Fred Hutch Cancer Center

Fred Hutchinson Cancer Center - Care Agreement

I permit Fred Hutchinson Cancer Center, University of Washington Medicine (including University of Washington Physicians and Dentists), Seattle Children's Hospital (Children's), and Children's University Medical Group (CUMG) (also known as "Providers"), to perform all needed and advised healthcare services, including exams, therapies, and medical procedures. I permit the Providers to communicate with me about my healthcare, healthcare payment and healthcare operations using telephone, SMS text messaging, mail, fax and email.

I understand that the Fred Hutch health care team consists of medical doctors, doctors in training (residents and fellows), nurses, other health care professionals, and students of the health sciences.

I understand that all Physicians providing services to me are independent contractors and are not employees or agents of Fred Hutch. I am aware that results of my care and treatment cannot be guaranteed or promised. I also understand that the Fred Hutch may take, use, and reproduce photographs and videos of me that are related to my healthcare. I permit Fred Hutch to use such photographs and videos for treatment, payment and healthcare operations purposes, but only as permitted by state and federal health information privacy laws.

I may qualify for free care or a discount on my hospital bill, whether or not I have insurance. Fred Hutch's Financial Assistance Application and Financial Assistance Policy are available at our website https://www.fredhutch.org/en/patient-care/patient-services/insurance-and-billing/financial-assistance.html and by calling (206) 606-6226.

Financial Agreement & Consent for Disclosure

By signing below, I agree:

1. To the release of all financial information to the Providers and/or their agents. I agree that Providers may verify my financial information. I permit the Providers to contact those I have named to confirm my insurance coverage and my ability to pay any charges.
2. To assign to the Providers all insurance benefits (including Medicare) in order for them to collect payment for services provided, not to exceed the balance due for services provided.
3. To pay Providers all balances remaining after insurance benefits.
4. That the Providers may charge reasonable interest, late charges, collection costs and/or legal fees should my account become unpaid or overdue. Any lawsuit for collections may be brought in King County, Washington.

I understand that:

1. The processing of insurance claims is a service provided by the Providers and does not relieve me of my financial responsibility.
2. All Fred Hutch facilities are licensed as part of the hospital and as such, health care services provided at Fred Hutch result in two types of bills. One bill will be for facility fees. Generally, this hospital facility charge will be greater than the professional fee charge. Depending on my insurance coverage, I may pay more out-of-pocket for certain outpatient services and procedures. The other type of bill is from the doctor's billing group, which includes the doctor's professional fee.

TEAM

NAME [M]

PT NO PLACE EPIC LABEL HERE [F]

DOB

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3. Information about the estimated charges of my health care services is available upon request. I understand my rights as a consumer to request good estimates of charges and I am aware of the dispute resolution process. Estimates are not exact; charges will depend on the actual services provided. Please review your insurance benefits or contact your insurance company to see what your policy will pay and what you may have to pay out-of-pocket.
4. Charges for donor work-up and collection of blood products (including bone marrow and stem cells) for infusion to anyone other than myself will be billed to that person and I will not be financially responsible.
5. The Providers may request Social Security Numbers to verify identity and access to federal health care benefits (42 U.S.C. 1320b-7(a), (b)). Providing my Social Security Number is voluntary.
6. The Providers may share my health information for payment purposes with any person or organization (including Medicare) that may be responsible for payment for services provided to me.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive health care from Fred Hutch and agree with the above statements. If there is any part of this form that is unclear, be sure to ask questions about it.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)	DATE

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

- ☐ 1. Guardian
- ☐ 2. Agent designated by a 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 in out-of-home placement
- ☐ 3. Parent(s)
- ☐ 4. Holder of signed authorization from parent(s)

TEAM

NAME

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