Welcome to Kalispell Regional Healthcare ("KRH"). Thank You for choosing us for Your care and treatment. KRH is an integrated health system that includes a number of organizations and health care services providers. A list of the KRH organizations is being provided to You along with this Patient Consent and Financial Agreement ("Agreement").

Please review this Agreement carefully. Except in cases of emergency care, we must have a signed and dated Patient Consent and Financial Agreement before Health Care Services (defined below) can be provided to You. If You have any questions about this Agreement, our staff will be happy to answer Your questions before You sign.

For purposes of convenience, this Agreement will refer to You as "You".

**CONSENT FOR TREATMENT AND CARE**

You hereby consent to any Health Care Services (as defined below in this paragraph) provided by KRH and by Health Care Services providers who are independent from KRH but who are authorized to provide Health Care Services to You as a KRH patient. These independent, non-KRH-employed providers include, but are not limited to physician and other medical and allied health professional staff members of Glacier Regional Pathology, Ltd.; Clinical Pathology Associates, LLC; Northern Rockies Anesthesia Consultants, PLLC; Northwest Imaging, PC; and Silvertip Emergency Physicians, PC (collectively, "KRH Affiliated Providers"). You understand and agree that resident physicians and other health care services education students may participate in or be observers of the Health Care Services You receive at KRH. These residents and students will be supervised by qualified instructors and KRH staff. Your health care services ("Health Care Services") may include, but are not limited to, hospital inpatient, outpatient, and/or emergency services; physician office services; diagnostic procedures; transportation; nursing care; and other health care services and products. You acknowledge that no guarantees have been made regarding the outcome of these Health Care Services. If You are not able to sign this Agreement personally, then the consent for Your care and treatment: (1) may be given by Your representative(s) who are legally authorized to make decisions and sign this Agreement on Your behalf, or (2) shall be implied in cases of emergency.

**REPORTING OF IMMUNIZATION RECORDS**

The Montana Department of Public Health and Human Services (DPHHS) has requested that we seek Your consent to share Your/Your child's immunization data with the DPHHS Immunization Information System (IIS). DPHHS may release IIS immunization data to other public health agencies as well as to Your/Your child's health care providers to assist in Your/Your child's medical care and treatment. In addition, DPHHS may release IIS immunization data to schools in order to comply with immunization requirements. Also, if You do not check the "I Opt Out" box at this time, You can always choose to opt out at a later time and/or have Your/Your child's immunization record removed at any time by contacting Your county's health department. You understand that any such revocation will be not effective as to uses and/or disclosures already made in reliance upon this authorization.

**FINANCIAL AGREEMENT**

**Agreement to Pay Charges and Billing Statements** – In consideration of the Health Care Services provided to You, You and/or any individuals who are directly responsible for Your medical bills, such as a parent or guardian, (collectively, “Guarantors”) agree to pay KRH's billed charges related to those Health Care Services (“Charges”), minus any contractual reductions from the Charges agreed to by KRH with Your Health Plan Payor (if applicable) and any other reductions to which You may be entitled, such as under the KRH financial assistance policy. You understand and agree that: (1) any KRH Affiliated Providers that provide Health Care Services to You in connection with Your care and treatment at KRH may have separate billing and collection practices that result in one or more separate bills for which Guarantors are responsible to pay; (2) the terms of this Agreement prevail over any conflicting terms and conditions in any other contract or plan to which You claim to be a party or a beneficiary; (3) it is possible that Your Health Plan will determine that Health Care Services provided to You are not Covered Services and that You will be responsible for paying for those Health Care Services; and (4) the terms of this Agreement are governed by the laws of the State of Montana. KRH does have policies on financial assistance to certain categories of patients which may affect how and when collection efforts may be taken by KRH and certain of its other health care services organizations. Please ask our staff for a copy of these policies or for a Patient Accounts representative to visit with You about these policies or look at the Financial Assistance Policy on the Kalispell Regional Healthcare website under the heading "Pay Bill".

**OUT OF NETWORK PATIENTS** – YOU UNDERSTAND AND AGREE THAT, EXCEPT WHEN PROHIBITED BY APPLICABLE LAW, KRH MAY COLLECT ITS CHARGES FROM GUARANTORS WHEN KRH DOES NOT HAVE A WRITTEN CONTRACTUAL RELATIONSHIP WITH AN INSURANCE COMPANY OR OTHER HEALTH PLAN PAYOR REGARDING AN AGREED UPON RATE OF PAYMENT FOR THE HEALTH CARE SERVICES PROVIDED TO YOU (called “OUT OF NETWORK”). YOU UNDERSTAND AND AGREE THAT WHEN RECEIVING HEALTH CARE SERVICES FROM KRH ON AN OUT OF NETWORK BASIS, GUARANTORS MAY ALSO BE REQUIRED TO MAKE PAYMENT AT THE TIME SERVICES ARE PROVIDED.

