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, SOD, CUMG and/or SCCA for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
3. To notify UW Medicine, SOD, CUMG and/or SCCA of changes to my insurance coverage and/or address.
4. That UW Medicine, 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, 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, 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 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, SOD, CUMG, and/or SCCA bill separately for their services.**
- **Patients who receive outpatient services at UWMC or HMC 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. At my request, clinic staff will provide me with an estimate of the billed charges for outpatient services I am likely to receive.**
- **UW Medicine 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.

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, 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)

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

FINANCIAL AGREEMENT & CONSENT FOR DISCLOSURE

U1865

UH1865 REV APR 13

WHITE – MEDICAL RECORD
CANARY – PATIENT