SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

AUTHORIZATION FOR TREATMENT AND PROMISE TO PAY (ASSIGNMENT OF BENEFITS)

AUTHORIZATION

I authorize and consent to my admission or treatment as a patient at SEARHC for all treatment, and evaluation including any diagnostic and therapeutic care recommended by my physician or other health care provider. I acknowledge I have been separately informed by my physician or other health care provider and understand that proposed treatment, the risks inherent in the proposed treatment, and any alternatives to the proposed treatment. I understand I have the right to make decisions concerning my plan of care, to refuse medical care, and to obtain information about my health needs and treatment from my physician or other health care provider.

PROMISE TO PAY

I authorize any third-party insurance benefits to be paid directly to SEARHC. I understand I am financially responsible for any services not covered by my insurance company.

I assign to SEARHC all insurance proceeds for medical services rendered, and I understand SEARHC does not assume responsibility for the collection of such proceeds. If my account becomes delinquent (90 days after services have been provided) and is assigned to a collection agency, a collection fee will be added to the delinquent balance.

> ***Eligible Alaska Native/American Indian (AN/AI) beneficiaries (with documented eligibility) will not be financially responsible for covered services. AN/AI beneficiaries (with documented eligibility) without third party insurance will be financially responsible for services not covered by SEARHC. These include, but are not limited to: eyeglasses, hearing aids, some dental services, flat rate services, elective procedures and medications not included in the SEARHC Medication Benefits Package.***

INJURY RELATED CLAIM

In the event of any injury, I authorize care and treatment for the person named below and agree to pay all fees and charges for such treatment as shown by statements for services rendered by SEARHC. I will not delay or withhold payment because of pending claims for insurance coverage.

SEARCH OF PATIENT AND BELONGINGS

I understand, pursuant to SEARHC's policies and procedures, all patients and their belongings can be thoroughly searched immediately upon arrival for any services or hospitalization, prior to any meals, vital signs, or when the facility suspects the patient possesses any contraband, weapons, alcohol, illicit drugs, or drug paraphernalia. I understand anything brought into the facility by visitors shall be subject to being screened and confiscated. Emergency services for medical stabilization will occur prior to patient searches being performed.

INFORMED CONSENT TELEHEALTH

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Alternatives have been explained to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners within SEARHC or outside of SEARHC at my request.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

6. I attest that I am located in the state of Alaska and will be present in the state of Alaska during all telehealth encounters with SEARHC healthcare providers.
7. I understand that telemedicine visits will be billed in the usual manner to my insurance, if applicable.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

INFORMED CONSENT ELECTRONIC VISITS (eVisits)

1. I understand that a variety of alternative methods of medical care may be available to me, including phone calls or patient portal messages at my request, and that I may choose one of these if it is appropriate for my situation.
2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to electronic visits.
2. I understand that I have the right to withhold or withdraw my consent to the use of electronic visits in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that electronic visits may involve electronic communication of my personal medical information to other medical practitioners at SEARHC or outside of SEARHC at my request.
5. I understand that I may expect the anticipated benefits from the use of eVisits in my care, but that no results can be guaranteed or assured.
6. I understand that eVisit will be billed in the usual manner to my insurance, if applicable.

I have read and understand the information provided above regarding telemedicine and eVisits, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine and eVisits in my medical care.

COMMUNICATION

I authorized representative agree, by providing my information including a landline phone number, a wireless phone number, VOIP number(s), or any other numbers/methods of communication, consent to receive calls and/or text messages including autodialed calls and artificial or prerecorded messages from the hospital, physicians, agents, and independent contractors (including service agencies and collection agencies) regarding hospital/medical services and any related financial obligations. This consent applies to all services and billing associated with any account for me regardless of the date of service. I/authorized representative acknowledge that text messages may be susceptible to certain privacy and security risks, such as being viewed by others with access to the phone or device on which the text is received or stored. I understand that your service provider might charge fees for sending and receiving such communication by a third party and that I am fully responsible for such charges. These charges could include but are not limited to cell phone minutes, text message minutes, airtime minutes, VOIP fees, and taxes imposed for the use of the communication services.

This authorization will be considered valid for one (1) year from the date of signature unless otherwise noted. If the below name is a minor, as the parent/legal guardian, I authorize medical care for the health and well-being of this minor.

Signed by responsible party (Patient, Parent, Guardian)

Date

The following is needed to meet Federal funding reporting regulations for SEARHC:

1. Ethnicity
   - □ Hispanic or Latino
   - □ Not Hispanic or Latino
   - □ Unknown by patient
   - □ Decline to Answer

2. Race
   - □ American Indian or Alaska Native
   - □ Asian
   - □ Black or African American
   - □ Hispanic, Black
   - □ Hispanic, White
   - □ White
   - □ Native Hawaiian or Other Pacific Islander
   - □ Unknown by Patient
   - □ Decline to Answer

3. Primary Language_____Interpreter required? □ Yes □ No

4. Preferred language _____

5. Are you a migrant worker? □ Yes □ No

6. Are you homeless? □ Yes □ No
   If yes: □ Homeless shelter □ Transitional □ Doubling up □ Street □ Other □ Unknown

7. Do you have internet access: □ Yes □ No
   If yes:
   - □ Home
   - □ Work
   - □ School
   - □ Health Care Facility
   - □ Library
   - □ Tribe/Community Center
   - □ Mobile Device

8. Email address: _____

9, I give permission for SEARHC to email generic health information: □ Yes □ No

10. Preferred method for receiving appointment reminders (select only one): □ Phone □ Email □ Mail

11. Number of persons in household _____

12. Estimated Household Income_____ □ Week □ Bi-Weekly □ Monthly □ Yearly

13. Do you need help to □ See □ Hear

14. Are you a Veteran? □ Yes □ No