St John's Medical Center

Annual Patient Agreement

Patient Name: _____

Patient DOB: _____

I, the undersigned patient, hereby understand and agree:

***Consent for Treatment*:** I have sought treatment from **Teton County Hospital District (including St. John's Medical Center and/or its medical clinics) for one or more medical conditions.** Risks of such treatment have been explained to my full satisfaction by St. John's' personnel, including my right to refuse any treatment to the extent permitted by law. The results of any treatment cannot be guaranteed. **In full knowledge of such risks, I consent to all treatment performed by St. John's and independent providers for the condition(s) for which I have sought treatment within one (1) year of this Agreement,** such as routine office visits, diagnostic procedures, and other treatment for such medical condition(s), and all related conditions, in one or more courses of treatment. **I accept that I may be asked to sign additional Patient Agreements for specific services such as emergency care, surgery, or inpatient care received within a year of signing this Agreement. I agree to allow students, observers, and the recording of my care for internal use.**

Financial responsibility: **I understand that I am financially responsible for all charges for services provided by St John's, including any amount not paid by my health care plans.**

Payment/Assignment of Benefits: I authorize, direct and assign any right to payment by my Payer(s)* otherwise payable to me directly to St. John's for services rendered by it. I understand that assignment of benefits does not waive my responsibility for payment. St John's reserves the right to refuse or accept assignment of medical benefits in accordance with applicable billing terms and restrictions. All information given by me in applying for payment under any payer plan (government or private) is correct. I authorize St John's to release all medical information to payers for processing of health care claims.

***Payer(s)** include but are not limited to insurance carriers, health-plan administrators, or other payers including the Centers for Medicare & Medicaid (CMS). We do not recognize ELAP as a valid payer.

Financial Charge: Financial charges are calculated each month on the amount of the unpaid balance after deducting payments or credits and before adding new services, and applies to the balance transferred to collection agencies. Balances are transferred to collection agencies after a reasonable effort to resolve the balance. Collection balances are subject to a finance charge of 12% APR.

Independent Contractors: I acknowledge that most doctors furnishing services are independent contractors and are not employees or agents of St. John's Medical Center.

Patient Personal Property: St. John's Medical Center is not responsible for lost, damaged or destroyed personal property if not deposited in a the facility safe that has been made available to me.

Video Surveillance: I understand that video surveillance is used throughout the facility for safety and security purposes and agree to video for internal use.

Patient Rights: **I have been fully informed regarding patient rights and responsibilities.**

Privacy Notification: **St. John's has offered me a copy of its Notice of Privacy Practices for Protected Health Information, located at Patient Access points and at www.tetonhospital.org.**

Advance Directives: **I have received information on how to execute an Advance Healthcare Directive, and additional information regarding Advance Healthcare Directives is located at Patient Access points.**

Signed: _____ Date/Time: _____

Patient (or personal representative/guardian if the patient is not legally able to sign)

Witness_____