Adventist Health
ADVENTIST MEDICAL CENTER
PO BOX 16800, PORTLAND, OR 97292 503-251-6170

CONDITIONS OF REGISTRATION

9. Financial Agreement: I accept financial responsibility for all services during this episode of care. I understand that I can expect to receive separate bills from physicians and specialty services.

Patient Initials: ____

I agree to promptly pay all hospital bills, in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate.

If your account is overpaid, a refund will automatically be issued. If the amount of the credit is less than $5.00, you agree that the Hospital will assess a service fee equal to the credit balance to avoid the administrative costs associated with processing a refund.

10. Assignment of Insurance Benefits: I assign and authorize direct payment to the hospital of all insurance and plan benefits that are payable for this episode of care. With this authorization, all parties agree that the insurance company's payment to the hospital shall satisfy the insurance company's obligations related to this episode of care. I further understand that I am financially responsible for charges not paid according to this assignment.

11. Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize the hospital and my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim(s).

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the financial Agreement and Assignment of Insurance Benefits.

Date: _____ Time: _____ Signature: _____

If signed by other than patient, indicate relationship: _____

Witness:_____

Interpreter Signature: _____ Language: _____

Interpreter Name: _____ Telephone Number: (_____) _____ - _____
(PRINTED)

Admit Date	Admit Time	Patient Name	Medical Record #	Patient's Account #