



**AUTHORIZATION FOR TREATMENT AND  
PROMISE TO PAY (ASSIGNMENT OF BENEFITS)**

**AUTHORIZATION**

I authorize and consent to my admission or treatment as a patient at SEARHC/Sitka Medical Center for all treatment, and evaluation including any diagnostic and therapeutic care recommended by my physician or other health care provider. I acknowledge I have been separately informed by my physician or other health care provider and understand the proposed treatment, the risks inherent in the proposed treatment, and any alternatives to the proposed treatment. I understand I have the right to make decisions concerning my plan of care, to refuse medical care, and to obtain information about my health needs and treatment from my physician or other health care provider.

**PROMISE TO PAY**

I authorize any third party insurance benefits to be paid directly to SEARHC/Sitka Medical Center. I understand I am financially responsible for any services not covered by my insurance company.

I assign to SEARHC/Sitka Medical Center all insurance proceeds for medical services rendered, and I understand SEARHC/Sitka Medical Center does not assume responsibility for the collection of such proceeds. If my account becomes delinquent (90 days after services have been provided) and is assigned to a collection agency, a collection fee will be added to the delinquent balance.

**Eligible Alaska Native/American Indian (AN/AI) beneficiaries (with documented eligibility) will not be financially responsible for covered services. AN/AI beneficiaries (with documented eligibility) without third party insurance will be financially responsible for services not covered by SEARHC/Sitka Medical Center. These include, but are not limited to: eyeglasses, hearing aids, some dental services, and medications not included in the SEARHC Medication Benefits Package.**

**INJURY RELATED CLAIM**

In the event of any injury, I authorize care and treatment for the person named below and agree to pay all fees and charges for such treatment as shown by statements for services rendered by SEARHC/Sitka Medical Center. I will not delay or withhold payment because of pending claims for insurance coverage.

**SEARCH OF PATIENT AND BELONGINGS**

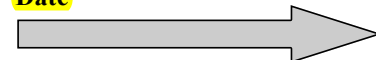
I understand, pursuant to current policies and procedures, all patients and their belongings can be thoroughly searched for the safety of all patients, visitors and staff, immediately upon arrival for any services or hospitalization, prior to any meals, vital signs, or when the facility suspects the patient possesses any contraband, weapons, alcohol, illicit drugs, or drug paraphernalia. I understand anything brought into the facility by visitors shall be subject to being screened and confiscated. Emergency services for medical stabilization will occur prior to patient searches being performed.

**This authorization will be considered valid for one (1) year from the date of signature unless otherwise noted. If the below names is a minor, as the parent/legal guardian, I authorize medical care for the health and well being of this minor.**

\_\_\_\_\_  
**Signed by responsible party (Patient, Parent, Guardian)**

\_\_\_\_\_  
**Date**

**CONTINUED ON BACK**



*Office Use Only*

Patient's Printed Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

MPI/Health Record Number: \_\_\_\_\_

The following data is needed to meet Federal funding reporting regulations for SEARHC/Sitka Medical Center.

1. Race:
  - American Indian or Alaska Native  White
  - Asian  Native Hawaiian or Other Pacific Islander
  - Black or African American  Other
  - Hispanic, Black  Unknown by Patient
  - Hispanic, White  Decline to Answer
  
2. Ethnicity:
  - Hispanic or Latino  Unknown by Patient
  - Not Hispanic or Latino  Decline to Answer
  
3. Estimated Household Income \_\_\_\_\_ Number in Household \_\_\_\_\_
  
4. Primary Language: \_\_\_\_\_ Interpreter Required?  Yes  No Other Languages spoken: \_\_\_\_\_
  
5. Preferred Language For Healthcare: \_\_\_\_\_
  
6. Migrant Worker:  Yes  No  
Homeless:  Yes  No
  
7. Internet Access?  Yes  No
  - Home  Library
  - Work  Tribe/Community Center
  - School  Mobile Device
  - Health Care Facility
  
- Email Address: \_\_\_\_\_
  
8. Do we (SEARHC/Sitka Medical Center) have permission to send generic health information to your email address?  Yes  No
  
9. What is your preferred method of receiving reminders?  
 Phone  E-mail  Mail
  
10. Do you need help to hear?  Yes  No
  
11. Do you have trouble seeing?  Yes  No
  
12. Are you a Veteran?  Yes  No