM MEDICARE FOR MEDICARE BENEFICIARIES" or "IMPORTANT MESSAGE FROM TRICARE FOR TRICARE BENEFICIARIES" (Medicare and Tricare Inpatients, only)**

_____ _____

Patient Signature/Authorized Representative/Guarantor Date

If an Authorized Representative/Guarantor, the nature of the relationship to the Patient: _____

_____

Patient Name _____ Acct # _____

Witness _____ MRN # _____

ORIGINAL TO MEDICAL RECORDS OR SCANNED TO ACCOUNT • PHOTOCOPY TO PATIENT