**Payment** – Guarantors may make payment to KRH: (1) at the time Health Care Services are provided to You; (2) in accordance with billing statements received from KRH; or (3) in accordance with a payment schedule that is agreed upon by both KRH and Guarantor(s). If Guarantors fail to make any scheduled payment when due, You understand and agree that: (1) KRH may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible...
for all costs associated with collection of the owed Charges, including reasonable attorney’s fees. You acknowledge and agree that payments to KRH Affiliated Providers must be made to them in accordance with their payment rules. No partial payment of the amount owed by Guarantors to KRH (whether the payment says it is in full payment or not) will be treated as full payment without a specific separate written agreement between Guarantors and KRH that is signed by both parties. KRH may also assign past due accounts to third party collection agencies.

Third Party Liability – In the event that any third party is or could be liable for part or all of the Charges for the Health Care Services provided to You (such as due to an automobile accident), You acknowledge that Guarantors remain responsible for the portion of the Charges that You are responsible to pay, but KRH is also legally authorized to bill for and recover from that third party the full Charges for the Health Care Services provided to You. KRH may do this whether or not KRH has also submitted a bill for the services to any federal, state, or private health care insurance/health benefits plans (collectively a “Health Plan Payor”) covering You. Guarantors will not be responsible for any amounts in excess of the portion of the Charges that You are responsible to pay, but KRH may recover from the third party an amount that permits KRH to receive up to the full Charges for the Health Care Services provided to You. Guarantors also acknowledge that KRH may submit a Health Care Provider/Facility Lien, as allowed by Montana Code Annotated Title 71, Chapter 3, Part 11, to the third party.

Refunds – Please let us know if Your address changes so that we can contact You in the event that Your account is overpaid and You are entitled to a refund. If we cannot locate You over a period of five (5) years after Your right to a refund has been identified, then Montana law requires us to send Your refund to the Montana Department of Revenue. Montana law permits us to impose a charge against Your refund during the time it remains unclaimed. KRH’s annual charge is Ten U.S. Dollars ($10.00) and will be imposed at the beginning of each annual period.

AUTHORIZATION
Without waiver or limitation of the above Financial Agreement, You hereby: (1) authorize KRH, on Your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and other responsible third party providing coverage for, or who may be otherwise liable for, payment of any of the Charges for the Health Care Services provided to You (“Responsible Third Parties”); and (2) direct those Health Plan Payors and Responsible Third Parties to which KRH submits a claim for payment to make payment(s) directly to KRH. You understand and agree that KRH: (1) is not required to submit a claim for payment to anyone other than Guarantors; but (2) may choose to submit a claim to one or more of Your Health Plan Payors and Responsible Third Parties. This authorization is limited only to the rights, on Your behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor and Responsible Third Parties. It does not entitle KRH to any other rights or bind KRH to any responsibilities that You may have under any Health Plan Payor agreements, third party liability agreements or policies or any other theories of coverage or liability. You hereby consent also to KRH providing notice of this authorization to Your Health Plan Payors and other Responsible Third Parties.

INSURANCE BENEFITS DISCLAIMER
If You are covered by a Health Plan Payor agreement that requires pre-authorization for Health Care Services, it is Your responsibility to obtain the pre-authorization from Your Health Plan Payor. You understand and agree that You are responsible for any Charges incurred should Your Health Plan Payor deny all or any portion of Your KRH Health Care Services or otherwise fail to make payment for the Charges.

RELEASE OF INFORMATION
You acknowledge that KRH and KRH Affiliated Providers are authorized by law to release medical and account information necessary for the purposes of treatment, payment, and health care operations. This information may be released to Health Plan Payors, liability insurance companies, billing companies, collection agencies, attending/consulting health care providers, governmental programs or medical review organizations and otherwise as permitted or required by law.

CONSENT TO CONTACT
You agree that, in order for KRH and/or KRH Affiliated Providers to request Your feedback about the Health Care Services provided to You, to service Your account, or to collect any amounts You may owe, KRH, KRH Affiliated Providers and their business associates, including without limitation any independent contractors, account management companies or collection agencies, may contact You by telephone, SMS text message or email at any cellular or residential telephone number or email address provided during Your registration process. These methods of contact may include auto-dialed, prerecorded and/or artificial voice message calls or texts as permitted by law.

PERSONAL VALUABLES
You acknowledge that KRH maintains a safe for securing money and/or other valuables. KRH shall not be liable for the loss of or damage to Your money, valuables, articles of unusual value, or any other personal property ("Property"), if Your Property is not deposited with KRH for storage in KRH’s safe.

BY SIGNING BELOW, YOU CONFIRM THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS AGREEMENT, (2) HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS AGREEMENT AND (3) HAVE RECEIVED AND REVIEWED AND, IF NEEDED, COMPLETED THE FOLLOWING:

• LIST OF KRH ORGANIZATIONS
• PATIENT BILL OF RIGHTS & RESPONSIBILITIES
• KRH JOINT NOTICE OF PRIVACY PRACTICES
• AN “IMPORTANT MESSAGE FROM MEDICARE” or “IMPORTANT MESSAGE FROM TRICARE”
• INITIAL DISCLOSURE STATEMENT & STATEMENT OF BILLING RIGHTS
• ADVANCE DIRECTIVES – You have been advised of Your right to formulate and execute Advance Directives and has been provided with written information regarding the same.

Patient Signature/Authorized Representative/Guarantor ____________________________ Date ____________________________

If an Authorized Representative/Guarantor, the nature of the relationship to the Patient: ________________________________________________________________

Patient Name ____________________________ Acct # ______________
Witness ____________________________ MRN # ____________________________

ORIGINAL TO MEDICAL RECORDS OR SCANNED TO ACCOUNT • COPY TO PATIENT

#344 REV. 2/09; 5/09; 10/09/; 5/10; 8/11; 8/12; 12/12; 3/13; 1/17

VERSION B
IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.
1. If You want to preserve Your rights under the Act, here’s what to do if You think Your bill is wrong or if You need more information about an item on Your bill:
   a. Do not write on the bill. On a separate sheet of paper write the following:
      i. Your name and account number.
      ii. A description of the error and an explanation, as best You can, of why You believe it is an error. If You only need more information, please explain the item You are not sure about. Do not send in Your copy of the itemized statement or other documents unless You have a duplicate copy for Your records.
      iii. The dollar amount of the suspected error.
      iv. Any other information (such as Your address) which You think will help us identify You or the reason for Your complaint or inquiry.
   b. Send Your billing error notice to the address listed on Your billing statement. Mail it as soon as You can, but in any case early enough to reach us within 60 days after the bill was mailed to You. YOU MAY TELEPHONE YOUR INQUIRY, BUT DOING SO WILL NOT PRESERVE YOUR RIGHTS UNDER THIS LAW NOR OBLIGATE US TO FOLLOW THE OUTLINED PROCEDURES.
2. We must acknowledge all letters pointing out possible errors within 30 days of receipt unless we are able to correct Your bill within 30 days. Within 90 days after receiving Your letter, we must either correct the error or explain why we believe the bill to be correct. Once we have examined the bill, we have no further obligation to You even though You still believe there is an error, except as provided in paragraph 4, below.
3. After we have been notified, in writing, neither we nor an attorney nor a collection agency may send You collection letters or take other collection action with respect to the amount in dispute; but periodic statements may be sent to You. You cannot be threatened with damage to Your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered Your inquiry. However, You remain obligated to pay the part of Your bill not in dispute.
4. If our explanation does not satisfy You and You notify us in writing within 10 days after You receive our explanation that You still refuse to pay the disputed amount, we may report You to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that You think You do not owe the money, and we must let You know to whom such reports were made. Once the matter has been settled between You and us, we must notify those to whom we reported You as delinquent of the subsequent resolution.

DISCLOSURES REQUIRED BY FEDERAL LAW

Your account is subject to the following terms and conditions:

1. If an account is referred for collection, You shall pay all collection and court costs, including a reasonable attorney’s fee. Otherwise than herein and above specified, You shall incur no additional charges to Your account.
2. No security interest in any property is retained or acquired for purposes of securing payment of any credit extended on Your account, except: (1) any security interest acquired by virtue of Montana’s Liens of Certain Health Care Providers law, MCA Title 71, Ch. 3, Part 11, and (2) any security interest in property retained by the hospital to secure payment of Your account.