REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. I acknowledge and agree that The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health, Navicent Health, Inc. d/b/a Atrium Health Navicent, Floyd Healthcare Management Inc d/b/a Atrium Health Floyd, Wake Forest University Baptist Medical Center, and any affiliates and wholly owned subsidiaries of the foregoing (collectively "Atrium Health") procures, contracts with, maintains or furnishes providers, personnel, equipment, supplies, transportation, facilities, drugs, tests and numerous other items and things in connection with and to provide me with medical care, diagnostics, and treatment (all such items, things, care and treatment being referred to collectively as the "Services," whether provided by Atrium Health or another person or entity). Patient (or, if applicable, the responsible party/ies executing this Authorization below for patient) (with all responsible party/ies, when referring to consent, authorization, payment and other obligations and matters for which they are acting on behalf of patient, along with patient, being referred to herein as "I" and "me") authorizes Atrium Health to perform and furnish all Services 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 to me. This form is not a substitute for such explanations, which are the responsibility of my providers according to recognized standards of medical practice. In the event of an unintended exposure to Patient's blood or body fluids, Patient consents to the drawing and testing of blood and body fluids for any blood borne infections such as Hepatitis C and HIV/AIDS. Patient consents to the release of such test results to whom it is deemed appropriate by Atrium Health and in accordance with applicable law. I acknowledge that Atrium Health and its employees are not responsible for providing me information concerning Services of providers not employed by Atrium Health. I consent to receive Services by audio, video, or data transmittal for consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications if appropriate for my condition, and I understand the risks and benefits of doing so and that alternative means of providing these Services are available upon my request. I choose to receive the Services even if an insurance plan does not cover specific Services rendered during my medical treatment.

HOSPITAL ADMISSION AND DISCHARGE PLANNING
If I am admitted to an Atrium Health Hospital or facility, **I acknowledge that I have been provided access to Atrium Health's Patient Rights Notice.** 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 hereby assign to Atrium Health all my rights to receive payments of all amounts due to me under every benefit plan and insurance policy that may provide compensation or payment to me, including but not limited to medical, hospital and outpatient insurance and benefit policies and plans, sick benefits, Med-Pay benefits, and injury judgments and settlements, including awards, amounts, and benefits due to me under my own insurance policy/ies or under the insurance policy/ies of any other person or entity, such as auto insurance or workers' compensation insurance. I also hereby assign to Atrium Health the proceeds of all insurance claims and judgments payable by any person, entity, employer or insurance company to or for me. These assignments are effective to the fullest extent not prohibited by law and up to the full amount I owe for all Services provided to me, and I hereby authorize direct payment of all amounts I am entitled to receive that are covered by these assignments to Atrium Health or, at Atrium Health's request or direction, to Atrium Health's wholly and partly owned direct and indirect subsidiaries, its affiliated entities, entities it manages, my providers, and professional groups or entities contracted by Atrium Health for Services provided to or performed for me (all referred to herein as "Payees"), including but not limited to Payees providing radiology and imaging, anesthesia and pain, pathology, radiation oncology, and emergency medicine Services. I warrant and represent that every insurance policy providing payments or amounts assigned herein is valid and in effect and that I have the right thereunder to make this assignment. I understand that I am financially responsible to each Payee for all amounts I owe or that are due to such Payee even if 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 it necessary, I authorize Atrium Health to file member grievances or appeals on my behalf with my health plan for any denied claims. I appoint representatives of Atrium Health to act as my representative in pursuing such grievances or appeals. I authorize Atrium Health, at its discretion and own expense, to obtain legal representation to assist in connection with grievances or appeals. I further agree that each Payee may apply any excess reimbursements or payments to any other indebtedness or amount owed by me, my spouse, or any child for whom I am financially responsible.

NOTICE OF INDEPENDENT CONTRACTORS. Some or all of the health care professionals performing services in Atrium Health facilities are independent contractors and are not Atrium Health agents or employees. Independent contractors are responsible for their own actions and Atrium Health shall not be liable for the acts or omissions of any such independent contractors. I understand that Atrium Health does contract with independent professional groups to provide certain medical Services at Atrium Health facilities on an exclusive basis, including but not limited to radiology and imaging, anesthesia and pain, pathology, radiation oncology, and emergency medicine Services. I understand that professional groups providing those Services are independent contractors, are not employees or agents of Atrium Health, and are not subject to control or supervision by Atrium Health in their delivery of professional Services. I understand that I may receive a separate bill from these independent professional groups.

