

## Consent & Conditions of Services

Patient Name	Date of Birth

As the patient or as the personal representative of the patient, I consent to the terms and conditions of this agreement. By signing below, I intend that the following apply to all my outpatient care provided by The Idaho Clinic. The terms "I," "my," and "you" in this agreement refer to the patient and to his or her authorized agent or legal representative. The term "The Idaho Clinic" refers to services provided in facilities owned or operated by The Idaho Clinic, or by The Idaho Clinic employees, medical staff, and independent contractors.

### Consent to Healthcare Services

1. I consent to healthcare services provided by The Idaho Clinic. This includes services I receive provided by The Idaho Clinic employees, medical staff, and independent contractors. Healthcare services include all healthcare and related medical, surgical, and diagnostic services, the implementing of physician orders, and all tests, studies, treatments and procedures ordered and performed in good faith. I may be asked to give additional consent for procedures, tests, or treatments that have additional risk. I understand that:
  - All healthcare services come with some risk, sometimes even the risk of serious harm. I accept this risk in the hope of a good result.
  - No promise has been made to me concerning a final result, outcome or cure.
  - I can change my mind or refuse care. If I do, I must tell my healthcare team as soon as possible.

### Independent Contractors

1. I understand that some of the people providing me with services may be independent contractors and not employees or agents of The Idaho Clinic. I understand that The Idaho Clinic is not responsible or liable for the judgment, conduct, actions, or inactions of independent contractors.

### My Protected Health Information

1. The Idaho Clinic will keep medical records confidential, as required by state and federal laws. I have been offered a copy of The Idaho Clinic's Notice of Privacy Practices, which describes how medical information may be used and shared and my rights. It may be revised from time to time, and I may ask to see a copy at any time.
2. I consent for my health information to be accessed by The Idaho Clinic, or its subcontractors, needing it for treatment payment, or healthcare operations, without further approval from me.

### Photographs and Recordings

1. I understand that The Idaho Clinic may take photos/video/audio for security purposes, to help with my care, to assist with documenting my visit, or to improve quality of care.
2. I agree that I will not take pictures or videos in The Idaho Clinic facilities without first obtaining the permission of everyone in the image or video. I understand that employees, providers, and others have the right to refuse being included in an image or video.
3. I understand that The Idaho Clinic may restrict my ability to take photographs, videos, or audio recordings, especially in patient care areas.

### Consent for Text, Digital and Email Communications

1. I hereby consent to receiving text, digital, and email communications (including auto-dialed, artificial, and pre-recorded messages and calls) to my cell phone number, email address, and any other telephone numbers provided during any interaction, agreement or communication with The Idaho Clinic, independent contractors, or their agents, and contractors. I acknowledge that text and email Communications are not a completely secure method of communication and accepts the risk that my information may be intercepted and read by a third party.

## Insurance and Government Payments

1. I consent for The Idaho Clinic to file for insurance benefits to pay for my care.
  - I transfer to The Idaho Clinic (and to any healthcare provider for whom bills) the benefits of any insurance policy or other arrangement that may pay for my care. I consent for The Idaho Clinic (and anyone it may assign as my legal representative) to negotiate claims with any insurance company or other payer to obtain payment for services provided to me.
  - I consent for The Idaho Clinic to deposit any money received against the charges of the facility (and of any other healthcare provider for whom The Idaho Clinic bills.)
2. I attest that any information I have used to apply for government benefits is correct. This includes Medicare, Medicaid, Tricare, or any other government program.
  - I consent for The Idaho Clinic (or anyone else with medical information needed to process a claim for payment) to share it with government program administrators or any other payer.
  - I request these payers to make payments for all these services directly to The Idaho Clinic.

## What I am Responsible to Pay

1. As the patient or as a person signing for the patient who is otherwise legally responsible to pay for the care of the patient (the "Responsible Party"), I agree to pay for the following charges:
  - All amounts owed for healthcare services I receive from The Idaho Clinic, as determined by The Idaho Clinic or an independent contractor.
  - My share of the costs, including all co-payments, deductibles, and co-insurances that apply.
  - All charges for non-covered services.
  - Interest on unpaid balances that are more than 30 days past due or are sent by The Idaho Clinic or an independent contractor for collection.
  - A service charge of \$25.00 for any check or form of payment that returns unpaid.
  - All costs and attorney fees (if used) The Idaho Clinic or an independent contractor incur if either refers to my overdue bill for collection.
  - If I am the Responsible Party, I hereby consent to credit bureau inquiries for The Idaho Clinic of the independent contractor's business needs, including any account management companies and debt collectors.
2. I understand that if I am a temporary caregiver for the patient (such as a nanny, youth leader, foster parent or some law enforcement agencies), I may not be financially responsible for the patient's care. I recognize that this statement about temporary caregivers is not an opinion by The Idaho Clinic whether I am or am not a temporary caregiver or whether I am responsible to pay the patient's care.
3. I agree that any overpayment I make will be applied to any other accounts with The Idaho Clinic owed by me with any excess being refunded to the proper party in accordance with The Idaho Clinic policy.

## Changes to This Consent

1. If I make changes to this consent, they are not valid.

## By signing below, I understand and Agree to the Following:

- A. I have had the opportunity to read this agreement, have it read to me, and I understand what I am agreeing to.
- B. I can ask for and receive a copy of this agreement.
- C. This document will remain in effect unless I revoke it in writing.

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I have received or been offered a copy of The Idaho Clinic's Notice of Privacy Practices.

Date	Signature of Patient or Representative	Print Name