

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a AtriumHealth (“AtriumHealth”), maintains certain providers, personnel and facilities needed in providing me medical care, and I authorize AtriumHealth 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 treatment or procedure and any available alternative methods of treatment, together with an explanation of the likely risks and benefits associated with 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 AtriumHealth and its personnel are not responsible for providing me this information for non-AtriumHealth providers. I consent to receive services by 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 an insurance plan may not cover or continue to cover specific services, including the specific services rendered during the medical treatment.

DISCHARGE PLANNING

At any time during my admission, I understand that I may request a discharge planning evaluation by Clinical Care Management.

ASSIGNMENT OF INSURANCE BENEFITS. I/we hereby assign all my rights to Atrium Health under any policy of insurance, including but not limited to, major medical insurance, hospital or outpatient 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 medical bill, and hereby authorize direct payment to AtriumHealth and/or my providers of all benefits to which I am entitled. This assignment includes payment of hospital, outpatient, surgical, and medical benefits as well as any professional group contracted by AtriumHealth for professional services, they may perform for me, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. 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 AtriumHealth, my providers, and those professional groups or entities included 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 as part of medical treatment. If Atrium Health deems necessary, I authorize Atrium Health to file member grievances on my behalf with my health plan for any denied claims. I appoint representatives of AtriumHealth to act as my representative in pursuing such grievances. 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 AtriumHealth, my providers, or those professional groups or entities for services in connection with this medical treatment, 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 AtriumHealth or any other facility or entity related to AtriumHealth, my providers, or other professional groups or entities included in this assignment.

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

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

PHONE AND TEXT MESSAGE COMMUNICATIONS. I authorize AtriumHealth and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automated dialing systems at any phone number associated with me or my personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise me of products or services that may be of interest to me. I can only decline to receive further calls or messages by following the reasonable instructions specifically provided by AtriumHealth. I understand that I am not required to agree to receive phone calls and messages in order to receive treatment or other AtriumHealth services. By providing my email address and cell phone number, I give permission for Atrium Health (including its agents and contractors) to send me information, reminders, and messages using those means of communication. I





authorize Atrium Health to send me unencrypted messages using these means of communication, and I understand and accept the risks associated with doing so.

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.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by Atrium Health and my physicians and other providers for my medical treatment. This guaranty includes charges for services not covered by any insurance, regardless of the reason that insurance coverage is denied. I agree to pay the Hospital account I incur in accordance with the rates and terms of the Hospital at the time of my discharge. If I fail to pay all charges and Atrium Health 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 Atrium Health 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 Atrium Health may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys.

PERSONAL PROPERTY. I understand that Atrium Health is not responsible for money, valuables and other personal property in my possession and has no liability for their loss.

APPOINTMENT AND RELEASE FOR FINANCIAL PURPOSES. I appoint the Financial Counseling staff of Atrium Health 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, including, but not limited to, including Medical Assistance, Aid to Families with Dependent Children, and Special Assistance. 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 Atrium Health, 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 have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. 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, the consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect. The undersigned hereby consents to such medical treatment as my provider(s) order and indicate the same by my (our) signature below. Witness my (our) hand(s) and seal(s) below.

Name of Patient: _____ (Seal) Phone number: _____

Patient/Responsible Party Signature (Seal) Relation, if not patient, circle:
Spouse Parent/s ___ Other (Specify) _____

Date Time

Witness Date Time

I have been provided access to Atrium Health's Notice of Privacy Practices

Patient/Authorized Representative Signature Relation, if not patient, circle:
Spouse Parent/s ___ Other (Specify) _____

Date Time

Reason Patient Unable/Unwilling to sign _____

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PATIENT LABEL

