Carolina Breast Imaging SPECIALISTS, PLLC

# AUTHORIZATION AND CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The term "healthcare provider(s)" in this document means Carolina Breast Imaging Specialists its agent and employees, members of the medical staff, their agents and employees and other healthcare practitioners who provide care to patients.

## CONSENT TO TREAT

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other healthcare providers

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

## RELEASE OF INFORMATION

The healthcare provider involved in my care may release information about me necessary to substantiate my insurance claims.

## FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the healthcare provider are not paid after reasonable notice, that account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees, including court costs and reasonable attorney fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees on amounts in default.

## MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Carolina Breast Imaging Specialists for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.
I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS 1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes the release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

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**Patient / Guardian signature** **Date**

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**Name of Patient** **Relationship of Guardian**

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**Witness** **Title** **Date**