REGISTRATION AGREEMENT AND SERVICE TERMS

Patient Name: _____Medical Record Number: _____ Date of Service: _____ Date of Birth: _____

This signed Agreement pertains to all care provided at an Gundersen St. Joseph Hospital and Clinics Facility or by an Gundersen St. Joseph Hospital and Clinics Provider at a **non-**Gundersen St. Joseph Hospital and Clinics Facility.
Services provided in an Gundersen St. Joseph Hospital and Clinics Clinic: agreement remains in effect for a period of one year hereafter date of service.
Services provided in an Gundersen St. Joseph Hospital and Clinics Hospital: agreement remains in effect from data of service until all treatments/hospital charges have been paid in full and there is a zero ($0) balance on the account.

REGARDING MY CARE, I CONSENT TO:
Rendering of medical care including routine diagnostic procedures and such medical treatment as my attending physician(s) or other Gundersen St. Joseph Hospital and Clinics staff consider to be necessary. I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician(s) or other authorized health care providers. I understand that if I choose to consent to receive any specialized medical care and/or non-routine services from Gundersen St. Joseph Hospital and Clinics, I will have the opportunity to provide my consent for such specialized medical care and/or non-routine services separately from this Agreement.
Medical services by telephone or telemedicine using videoconferencing that involve the delivery of health care by electronic communication with a provider who is at a different physical location.
Medical care and treatment provided by Advanced Practice Clinicians, RNs, and other health care providers. Visual Monitoring: Visual monitoring may be used for patient safety.
No guarantee or assurance has been made as to the results that may be obtained.

REGARDING NON-AFFILIATED HEALTH CARE PROVIDERS WHO MAY PROVIDE CARE AT Gundersen St. Joseph Hospital and Clinics **LOCATIONS, I UNDERSTAND AND AGREE THAT:**
These providers have clinical privileges but are not employed agents of Gundersen St. Joseph Hospital and Clinics.
Gundersen St. Joseph Hospital and Clinics employees, agents and representatives may follow the instructions of these providers.
Gundersen St. Joseph Hospital and Clinics is not liable for the actions, failures to act, or the instructions given by the provider(s) while I am at Gundersen St. Joseph Hospital and Clinics.
Fees of any provider are not included as a part of any bill I receive from Gundersen St. Joseph Hospital and Clinics.
No guarantee or assurance has been made as to the results that may be obtained.

THE FOLLOWING PROVISIONS APPLY IF YOU ARE SEEKING CARE AT A CRITICAL ACCESS HOSPITAL ON YOUR DATE OF SERVICE:
Notice of On-Site Physician Coverage: This Critical Access Hospital may not have a physician in the facility 24 hours per day. To meet your needs if an emergency medical condition develops, a physician is on-call and readily available to come to the hospital.
Rx Drug Packaging: I accept non-safety closure lids on any medications dispensed through the emergency room or urgent care clinic for self-administration.
Iowa – **Physician Fee**: Pathology and radiology services are medical services performed or supervised by physicians, and the personnel and facilities are or may be furnished by the hospital for said services. Charges for such services are or may be collected, however, by the hospital on behalf of said physicians pursuant to an agreement between said physicians and the hospital, and from said charges I consent that an agreed sum will be retained by the hospital in accordance with an existing agreement between the physician and the hospital.

I GIVE PERMISSION TO Gundersen St. Joseph Hospital and Clinics **TO RELEASE ANY **MEDICAL INFORMATION ABOUT ME TO:**
Medicare or other insurers and its agents for the purpose of deciding benefits and processing claims; this may include but is not limited to, requesting prior authorization, or appealing denied claims.
The Guarantor for handling of billing and payment on my account.
Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations. My other health care providers for treatment purposes; and not condition treatment, payment enrollment, or eligibility for benefits on my agreeing to this provision.
Gundersen St. Joseph Hospital and Clinics entities for the purpose of providing information regarding the services and goods of Gundersen St. Joseph Hospital and Clinics and its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party as outlined in the Notice of Privacy Practices, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable laws.
I authorize Gundersen St. Joseph Hospital and Clinics and my insurer(s) to share my past, current and future health, treatment, and account records about services I've received from Gundersen St. Joseph Hospital and Clinics, and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

REGARDING ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY, I UNDERSTAND AND AGREE THAT:
Payment of authorized insurance benefits will be made to Gundersen St. Joseph Hospital and Clinics for any services provided to me by

Gundersen St. Joseph Hospital and Clinics.
I may receive a separate bill for health care services I receive from a health care provider not employed by Gundersen St. Joseph Hospital and Clinics and am responsible for all such charges.
I am responsible for all charges for services provided, including any amount not paid by my health plan(s), other than billing terms and restrictions under a government program.
I authorize Gundersen St. Joseph Hospital and Clinics to apply any credit balance on my account to any amounts that I may owe to one or more Gundersen St. Joseph Hospital and Clinics entities. Any outstanding balances are a family obligation, and our marital assets and my individual assets should be available to satisfy this obligation. I authorize Gundersen St. Joseph Hospital and Clinics to apply any credit balances to those accounts.

REGARDING SERVICE TERMS AT Gundersen St. Joseph Hospital and Clinics**, I UNDERSTAND AND AGREE THAT:**
Use of Phone: Gundersen St. Joseph Hospital and Clinics, its Affiliates, and its Business Associates (including third parties and third-party debt collectors) have my express permission to contact me for any purpose associated with my account, including wireless telephone number. I understand that this may include the use of automated dialing equipment, prerecorded voice, or text messages. I understand standard messaging rates may apply.

I have either received or declined a copy of the Gundersen St. Joseph Hospital and Clinics **System Notice of Privacy Practices, Rights and Responsibilities, and Notice of Language Assistance, and Notice of Nondiscrimination.**

PERSONAL VALUABLES: I understand I am responsible for all personal belongings during my visit. I assume responsibility for any loss or damage to valuables.

ATTENTION: This is a legal document. Changes will not be accepted on this form. By signing this Agreement, you understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on you signing this Agreement. When the following information is used or disclosed to the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed. Copies of records may be obtained with reasonable notice.

Signature : _____ Date:_____

If signed by someone other than the patient: ☐ Parent/Legal Representative ☐ Health Care Agent (Health Care Power of Attorney)