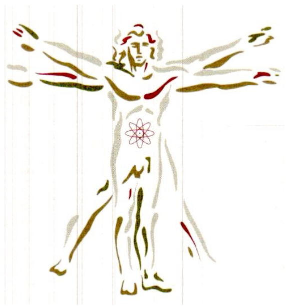

PATIENT CONSENT AND ASSIGNMENT OF INSURANCE BENEFITS

Consent for Diagnosis and Treatment; Contractor Personnel Not Agents of Burlington Medical Center

I have a condition requiring health care and hereby consent to the provisions of such care, which may include diagnostic procedures, including HIV testing, and such treatment as the attending physician and other Burlington Medical Center medical staff members may consider necessary. I understand that such care may be enhanced through photography, video recording and visual monitoring. I understand that some physicians and affiliates (Contractor Personnel) provide their services directly to the patient independently, that these personnel are not employees or agents of Burlington Medical Center and that Burlington Medical Center is not liable for their acts of omission. If I desire to decline HIV testing I will request and complete a paper copy of this form.
I decline HIV testing: ___________________

Patient's Certification, Assignment of Insurance Benefits and Guaranty of Payment

I certify that the information given to me in applying for payment under Titles XVIII and XIX of the Social Security Act or any other government or insurance benefits is correct. I authorize payment of benefits directly to all treating and consulting physicians and vendors.

I understand that I am financially responsible for, guarantee and agree to pay in full, in accordance with the regular rates and other terms of Burlington Medical Center at the time of the patient's treatment, all charges for services provided to me or other independent healthcare professions involved in providing treatment or consultation to me at Burlington Medical Center. I understand that I am financially responsible if such treatment is not covered by insurance or other payor. If covered, I am responsible for any non-covered items, copays, deductibles, co-insurance and any other out of pocket expenses related to my care. I understand that Burlington Medical Center may have self-pay policies at the time of service that, if I qualify, may make assistance available to me. I understand that my bill will be sent to the address on file unless I complete a request for my bill to be sent to an alternate address.

By initialing this statement, I am requesting that no Protected Health Information for services received and paid by me be released to my Health Plan. If payment in full is not received within 30 days, Burlington Medical Center will pursue reasonable collection efforts to include, but not limited to, filing insurance.

I authorize Burlington Medical Center and any independent practitioner(s) that have provided services to me at Burlington Medical Center to act on my behalf with regard to: (1) collection of benefits from any responsible third party through whatever means necessary and (2) Endorsement of benefit checks made payable to me and/or Burlington Medical Center or such independent practitioner(s). If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including reasonable attorney fees.

I authorize payment of any refund that is due of any overpaid insurance benefits to be paid to the appropriate payer in accordance with my insurance policy conditions or any applicable benefit provisions where my coverages are subject to a coordination of benefits clause. With regard to any refund due to me, I authorize immediate application of any such refund to any amount that I am personally legally obligate to pay for care and services provided by Burlington Medical Center. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

I authorize Burlington Medical Center, its affiliates, independent contractors, associated entities and all agents and representatives retained by Burlington Medical Center, including any collection agency, attorney, debt collector or other entity, to obtain current information about me, including my address, phone number(s) and other information to assist in locating and communicating with me for the purpose of collection of accounts that may be owed by me. I agree that Burlington Medical Center may contact me by telephone, electronic messages, mail or cell phone as provided by me. These calls include but are not limited to cellular phone service. I understand that my agreement to the terms of the Patient Consent and Assignment of Insurance Benefits is not a condition of willingness to provide treatment to me. I consent to any and all of the communication methods even if I will incur a fee or cost to receive such communications. I agree that the consent and authorizations I have provided herein may be revoked in writing addressed to Burlington Medical Center.

HIPPA and other Regulations Governing Protected Health Information

I understand that my medical information could include medical history or information regarding first-time or subsequent diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, etc.), mental illness, alcohol, drug or substance abuse, or developmental disability. Burlington Medical Center, physicians, and other health care professionals involved in providing my care at Burlington Medical Center are authorized to obtain and release such medical information obtained or needed for purposes of treatment, payment and health care operations as stated in the Burlington Medical Center Notice of Privacy Practices available in a printed version from Burlington Medical Center.

Release of Liability for Valuables

Burlington Medical Center does not assume liability for money or valuables left unattended or taken to a patient's room or treatment area.

I UNDERSTAND AND CONSENT TO THE ABOVE AGREEMENTS, RELEASES, AUTHORIZATIONS AND ASSIGNMENTS OF BENEFITS.

Signature: ____ **Date:** ______________________

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