PLEASE PRINT YOUR NAME: ______________________________

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, New York 10029

Authorizations and Assignments

Ruttenberg Treatment Center

1. Financial Agreement/Guarantee of Payment (All Patients) ☐ **Yes** ☐ **No (please initial)** __________

In consideration of services, assignment of benefits, and care rendered; I agree that I am responsible for any and all charges billed by The Mount Sinai Hospital and The Mount Sinai School of Medicine with respect to such services and care unless the contract between the aforementioned parties and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon.

I authorize payment of medical benefits to which I am entitled directly to The Mount Sinai Hospital or The Mount Sinai School of Medicine (as appropriate) to cover the cost of the care and treatment rendered either to myself or my dependents in the Ruttenberg Treatment Center.

Upon receipt of a treatment bill, I agree to immediately pay all amounts not covered by insurance. 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 the Hospital and/or physician immediately upon learning of such coverage.

2. Release of Information ☐ **Yes** ☐ **No (please initial)** ___________

In the event my insurer denies payment to The Mount Sinai Hospital or The Mount Sinai School of Medicine for services rendered to me, I hereby give my consent to have an authorized representative of the above-mentioned parties contact my insurer and provide to my insurer all information and documentation regarding the services rendered to me by the Hospital and/or School of Medicine that may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize The Mount Sinai Hospital and The Mount Sinai School of Medicine, 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, and guarantors solely if needed for payment of Hospital and/or professional charges.

3. Medicare-Release of Information & Assignment of Benefits (Medicare only Part A and Part B Providers)
☐ **Yes** ☐ **No (please initial)** ___________

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize 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 carriers 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 be made on my behalf. I assign benefits payable to the physician(s) and/or Hospital Services to the physician(s) or organizations providing the service(s).

I have read, understand, and agree with the above items.

______________________________ ______________________________
Signature of Patient or Authorized Representative — Dated

______________________________ ______________________________
Relationship to Patient — Witness to Signature