TERMS AND CONDITIONS OF SERVICE

CONSENT FOR TREATMENT

HEALTH CARE CONSENT: I request and agree to receive all services provided by the health care professionals authorized to care for me at OHSU. I understand that these services may include:

- Services provided under the supervision, direction or instruction of attending physicians and other authorized health care professionals.
- Routine procedures used for diagnosis.
- Additional or related treatments and procedures my OHSU providers determine are necessary and in my best interest including the use of photos, and video/audio monitoring and/or recording.

I also understand:

- There may be risks and alternatives to a particular treatment or procedure my health care provider recommends or prescribes.
- My health care provider may need to explain and discuss with me certain treatments or procedures. He or she also may need to ask for my consent before performing them.
- It is important for me to ask questions or ask for more information about the care or treatment I may receive at OHSU.

I understand the practice of medicine, surgery and dentistry is not an exact science. I have not received any promises or guarantees about the results I may expect from my care at OHSU.

TEACHING/RESEARCH: OHSU is an academic research center and all human research undergoes an ethical review process. I understand that OHSU health care providers or clinical researchers may contact me to ask me if I would like to volunteer to take part in educational or clinical research projects that require consent.

I understand that OHSU is a teaching institution, and that attending staff providers direct the care provided at OHSU. As part of OHSU's education programs and activities, students, resident physicians, post-graduate fellows or others involved in undergraduate and graduate health care education programs may watch and/or take part in the care or procedures I receive at OHSU.

I understand I can refuse to participate in education programs and activities, and my refusal will not affect my care at OHSU.

STATEMENT OF FINANCIAL RESPONSIBILITY

FINANCIAL AGREEMENT: If I have health insurance, I understand that the terms of my health insurance or health benefit plan(s) may reduce, limit or control what I am required to pay OHSU for the services I receive at OHSU. Whether or not I have health insurance, I agree to be financially responsible and pay for the services provided to me by OHSU if the services are not covered or fully paid for by insurance and the law allows OHSU to collect from me the amount owing. I also agree to pay OHSU's reasonable costs for collecting payments if I do not pay on time the amounts I am responsible for paying. These collection costs may include reasonable attorney fees whether or not legal action has been filed or appealed.

ASSIGNMENT: I assign to OHSU the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, physician and other services I receive at OHSU.

I authorize my health insurance and health plans to make payments directly to OHSU, OHSU Hospital, OHSU Practice Plan, Faculty Dental Practice, or other related professional billing services. I understand the payments from my health insurance or plan for services provided to me at OHSU will be applied to my patient account balance and total financial responsibility. I agree to pay within 30 days following OHSU's notification any charges I owe which are not covered and paid by insurance(s).

ORIGINAL: HEALTH INFORMATION SERVICES COPY: PATIENT/GUARDIAN/RESPONSIBLE PARTY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

SOCIAL SECURITY PROGRAMS: I certify the information I gave when I applied for Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act) is correct. If these benefits end, I understand I will receive a notice and I will then be responsible for paying for hospital care if I choose to stay in the hospital and/or continue to receive services. I request that payment of authorized benefits be made on my behalf directly to the provider. If I have not signed up for any Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act), I agree that if/when I do sign up for such benefits, I agree I will provide accurate information and that this paragraph shall apply to me upon my application for Medicare and/or Medicaid benefits

OTHER

SOCIAL SECURITY NUMBERS: I understand that OHSU collects administrative and nonmedical patient information including Social Security numbers to identify patients, comply with federal and state reporting requirements, bill insurance carriers, and collect payments, as authorized by ORS 353.050. I understand I do not have to give OHSU my Social Security number. If I provide this information, I authorize OHSU to use it for the purposes listed above.

BLOOD/BODY FLUID EXPOSURE: If an OHSU workforce member is exposed to my blood and/or body fluids, and there is the potential for transmitting the human immunodeficiency virus (HIV) or Hepatitis B or C to the OHSU workforce member because of the exposure, I understand that OHSU may obtain and test my blood for HIV and Hepatitis B and C and release the results to the OHSU workforce member who was exposed in accordance with applicable law. I also understand that I may opt out of such testing by signing the "Opt Out for Blood Testing in the Event of an OHSU Worker Exposure to Blood or Body Fluids" form. I can request a copy of this form from Patient Access Services at 503-494-8927

CLAIMS: I understand that each person is responsible to be informed about laws that affect him or her. I also understand, however, that OHSU wishes to alert me to a limitation in the law that relates to OHSU Because OHSU is a public body, Oregon law may limit the dollar amount that a person may recover from OHSU or its caregivers for a claim relating to care at OHSU, and the time within which a person may bring a claim. If I have any questions about this, I understand that I am free to ask or seek advice from any independent person or source.

COMMUNICATION: I expressly agree to receive communications from OHSU, its employees, contractors and/or agents via one or more of the following contact methods: postal mail, telephone (i.e., landline or mobile), personal delivery, OHSU MyChart® (i.e., if I have signed up for the service), manual dialing, auto dialing, texting, live operator, auto texting, e-mail, two way audio-video and pre-recorded and predictive dialing methods for treatment, payment and health care operation purposes, as allowed by OHSU's Notice of Privacy Practices and applicable information privacy and security laws.

PERSONAL BELONGINGS: I agree OHSU is not liable for losing or damaging any personal property I bring into OHSU or onto OHSU property.

This document applies to all care received at OHSU Hospitals and Clinics and will remain in effect unless revoked in writing.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

Patient	Date/Time

Parent, Guardian, Responsible Party Legal Representative (if applicable)	Date/Time	Witness	Date/Time

OHSU HEALTHCARE

Inclusive Patient Care and Communication

OHSU IS COMMITTED TO PROVIDING INCLUSIVE PATIENT CARE.

OHSU complies with applicable state and federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of:

- Race
- Color
- National origin
- Age
- Disability; or
- Sex.

WE ARE HAPPY TO HELP YOU WITH COMMUNICATION AIDS AND LANGUAGE ACCESS.

OHSU provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and other formats)

OHSU also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your care provider's office. They will make the language services arrangements for you. OHSU offers free language services in over 120 languages.

WE ARE HERE TO HELP YOU WITH YOUR CONCERNS.

If you believe that OHSU has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in writing with the Patient Advocate at the Patient Relations Office, 3181 SW Sam Jackson Park Road, Mail Code: UHS-3, Portland OR 97239, Phone: 503-494-7959, Fax: 503-494-3495, Email: advocate@ohsu.edu. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Patient Advocate is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE SERVICES NOTIFICATION: TRANSLATIONS FOR MOST-SPOKEN LANGUAGES IN OREGON.

Language assistance services (in person, live over the phone or live video) are available to you free of charge upon request. Please let your provider's office staff know that you need language services for your visit.

English
If you speak [insert language], language assistance services, free of charge, are available to you. Call your care provider's office and they are happy to make the language services arrangements for you.

Español (Spanish)
Si usted habla español, contamos con servicios de asistencia de idiomas, sin costo, disponibles para usted. Si necesita estos servicios, comuníquese al consultorio de su proveedor de atención médica. Ellos gustosamente coordinarán los servicios de idiomas para usted.

Tiếng Việt (Vietnamese)
Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn dành cho bạn. Nếu bạn cần những dịch vụ này, hãy liên lạc văn phòng của bác sĩ chăm sóc của bạn. Họ sẽ sẵn sàng thu xếp các dịch vụ ngôn ngữ cho bạn.

中文(Chinese-Simplified)
如果您说中文，可为您提供免费的语言援助服务。如果您需要这些服务，请联系您保健提供者的办公室。他们将乐意为您安排语言服务。

Русский (Russian)
Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Если вам требуются такие услуги, обратитесь в офис своего поставщика медицинских услуг. Сотрудники с радостью предоставят вам переводчика!

한국어 **(Korean)**
한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 서비스가 필요하시면 귀하의 의료 제공자 사무실에 연락하십시오. 귀하를 위해 기꺼이 언어 서비스를 준비해드릴 것입니다.

Українська (Ukrainian)
Якщо ви розмовляєте українською мовою, послуги мовної допомоги доступні для вас безкоштовно. Якщо вам потрібні ці послуги, зв'яжіться з офісом вашого постачальника послуг. Вони будуть раді надати вам послуги мовної допомоги.

日本語 **(Japanese)**
あなたの母語が日本語であれば、言語サポートサービスを無料にてご用意しています。サービスをご希望の場合には、あなたのケアプロバイダー事務所までご連絡ください。喜んで言語サポートサービスの手配をいたします。

العربية **(Arabic)**
إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. إذا كنت تحتاج إلى هذه الخدمات، فاتصل بمكتب مقدم الرعاية الخاص بك. سيكون الموظفون هناك سعداء بإجراء الترتيبات المتعلقة بالخدمات اللغوية من أجلك.

Română (Romanian)
Dacă vorbiți română, puteți beneficia de asistență lingvistică gratuită. Dacă aveți nevoie de astfel de servicii, luați legătura cu biroul furnizorului dvs. de servicii medicale. Reprezentanții acestuia vă vor ajuta cu plăcere să beneficiați de asistență lingvistică.

មន-ខ្មែរ (Mon-Khmer Cambodian)
បុរសិនបើលោកអ្នកនិយាយភាសាមន-ខ្មែរ, ភាសាខ្មែរ នោះសេវាជំនួយផ្នែកភាសាមានផ្តល់ជូនលោកអ្នកដាយឥតគិតថ្លៃ។ បុរសិនបើលោកអ្នកត្រូវការសេវាទាំងនេះ សូមទំនាក់ទំនងទៅកាន់ការិយាល័យអ្នកផ្តល់ការថែទាំរបស់លោកអ្នក។ ពួកគេពេញចិត្តកុងការរៀបចំសេវាជំនួយកែភាសាជូនលោកអ្នក។

Oroomiffa (Oromo)
Afaan Kuush (Oromoo) , dubbattu yoo ta'e, tajaajilliwwan deeggarsa afaanii, kaffaltii irraa bilisa ta'an, isiniif ni jiraatu.Tajaalilawwan kanneen ni barbaaddu yoo ta'e , wajjira dhiyeessaa deeggarsa keessanii qunnamaa. Isaan gammachuudhaan tajaajilawwan afaanii isiniif mijeessu.

Deutsch (German)
Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistenzdienste zur Verfügung. Wenn Sie diese Dienste in Anspruch nehmen möchten, wenden Sie sich bitte an das Büro Ihres Leistungserbringers. Dort wird man die Sprachassistenzdienste gerne für Sie arrangieren.

فارسی **(Farsi)**
اگر به زبان فارسی صحبت می کنید، سرویس کمک زبانی به صورت رایگان در دسترس شما خواهد بود. اگر به این سرویس ها نیاز دارید، با دفتر ارائه دهنده خدمات تماس بگیرید. آنها حتماً مقدمات لازم را برای دسترسی به سرویس های زبانی در اختیارتان قرار می دهند.

Français (French)
Si vous parlez français, des services d'aide linguistique gratuits sont à votre disposition. Si vous nécessitez ces services, contactez le cabinet de votre prestataire de soins. Ils se feront un plaisir d'organiser ces services linguistiques pour vous.

ไทย **(Thai)**
หากท่านพูดภาษาไทย จะมีบริการความช่วยเหลือทางด้านภาษาโดยไม่มีค่าใช้จ่าย หากท่านต้องการใช้บริการดังกล่าว โปรดติดต่อสำนักงานผู้ให้บริการดูแล ซึ่งพร้อมที่จะจัดหาบริการทางด้านภาษาให้แก่ท่าน