AUTHORIZATION FOR TREATMENT: The undersigned hereby applies for outpatient treatment and/or admission of the patient to Carolinas Medical Center-NorthEast and gives permission to the health care provider in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination in this hospital. I understand that students or residents in various health-related training programs may participate in my care or observe special procedures. No individual shall be subject to discrimination or denied the benefits of any of the services, programs, or activities at any facility of Carolinas Medical Center-NorthEast on the basis of race, color, religion, national origin, sex, age, disability or source of payment.

RELEASE OF INFORMATION: The undersigned authorizes CMC-NorthEast to disclose all or any parts of the patient's medical record to any of the following: listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning worker's compensation case, any review agency which conducts reviews of hospital utilization under an agreement with the patient's employer or other payment source, and any health care organization, healthcare provider or agency needing medical information to assist in the patient's continuing care. The disclosed medical record may include information regarding the treatment of psychiatric and drug and alcohol abuse conditions, information concerning AIDS, AIDS-related conditions or HIV status. CMC-NorthEast will make every effort to pre-certify and/or pre-authorize treatment with third party payors who conduct Utilization Review as a service to patients; however, CMC-NorthEast does not accept responsibility for lack of pre-certification and/or preauthorization and is not responsible for the final payment outcomes or timing constraints. I also understand that I may revoke this authorization by providing written notice to the hospital.

MEDICARE/TRICARE, MEDICAID PATIENT'S INFORMATION: I certify that the information I have given in applying for payment under Title V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I understand that the health care services paid for under 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 CMC-NorthEast and the applicable County Department of Social Services (e.g., Cabarrus, Mecklenburg, Rowan, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. This information may include the following: date of application, application status, the reason my application remains pending, any verification required to complete my application, the date and reason of denial (if applicable). I have received the document titled "An Important Message from TRICARE" or "Medicare" at the time of my admission. My signature only acknowledges my receipt of this message from CMC-NorthEast and does not waive any of my rights to request a review or make me liable for any payment.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to CMC-NorthEast and all health care providers 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 health care providers 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 health care providers 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. I consent and authorize CMC-NorthEast 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 CMC-NorthEast may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys.

INDEPENDENT CONTRACTORS: **I understand that many health care providers (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 health care provider (and assistant) services provided to me.**

PERSONAL VALUABLES: I hereby release the hospital and health care providers from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

Signature of Patient (or legally authorized representative): Relationship to patient:	Date/Time	Signature of Guarantor (or responsible party): Relationship to patient:	Date/Time
Witness:		Patient is a minor of _____years of age or is unable to sign because: _____	

TELEPHONE CONSENT FOR TREATMENT

Name/Title of 2 Persons Witnessing Consent: _____ _____	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. 10/11 ***933***

DOS: **DOB: // Sex:**

Age: Race: Serv.Type: Visit Type: Loc: Rm:

Attend. Phy: