CARE AGREEMENT

This form contains facts you should know about your health care at UW Medicine and from Children’s University Medical Group, University of Washington Dentists and Oral Surgeons, and Seattle Cancer Care Alliance. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

UW Medicine includes:

- University of Washington Medical Center and Clinics
- Harborview Medical Center and Clinics
- UW Medicine Neighborhood Clinics
- UW Physicians Sports Medicine Clinic
- UW Medicine Eastside Specialty Center
- Hall Health Primary Care Center, and
- UW Physicians

Your healthcare team consists of medical doctors, doctors who have completed medical school but are receiving additional training (residents and fellows), nurses, other healthcare professionals, and other health sciences students (for example, nursing students). They will work together to diagnose and treat you. You will have an attending physician. This is the doctor who has primary responsibility for your care.

Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your medical record.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive health care from UW Medicine. If there is any part of this form that is unclear, be sure to ask questions about it.

<table>
<thead>
<tr>
<th>SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)</th>
<th>PRINT NAME</th>
<th>DATE</th>
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IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

- 1. Guardian
- 2. Durable Healthcare Power of Attorney
- 3. Spouse/registered domestic partner
- 4. Adult Child(ren)
- 5. Parent(s)
- 6. Adult Brother(s)/sister(s)

FOR MINOR PATIENTS:

- 1. Guardian/legal custodian
- 2. Court-authorized person for child in out-of-home placement
- 3. Parent(s)
- 4. Holder of signed authorization from parent(s)
- 5. Adult representing self to be a relative responsible for the minor’s health
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The UW Medicine Notice of Privacy Practices describes how medical information about you may be used and disclosed, how you can get access to this information, and which procedures you may use if you have questions, concerns or complaints.

We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, and follow the information practices that are described in this notice. If you have any questions, please contact: UW Medicine Privacy Office 1-866-964-7744.

Please do not write comments on this form. Refer to the “Joint Notice of Privacy Practices of UW Medicine and Certain Other Providers” brochure for instructions to make special requests about your Privacy Rights.

Note: We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from the UW Medicine Privacy Office 866-964-7744, or at www.uwmedicine.org.

By signing below, I agree that I have received the UW Medicine Notice of Privacy Practices.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION) DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT AND DESCRIPTION OF THEIR AUTHORITY

FOR OFFICE USE ONLY: REMARKS for the UW Medicine Notice of Privacy Practices:

(This section below is to be filled out by UW Medicine staff only)

We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):

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<th>“√”</th>
<th>Reason</th>
<th>Comments</th>
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<tr>
<td></td>
<td>Emergency Situation</td>
<td></td>
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</tbody>
</table>

UW Medicine
Workforce Member
Signature: ____________________________ Date: __________________

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

"U2045" WHITE – MEDICAL RECORD
YELLOW - PATIENT

UH2045 REV AUG 06
Financial Agreement

I agree:

1. That University of Washington Medical Center and Clinics (UWMC), Harborview Medical Center and Clinics (HMC), UW Medicine Neighborhood Clinics (UWPN), UW Physicians Sports Medicine Clinic (UW Sports Med), UW Medicine Eastside Specialty Center (ESC), Hall Health Primary Care Center (HHPC), and University of Washington Physicians (UWP), collectively “UW Medicine”, University of Washington School of Dentistry (SOD), Children’s University Medical Group (CUMG) and Seattle Cancer Care Alliance (SCCa) may share any financial information I provide to facilitate payment.

2. To assign to UW Medicine, SOD, CUMG and/or SCCA all insurance benefits payable for services provided.

3. To pay UW Medicine, SOD, CUMG and/or SCCA for balances remaining after insurance benefits are paid, unless prohibited by law or contract.

4. To notify UW Medicine, SOD, CUMG and/or SCCA of changes to my insurance coverage and/or address.

5. That UW Medicine, SOD, CUMG and/or SCCA may impose reasonable interest, late charges, costs and/or reasonable attorney’s fees should my account become delinquent.

6. That any lawsuit for collection of my account may be brought in King County, Washington.

7. To notify UW Medicine, SOD, CUMG, and/or SCCA if I am not able to pay my balance due within 30 days of receipt.

8. To apply to other financial programs that I may qualify for as requested by UW Medicine, SOD, CUMG and/or SCCA, should I be unable to pay my account.

I understand that:

- UW Medicine entities, SOD, CUMG, and/or SCCA each bill separately for their services.

- Patients who receive outpatient services at UWMC or HMC receive two bills: one bill from the physician or other provider (for the costs of the professional services) and one bill from the hospital (for the facility costs, i.e. building, equipment, supplies, staff time). Each of these bills may incur a co-payment or co-insurance responsibility, depending on my insurance coverage. The exact amount of the co-insurance or co-payment will depend upon the actual services provided and the coverage provisions of any insurance I have.

- UW Medicine requests my Social Security Number to verify my identity and to facilitate access to any potential federal health care benefits (42 U.S.C. 1320b-7(a), (b)). Providing my Social Security Number is voluntary.

Statement to Permit Payment of Medicare Benefits to Provider

I request payment of authorized Medicare benefits for any services furnished to me by UW Medicine, SOD, CUMG, and/or SCCA. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION)               DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, PLEASE PRINT NAME, PROVIDE REASON, RELATIONSHIP TO PATIENT AND DESCRIPTION OF THEIR AUTHORITY

PT.NO  NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

PATIENT FINANCIAL AGREEMENT

"U1865"

UH1865 REV FEB 06

WHITE – MEDICAL RECORD
CANARY - PATIENT