REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System, "the Hospital", maintains personnel and facilities to assist my providers in providing me medical care, and I authorize the Hospital personnel to perform on me the care ordered by my providers. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my providers to provide according to recognized standards of medical practice, and I acknowledge that the Hospital and its personnel are not responsible for providing me this information. I consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so. I choose to receive the services even if my insurance plan may not cover or continue to cover specific services, including the specific services rendered during the admission.

ASSIGNMENT OF INSURANCE BENEFITS. I/we hereby assign all my rights to The Charlotte-Mecklenburg Hospital Authority ("CHS") under any policy of insurance, including but not limited to, major medical insurance, hospital benefits, sick benefits, injury benefits due to me because of liability of a third party, such as auto insurance or Workers' Compensation insurance, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient up to the full amount of the hospital bill, and hereby authorize direct payment to the Hospital and/or my attending providers of all benefits to which I am entitled. This assignment includes payment of hospital, surgical, and medical benefits those groups who provide certain services at CHS facilities, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services or any other professional groups contracted by CHS for professional services they may perform for me. In addition, I/we further warrant and represent that any insurance which I/we assign is valid insurance and in effect and that I/we have the right to make this assignment. I understand that I am financially responsible to the Hospital, my providers, and those entities named in this assignment for amounts due that are not covered by this assignment. For example, I know that sometimes insurance companies will not pay for services ordered by my providers and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my provider's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered during this admission. I further agree that in the event benefits paid under this assignment or any other amounts paid by me/us or on my/our behalf exceed the amounts due the Hospital, my providers, or those entities for services in connection with this hospitalization, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to the Hospital or any other facility or entity related to CHS, my providers, or these other entities.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that CHS has contracted with certain independent professional groups for such groups to exclusively provide certain services at CHS facilities, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. I understand that these professional groups are independent contractors, are not employees or agents of CHS, and are not subject to control or supervision by CHS in their delivery of professional services.

RELEASE OF MEDICAL INFORMATION. I understand that the Hospital and my providers can use my information for treatment, payment, and health care operations, as further outlined in the CHS Notice of Privacy Practices. As clarification, I understand the Hospital and my providers may furnish any medical information relating to my hospitalization or treatment to my insurance company, governmental or charitable agencies and their agents, and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my hospital and medical care. I also understand the Hospital and my providers may release any medical information to any licensed provider or medical facility to which I may be referred or transferred for further medical care. I authorize the Hospital and my provider to take and produce pictures, recordings, and/or video of me for treatment and health care operation purposes. I can object to, or rescind my permission for, pictures, recordings, and video being taken or produced for reasons other than treatment and health care operations at any time. In addition, I authorize the Hospital and my providers to release any medical information necessary to prove the Hospital's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts.

AUTHORIZATION TO RELEASE MEDICARE AND MEDICAID INFORMATION. I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Request for Treatment and Authorization

I understand that health care services paid for under the Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued hospital care. I authorize those agencies responsible for determining eligibility under these programs to provide to the Hospital any information relating to the determination of my eligibility. I request payment of benefits under these programs be made to the Hospital and my providers on my behalf.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by the Hospital and my providers during my hospitalization or treatment. This guaranty includes charges for services not covered by my insurance, regardless of the reason that insurance coverage is denied. I agree to pay the Hospital account I incur in accordance with the regular rates and terms of the Hospital at the time of my discharge. If I fail to pay all charges and the Hospital or my providers use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I consent and authorize CHS and its agents and subcontractors to contact outside data sources of its choosing, including credit reporting agencies, for purposes related to my account, including evaluating and assessing my credit worthiness, my charity eligibility, and the viability of collecting any amounts due for the treatment I receive, whether at this time or on subsequent visits. I understand and agree that CHS may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Hospital and third party agents of Hospital to contact me by telephone at any number associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

PERSONAL PROPERTY. The Hospital will hold any money, valuables or other personal property in my possession until I am able to return them home for safekeeping. I understand the Hospital is not responsible for money, valuables and other personal property retained in my room and has no liability for their loss.

APPOINTMENT AND RELEASE FOR FINANCIAL PURPOSES: I appoint the Financial Counseling staff of the Hospital as my (and the patient's) agent and personal representative for the purpose of initiating applications for Medical Assistance programs and/or conducting any and all activities associated with determining eligibility for such benefits. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to send copies of all notices, requests for information, and actions taken in my case including approvals and denials, and to provide such information to the Financial Counselor electronically or via telephone if requested. I authorize the Hospital, at its own expense, to obtain legal representation to assist in the evaluation, application or appeal processes. The doctrine of informed consent has been explained to me. I acknowledge that this consent is voluntary and that it may be revoked by me in writing at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one (1) year from the date of authorization, or until final determination of any benefits application as described above, whichever is later; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. Witness my (our) hand(s) and seal(s) below.

_____ _____

Patient (Seal) Responsible Party/ies (Seal)

_____ Relation to Patient

Witness

_____ ____ Husband ____ Parent/s

Date Time ____ Wife ____ Other (Specify)

- I have been provided access to CHS's Notice of Privacy Practices

Signature _____ Date:_____ Time: _____

(Patient or Authorized Representative)

Relationship to Patient:_____

Reason Patient Unable/Unwilling to sign _____

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