**Pt Name:_____ MRN:_____**

**Pt DOB:_____**

# Conditions of Service

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-406-657-4760 (TTY: 1-800-537-7697).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-406-657-4760 (TTY: 1-800-537-7697
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-406-657-4760（TTY：1-800-537-7697）
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-406-657-4760 (TTY: 1-800-537-7697).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-406-657-4760 (TTY: 1-800-537-7697).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-406-657-4760（TTY: 1-800-537-7697）まで、お電話にてご連絡ください。
- FIIRO GAAR AH: Haddii aad adigu ku hadasho Kuush, adeegyada ka caawinta luqadda ayaad lacag la'aan ku heli kartaa. Wac 1-406-657-4760 (TTY: 1-800-537-7697).
- KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-406-657-4760 (TTY: 1-800-537-7697).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-406-657-4760 (ATS : 1-800-537-7697).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-406-657-4760 (TTY: 1-800-537-7697)번으로 전화해 주십시오.
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-406-657-4760 (رقم هاتف الصم والبكم: 1-800-537-7697)
- В Н И М А Н И Е: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-406-657-4760 (телетайп: 1-800-537-7697).
- MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-406-657-4760 (TTY: 1-800-537-7697).
- ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-406-657-4760 (टिटिवाइ: 1-800-537-7697).
- เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-406-657-4760 (TTY: 1-800-537-7697).

**1. Consent to Services:** I am requesting outpatient and/or inpatient services to diagnose and/or treat medical conditions. I consent to and authorize Billings Clinic to provide care including all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the physicians and others taking care of me. I understand that I am under the care and supervision of my physician(s). The hospital and its nursing and other staff are responsible for carrying out my physicians' instructions. My physician and care team are responsible for obtaining my specific informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me. During the course of receiving health care services, medical imaging may be needed to document the course of my disease or treatment. I acknowledge that video, audio and/or photographs may be taken or produced at the request of my provider or other member of my care team I voluntarily consent to HIV, hepatitis and testing for other blood and fluid borne pathogens, if a health care worker or employee is exposed to my blood or other body fluids. This consent shall also apply to the admission and medical treatment of newborn infant(s) who deliver during my hospitalization.

**2. No Liability for Loss of Personal Property:** If I keep any valuables, including hearing aids, glasses, dentures, personal electronic devices, or other personal property with me, I understand that Billings Clinic is not responsible for their safety. I understand that Billings Clinic has a safe where my property can be stored at my request if I am admitted. Billings Clinic recommends anything of value be left at home, or if the patient is admitted, be placed in the safe.

**3. Notification of Admission:** I have the right to have a family member contacted in the event I am admitted to the hospital and that my primary care provider, if any, will be notified if I am admitted to Billings Clinic hospital.

**4. Notices:** I acknowledge I have received Billings Clinic's Notice of Privacy Practices and Notice of Patient Rights.

**5. Identification of Physicians and Other Licensed Health Care Providers:** I acknowledge that Billings Clinic's medical staff consists of physicians and providers who are employees of Billings Clinic as well as independent physicians and providers, such as anesthesiologists, who are not employees or agents of Billings Clinic. Billings Clinic, as a teaching facility, provides education and training to residents and students.

Billings Clinic
2800 Tenth Avenue North
Billings, MT 59101

**6. Billing By Independent Providers and Anesthesia Services:** I understand that if I receive services from anesthesiologists or other physicians who are not Billings Clinic employees, I will receive a separate bill for these services directly from the independent physician or group. Billings Anesthesiology, PC can be reached at 406-248-3290.

**7. Contact by Mobile Phone:** By providing Billings Clinic with a mobile telephone number, I consent for healthcare related calls and messages to be made to the mobile phone number.

**8. Assignment of Benefits and Promise of Payment:** I authorize my insurance company or health plan to pay medical benefits on my behalf direct to Billings Clinic. I understand and agree that I remain financially responsible for the payment of all medical services provided by Billings Clinic, my attending physicians or other health care providers. If Billings Clinic is not a participating provider with my health plan, I understand and agree that Billings Clinic may choose not to bill my health plan and that I will be billed for all services. I authorize Billings Clinic to use or disclose my healthcare information to assist in obtaining reimbursement for services rendered. Payment is due within thirty (30) days from invoice date. A Financial Representative is available to discuss payment arrangements or one of our financial programs including financial assistance.

If I default or do not pay my bill, I understand and agree that I will pay the full amount owed plus the cost of retaining a collection agency or law firm plus other expenses related to collection. I understand unpaid portions of my account balance(s) may be subject to a finance charge.

**9. Appointment of Billings Clinic as Authorized Representative:** I understand that Billings Clinic may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint Billings Clinic to act on my behalf and/or on behalf of my covered child/ dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to Billings Clinic. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to Billings Clinic and my insurance carrier(s)

**10. Hospital Directory.** If I am admitted to the hospital, I have the choice whether or not to be listed in the hospital directory. The hospital directory includes your name, location in the hospital, sex, and general condition. I have a right to decide if I want to be listed in the hospital directory and have my information available to the general public. I may change my status at any time. My choice for listing in the hospital directory is indicated by checking a box below:

I wish to be listed in the facility directory: Yes ☐ No ☐

**The undersigned has read and understands the Condition of Service and accepts its terms.**

Patient/Authorized Representative* Signature: _____ Date: _____ Time: _____

Printed Name of Authorized Representative: _____Relationship to Patient: _____

☐ Patient unable to sign due to condition. _____ _____/_____

Witness signature Date Time

Staff Name _____

**Non-Discrimination – This health care facility is required by law to make its services available to all people in the community.**
Billings Clinic is a not-for-profit healthcare organization committed to providing care to all persons regardless of race, creed, color, gender, age, national origin, disability, sexual orientation, gender identity or expression. We accept patients covered by Medicaid and/or Medicare and we offer substantial financial assistance and charity care to those in financial need.
**If you believe you have been improperly denied services, contact the Director of Patient Relations at (406) 238-5771 or the Office of Civil Rights toll free at 1-800-368-1019 or TDD 1-800-537-7697.**

**Joint Commission, Montana Department of Public Health and Human Services, US Department of Health and Human Services**
Anyone with unresolved concerns about the organization's quality and/or safety of care and/or safety of the environment in which care is provided may contact the following organizations:

**Office of Quality Monitoring Services**
The Joint Commission
One Renaissance Blvd
Oakbrook Terrace, IL 60181
Tele: 1-800-994-6610
Fax: 630-792-5636
Email: complaint@jointcommission.org

**Montana Department of Public Health**

**Certification Unit of Quality Assurance**
2410 Colonial Dr.
Helena, MT 59620
Tele: 1-406-444-2037
Fax: 406-444-1742
www.dphhs.mt.gov/qad

**U.S Department of Health and Human**

Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850
1-800-Medicare (1-800-486-2048)
TTY users call 1-877-486-2048

Billings Clinic
2800 Tenth Avenue North
Billings, MT 59101