Mount Sinai Morningside

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Mount Sinai Morningside Hospital ("MSM") with respect to such services and care unless the contract between MSM and my insurance company provides otherwise and/or unless otherwise provide by law. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for al services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to MSM, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of an MSM bill, I agree to immediately pay all amounts not covered by insurance unless otherwise provided by law. If any insurance I have rejects my claim or pays, part of the claim, I shall be responsible for payment of any balance as determined by MSM immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to MSM, for services rendered to me, I hereby give my consent to have an authorized representative of MSM contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by MSM which may be required in order for my insurer to reevaluate its decisions to deny payment for such services.

I authorize MSM, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital (format) to insurers, various credit agencies guarantors solely if needed for payment of MSM charges and/or
and guarantors solely if needed for payment of MSM charges and/or professional charges (no clinical information will be disclosed to any credit agency)

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only Part A Part B providers

I certify that the information given by me to applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits to be made on my behalf. I assigned benefits payable to physician (s) and/or MSM Services to the physician (s) and/or MSM Services to the physicians (s) or organizations providing the service (s).

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK"

I understand that MSM is a participating provider in many health plan networks, and that a list of the plans that MSM participates in can be found at http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msm!

I understand the physicians and other providers who render services at MSM may be employed by or contracted by MSM or may be independent practitioners who are **not** employed or contracted by MSM. I further understand that physicians/providers who provide services at MSM may not participate in the same health plans as MSM, even if they employed by or contracted by MSM.

I understand that charges for physicians'/providers' "professional services" performed at MSM, are **not** included in MSM's charges, and that physicians/providers may bill for their "professional services" separately from MSM, even if they are employed by or contracted by MSM.

I understand that I can check with the physician(s) arranging for my hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician/practice whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by MSM to provide services (including anesthesiology, Pathology and/or radiology) are reasonably anticipated to be provided to me.

I understand that I can determine the health plans participated in by physicians who are employed by MSM by accessing the "find a doctor" at the toolbar at http://www.mountsinaihealth.org and navigating to physicians' profiles to view their insurance participation information.

I understand that contact information for physician groups contracted by MSM to provide services at MSM is available at http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msm

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

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SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE