1. Legal Relationship Between Facility and Physician: The undersigned recognizes that any and all physicians and/or surgeons, including but not limited to radiologists, pathologists, anesthesiologists and emergency room physicians furnishing services to the patient at the Facility are independent contractors, and are not, in any way, employees of the Facility. *Their fees are not included as a part of the Facility bill.*

2. Release of Information for Reimbursement: To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

The undersigned have read this disclosure and agree that the Lender/Creditor and its agents may contact me/us as described above.

3. Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

4. Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/ Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment, or for not cooperating with requests for information by the insurance company/Health Care Service Plan.

5. Health Care Service Plans: The Facility has contracted with multiple Health Care Service Plans. It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. It is also the responsibility of the undersigned to verify if the Facility is within their covered Network _____ .
Initials

The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non-covered benefit, and payable by the undersigned.

☐ Unable to sign

The undersigned acknowledges he/she has read and understands the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation and all other applicable provisions above and received a copy thereof, and is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept its terms.

SIGNATURE: PATIENT, LEGAL REPRESENTATIVE, AGENT	DATE/TIME	RELATIONSHIP IF NOT PATIENT	WITNESS

☐ Unable to sign

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation, and all other applicable provisions above.

FINANCIALLY RESPONSIBLE PARTY	DATE/TIME	WITNESS

☐ Unable to sign

ADMIT-11 (1/17/19)

PATIENT LABEL

JOHN MUIR HEALTH

FINANCIAL AGREEMENT

WHITE - BUSINESS OFFICE YELLOW - PATIENT