REQUEST FOR TREATMENT AND AUTHORIZATION FORM
Atrium Health Medical Group

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health and Carolinas Physicians Network, Inc. d/b/a Atrium Health Medical Group ("Atrium Health") maintains certain providers, personnel and facilities needed in providing me medical care, and I authorize Atrium Health, those providers and 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 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. I acknowledge that Atrium Health and its providers and personnel are not responsible for providing me this information for non-Atrium Health 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 my insurance plan may not cover or continue to cover specific services, including the specific services rendered during medical treatment.

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 Atrium Health and/or my providers of all benefits to which I am entitled. This assignment includes payment of hospital, outpatient, surgical, and medical benefits to any professional group contracted by Atrium Health 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 Atrium Health, 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. 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 Atrium Health, 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 Atrium Health or any other facility or entity related to Atrium Health, my providers, or other professional groups or entities included in this assignment.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that Atrium Health has contracted with certain independent professional groups for such groups to exclusively provide certain medical services at Atrium Health facilities, including but not limited to radiology, anesthesiology, 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.

USE OF MEDICAL INFORMATION. I understand that Atrium Health, 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 Atrium Health Notice of Privacy Practices. As clarification, I understand that Atrium Health and my providers may give any medical information relating to my medical treatment to my 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 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 authorize Atrium Health 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 Atrium Health and my providers to release any medical information necessary to prove Atrium Health's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts.

PHONE AND TEXT MESSAGE COMMUNICATION. I authorize Atrium Health and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automatic 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 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 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.

Request for Treatment and Authorization

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PATIENT LABEL

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 medical care. I authorize those agencies responsible for determining eligibility under these programs to provide to Atrium Health any information relating to the determination of my eligibility. I request payment of benefits under these programs be made to Atrium Health and my health care providers on my behalf.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by Atrium Health and my physicians or other providers for my medical 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 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.

ADDITIONAL AUTHORIZATION AND CONSENT: I authorize the Financial Counseling staff of Atrium Health 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. 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. 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. This consent shall remain valid and enforceable until it is revoked or replaced by a new form of consent, signed by me.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. The undersigned hereby consents to such medical treatment as my provider(s) order and indicate the same by my (our) signature below.

Name of Patient: _____ Phone number: _____

_____
Patient/Responsible Party Signature

_____
Date Time

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

_____
Witness Date Time

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

_____
Patient/Authorized Representative Signature

_____
Date Time

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

Reason Patient Unable/Unwilling to sign _____
_____

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