REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the Hospital personnel to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians 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 physicians 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 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 hereby authorize payment directly to CMC-NorthEast and all physicians involved in my treatment or diagnosis at CMC-NorthEast by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of hospitalization or Outpatient Services of the below named patient. I unconditionally assign any insurance benefits to CMC-NorthEast and all physicians involved in my treatment and further authorize both to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that many physicians (and their assistants) providing care at CMC-NorthEast are independent contractors and NOT CMC-NorthEast employees. I consent to care by these non-employees. I understand that I will receive a separate bill for all physician (and assistants)j services provided to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I authorize the Hospital and my physicians to furnish any medical information relating to my hospitalization or treatment to my insurance company, governmental or charitable agencies and their agents, my employer 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 authorize the Hospital and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize the Hospital and my physicians 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. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, except to the extent that: (i) action has already been taken, or (ii) in the event of my death, the release of medical information is necessary to verify any charges incurred by me.

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. 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 physicians 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 physicians or other 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. If I fail to pay all charges and the Hospital or my physicians 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.

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.

RELEASE OF INFORMATION. I authorize the Financial Counseling staff of the Hospital to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the Patient within six months of the date of this authorization. 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 provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. I request that if my benefits are approved or denied, a copy of the approval or denial be attached to and returned with the referral form. 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 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.

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)

Witness

Date Time

Policyholder (if other than patient)

Responsible Party/ies (Seal)

Relation to Patient

____ Husband
____ Wife
____ Parent/s
____ 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

TELEPHONE CONSENT FOR TREATMENT		
Name/Title of 2 Persons Witnessing Consent: 1. _____ 2. _____	Date Time	Person Called: Relationship to Patient:
Consent Granted: Yes _____ No _____	Remarks: _____	

Carolinas Medical Center NorthEast
920 Church St., North-Concord, NC 28025
CONSENT FOR TREATMENT
GEN0103 Rev. 4/12

DOS: DOB: // Sex:
Age: Race: Serv.Type: Visit Type: Loc: Rm:
Attend. Phy: