Mount Sinai Hospital

Name

Date of birth

MRN

AUTHORIZATIONS AND ASSIGNMENTS

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

In consideration of services (technical and/or telehealth), assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **The Mount Sinai Hospital ("MSH")** with respect to such services and care unless the contract between **MSH** and my insurance company provides otherwise and/or unless otherwise provided by law. 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, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to **MSH**, to cover the cost of the care and treatment (technical and/or telehealth) rendered to myself or my dependents in the hospital.

Upon receipt of an **MSH** 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 **MSH** immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

I authorize **MSH**, 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 **MSH** charges and/or professional charges (no clinical information will be disclosed to any credit agency). I also authorize and consent to being contacted with regards to these charges by the providers in question and to cooperate in the resolutions via secure text on the cell phone number provided as permitted under 47 U.S.C. § 22.

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

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

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 physician (s) and/or **MSH** Services to the physician (s) or organizations providing the service(s).

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

I understand that **MSH** is a participating provider in many health plan networks, and that a list of the plans that **MSH** participates in can be found at mountsinai.org/about/insurance/MSH

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

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

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 **MSH** 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 **MSH** by accessing the "find a doctor" toolbar at mountsinaihealth.org and navigating to physicians' profiles to view their insurance participation information.

I understand that contact information for physician groups contracted by **MSH** to provide services at **MSH** is available at mountsinai.org/about/insurance/MSH

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

Signature of patient or authorized representative

Date

Relationship to patient