



CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT: The undersigned consents to the performance of all routine medical care and treatment, (e.g. laboratory procedures, x-ray examinations, anesthesia, therapies, etc.) which may be performed on an outpatient basis, under the instruction of the treating provider for each patient. I give my consent for Barton Health, its providers and agents, including debt collectors to place calls to my designated cellular or residential phone using any type of artificial or pre-recorded voice, text message, or auto-dialer technologies for any permissible purpose. _____ (Initials)

FINANCIAL OBLIGATION, BENEFITS ASSIGNMENT AN INTEREST CHARGE NTOICE: I understand I am responsible for all charges incurred. I authorize all insurance benefits to be paid directly to Barton Memorial Hospital and/or TCVMG for services rendered. If my insurance does not cover all charges, I agree to pay any difference upon request. If my account is referred to an attorney or collection agency for collection, I will be responsible for any and all collection expenses including attorney fees. All outstanding accounts are subject to interest at the legal rate.

RELEASE OF INFORMATION: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the facility may disclose portions of the patient’s record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the facilities charges, including but not limited to insurance companies, health care service plans, or worker’s compensation carriers. To ensure coordination of my medical care with my primary care physician, and/or referral source, I authorize release of my medical information.

OTHER BILLS: Patients may also receive separate bills from Radiologist, Pathologist, Physicians, and Ambulance services.

PROP 65: Products used at this facility may contain chemicals known to the State of California to cause cancer, birth defects, and reproductive harm.

NOTIFICATION: The undersigned certifies that he/she has been instructed on how to report concerns related to care, treatment, services, and patient safety issues by calling by calling Barton Memorial Risk Management at 530-543-5845 or the California Department of Public Health Services 916-558-1784.

CHILD SAFETY ALERT: It is illegal to transport a child, under the age of 8 or less than 4ft. 9in. by vehicle without using a federally approved safety seat.

AUTHORIZATION: The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient’s legal representative, or is duly authorized by the patient as the patient’s general agent to execute the above and accept its terms.

_____	_____	_____
Patient Signature	Date	Witness Signature

	Time	
_____	_____	_____
Guardian/Representative	Date	Relationship