USE OF MEDICAL INFORMATION. I understand that Atrium Health and my providers and independent professional groups providing Services can use my information for treatment, payment, research, medical education, and health care operations, as further outlined in the Atrium Health Notice of Privacy Practices. As clarification, I understand that Atrium Health and my providers and independent professional groups providing Services may give any medical information relating to my medical treatment to every insurance company, governmental or charitable and social service agency (and their agents), and professional review organizations with whom I may have insurance coverage or who may provide payment for my Services. I authorize use and release of my information for Atrium Health to determine whether I have insurance coverage or other benefits for the Services I receive, and if I do, to bill such insurance or benefit provider for the Services. I also understand and agree that Atrium Health 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 acknowledge that Atrium Health, in accordance with applicable state and federal law (HIPAA), may share my medical information with healthcare providers affiliated with my care through an electronic healthcare information exchange. I authorize Atrium Health and my provider to take and produce pictures, recordings, and/or videos of me for treatment, training, education, 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 Atrium Health and my providers to release any medical information necessary to prove Atrium Health's damages in any legal proceeding brought to recover any unpaid balance on any of my accounts.

ELECTRONIC COMMUNICATIONS. I authorize Atrium Health 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, account, or research activities, 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 Atrium Health. I understand that I am not required to agree to

receive phone calls and messages in order to receive treatment or other Atrium Health Services. By providing an 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 for the reasons outlined above. I authorize Atrium Health to send 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. I understand that health care services paid 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 medical care. I authorize those agencies responsible for determining eligibility under these programs to provide Atrium Health any information relating to the determination of my eligibility. I request payment of benefits under these programs to be made to Atrium Health and my health care providers on my behalf.

PAYMENT OBLIGATION AND GUARANTY. I agree to pay all charges of Atrium Health and of Atrium Health's wholly and partly owned direct and indirect subsidiaries, its affiliated entities, and entities it manages, as well as all charges of my providers and of professional groups or entities contracted by Atrium Health for Services provided to or performed for me, including but not limited to radiology and imaging, anesthesia and pain, pathology, radiation oncology, and emergency medicine Services. This contractual obligation (of patient) and guaranty (by responsible party/ies) requires payment in full for all Services provided, including but not limited to all Atrium Health charges the patient incurs in accordance with Atrium Health's regular rates and terms as set forth in the "chargemaster" in effect at the time of treatment that Atrium Health is required to maintain pursuant to 42 U.S.C. § 300gg-18(e). For clarification, such contractual obligation and guaranty each require payment of all charges that are not covered by insurance, regardless of the reason that insurance coverage is denied. If I fail to pay such charges and Atrium Health or any other person or entity to which I owe payment uses 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 creditworthiness, my financial assistance eligibility, and the viability of collecting any amounts due from me, whether at this time or on subsequent visits. I understand and agree that Atrium Health may assign accounts as it deems necessary for purposes of collecting any amounts owed, 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 COVERAGE PURPOSES. I appoint Atrium Health and its financial counseling or coverage assistance personnel (the "Representative") as my and the patient's agent and representative for purposes of exercising, in its discretion, any or all rights and responsibilities I or the patient may have or later acquire related to pursuing, disputing, receiving, enrolling in, disenrolling from, requesting continuation of, or appealing benefits or health coverage that are funded with local, state, or federal funds including programs under the Social Security Act including but not limited to Medicaid and Medicaid waivers ("Assistance"). The Representative is also authorized to access and inspect, and shall receive copies of, any records, information, or notices to which I or the patient may be entitled, including but not limited to financial, tax, employment, insurance, health, and other information that may relate to Assistance as well as denial notices, approval notices, requests for information, adverse benefit determinations, and notices of resolution. I authorize the Representative, at its discretion and own expense, to obtain legal representation, which shall have the same authority as the Representative. If the Representative has already taken actions consistent with this appointment and release, This appointment and authorization for coverage purposes remains effective until revoked by me or the patient in writing delivered to the Representative and shall not be impaired by my or the patient's death or incapacity.

I hereby consent to such medical treatment as my provider(s) order and all other assignments, appointments and authorizations within this document and indicate the same by my signature below. The consent to medical treatment provided herein is voluntary and may be revoked through a clear and unequivocal expression of a desire to withdraw consent but only if it is medically feasible for the provider to cease treatment at that time. Consent regarding appointments, assignments and authorization post-service may be revoked in writing at any time except to the extent that action has already been taken in reliance on it. I have read the foregoing Authorization in its entirety and agree to be bound by all terms and conditions herein even if I revoke consent to further treatment. Witness my (our) hand(s) and seal(s) below.

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

_____(Seal)
Patient/Responsible Party Signature

Relation, if not Patient:
____Spouse
____Parent/s
____Other (Specify:_____)

_____
Date Time

_____
Witness Date Time

I acknowledge I have been provided access to Atrium Health's **Notice of Privacy Practices** and access to the Atrium Health **Patient Right's Notice.**

_____
Patient/Authorized Representative Signature

Relation, if not Patient:
____Spouse ____Parent/s

____Other (Specify:_____)

_____
Date Time

PATIENT LABEL

Reason Patient Unable/Unwilling to sign _____
_____

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