EXCELSIOR FAMILY MEDICINE

PH: 509-467-1100 FAX: 509-468-0173
NORTH: 9631 N Nevada, Ste 202, Spokane, WA 99218
WEST: 3754 W Indian Trail, Spokane, WA 99208

Consent and Financial Responsibility

1. RELEASE OF PRESCRIPTION HISTORY: I understand that Excelsior has the right to ask for any data regarding my medication history. I also understand that Excelsior may get any data regarding my medication history. This includes data that may be held by the Washington Prescription Monitoring Program and other sources.
2. HIV TESTING DISCLOSURE: I may be tested for HIV, Hepatitis B or C viruses without my permission, if contact with my body fluids occurs during a medical treatment. The results of these tests will be given, without my permission, to the person that came in contact with my body fluids.
3. ASSIGNMENT OF BENEFITS: I assign Excelsior and any independent providers working at Excelsior any money which I may receive from any insurance, workers compensation or disability benefits related to my medical treatment. I authorize any attorney paying out such money to pay Excelsior directly what I owe on any Excelsior bill.
4. PAYMENTS DUE AT TIME OF SERVICE: Excelsior will bill most insurance companies for patients, even though Excelsior does not have to do so. If my insurance company does not pay all or part of my bill, I will pay. Full payment is due at the time of service. I may make other arrangements if I cannot pay at the time of service. I will be charged $30.00 for returned checks. I give permission to Excelsior to apply any overpayment from another Excelsior account to any other bill I may owe.
5. INSURANCE REFERRALS & AUTHORIZATIONS: I understand that it is my duty to fully follow all steps required by my insurance coverage for preauthorization of any treatment. If I elect to be treated without a referral from an approved doctor, it is my sole responsibility to pay my bill. I understand that my insurance may not pay anything if I am treated without a referral.
6. MULTIPLE BILLS: I understand that while I am treated at Excelsior, I may receive separate bills for services within different departments. I agree to pay any bills received that are not paid by my insurance company.
7. PATIENT/FAMILY BEHAVIOR: While in an Excelsior office or facility, I will be polite to staff. I will be polite to all medical providers and counselors. I will be polite to other patients.
8. EXCELSIOR IS NOT RESPONSIBLE FOR LOSS OF PERSONAL BELONGINGS: Excelsior is not responsible for any loss, theft, or damage to my personal belongings.
9. EMAIL: By providing my email address to Excelsior, I permit them to send me messages on health-related issues. I also permit them to use my email address to send me messages on health services. I can choose not to receive such messages from Excelsior by contacting them.
10. NO SHOW PATTERNS: I understand that my appointment time is designated for me and I respect my provider and support staff in preparing for my visit. If I miss more than three appointments in a rolling 12 months, without 24-hour notice of cancellation, I may be discharged from services.
11. PHOTO RELEASE: I understand that during my visit, photos may be taken associated with a condition for which I am being treated. These images will be stored in my chart for comparative purposes.

12. AUTHORIZATION FOR MEDICATION AID PROGRAMS: Excelsior partners with drug companies to get medication for low-income, uninsured patients who qualify. I consent to send my medical and financial information to drug companies for aid. I also consent to Excelsior and its agents to complete the drug companies' application and to sign on my behalf.
13. CELL PHONE COMMUNICATION: I agree to share with Excelsior my cell phone number so that Excelsior and its independent contractors and agents can call me. This means that I agree to receive calls and messages including automated messages on my mobile number or other type of phone number. This will apply to both calls for treatment as well as unpaid balances.
14. NOTICE OF PRIVACY PRACTICES: I am aware of Excelsior's Notice of Privacy Practices. I have been offered a copy of these practices. If I am asked for, by name, while being treated at Excelsior, I agree that Excelsior may confirm my location at the facility and my general medical status.

I agree to these terms.

Printed Name

Date of Birth

Signature

Relationship to Patient