

AMBULATORY CONSENT FOR CARE AND FINANCIAL AGREEMENT

1. CONSENT FOR CARE

I, patient/parent/authorized representative, give permission for examinations, diagnostic procedures, medical treatment and other hospital services. Such services will be performed or prescribed by or at the direction of the attending doctors/dentists and their designees as judged necessary for the medical care of the patient. These may include x-ray examinations, lab tests, sedation, and the use of local anesthesia (whether performed at Seattle Children's Hospital (Children's) or at other facilities). I understand that Children's is a teaching hospital and that doctors in training and other health care students may join in or observe the care of the patient. I give permission for my/the patient's body fluids (blood, urine, etc.), tissues and organs removed during the course of treatment to be used for scientific and/or research purposes. This biological material will be unmarked to protect my/the patient's identity and used only after diagnostic and/or therapeutic uses have been completed.

2. FINANCIAL AGREEMENT

I agree:

- To assign to Seattle Children's Hospital (Children's) and Children's University Medical Group, University of Washington Physicians (CUMG/UWP) all insurance benefits payable for services rendered.
- To pay Children's and CUMG/UWP in a timely manner for any uncovered services or balance remaining after insurance benefits.
- To notify Children's and CUMG/UWP of changes to my insurance coverage and/or address and phone number.
- That Children's and CUMG/UWP may charge me reasonable interest, late charges, costs and/or reasonable attorney fees should my account become overdue.
- That any lawsuit for collection of my account will be brought in King County, Washington.

I understand that:

- Seattle Children's Hospital and CUMG/UWP send separate bills. CUMG/UWP bills professional fees on behalf of many of the physicians.
- If I am eligible for financial assistance, my bill may be reduced or waived.
- If I dispute a claim, or a claim involves a third party, Children's will not negotiate with the third party for me. It is my responsibility to pay the bill on time, settle the dispute, and/or collect from the third party.

For Medicare Beneficiaries:

I request payment of authorized benefits, when applicable, be made on my/the patient's behalf. I authorize any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits for related services.

3. PHOTOGRAPHS/VISUAL IMAGES/AUDIO RECORDINGS

I authorize Seattle Children's Hospital to take and reproduce photographs, video and audio recordings in connection with my/the patient's diagnosis, care and treatment, and other operational purposes such as medical education.

SIGNATURES	SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT	RELATIONSHIP TO PATIENT	TODAYS DATE DATE ___ / ___ / ___ month day year
	SIGNATURE OF ADDITIONAL FINANCIAL GUARANTOR	RELATIONSHIP TO PATIENT	
	WITNESS	2ND Telephone Witness	A language interpreter was used to explain this consent Name of Interpreter _____



Patient Label

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