CONE HEALTH

CONE HEALTH HOSPITALS, CONE HEALTH MEDICAL GROUP, AND CONE HEALTH OUTPATIENT SERVICES

PATIENT CONSENT AND ASSIGNMENT OF INSURANCE BENEFITS

Consent for Diagnosis and Treatment; Contractor Personnel Not Agents of Cone Health

I have a condition requiring health care and hereby consent to the provision of such care, which may include diagnostic procedures, including HIV testing, and such treatment as the attending physician(s) and other Cone Health medical staff members may consider necessary. I understand that such care may be enhanced through photography, video recording, and visual monitoring. I understand that Cone Health is a teaching institution and I agree that students training to be physicians or other health professionals may observe or assist in providing my care and that my medical records may be used in connection with such training, including with students not directly involved in my care. 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 Cone Health, and that Cone Health is not liable for their acts or omissions. Contractor Personnel include, without limitation, physicians with the following groups: Greensboro Radiology, PA.; Burlington Radiology Associates, PA; Southeast Anesthesiology Consultants, PLLC.; GPA Laboratories, Inc.; Wake Forest University Health Sciences; Greensboro Radiation Oncologists, PA; American Anesthesiology of North Carolina, PLLC; Eagle Hospital Physicians; and Piedmont Neonatology, P.C.

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 by 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 hospital insurance, government or other third-party benefits, including major medical, directly to Cone Health. 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 Cone Health at the time of patient's treatment, all charges for all services provided to me by Cone Health, independent physicians, or other independent healthcare professionals involved in providing treatment or consultation to me at Cone Health. I understand I am financially responsible if such treatment is not covered by insurance or other payer. If covered, I am responsible for any non-covered items, copays, deductibles and any other out-of-pocket expenses related to my care. I understand that Cone Health Hospitals may have charity and self-pay policies at the time of my 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, Cone Health will pursue reasonable collection efforts to include, but not limited to filing insurance. I am opting out of my Health Insurance Plan to be billed for these services. _____

I authorize Cone Health and any independent practitioner(s) that have provided services to me at Cone Health to act on my behalf as attorney-in-fact 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 Cone Health 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 attorneys' 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 obligated to pay for care and services provided by Cone Health. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

I authorize Cone Health, its affiliates, independent contractors, associated entities, and all agents and representatives retained by Cone Health, including any collection agency, attorney, debt collector, or other entity

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(collectively "Cone Health"), 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 Cone Health may contact me by telephone, electronic messages, mail, or cell phone as provided by me. These calls include but are not limited to using an automatic telephone dialing system, artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service ("Authorized Communications"). I understand that my agreement to the terms of this 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 authorized communication methods even if I will incur a fee or a cost to receive such communications. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the relevant entity's Patient Accounting Director.

Consent for Release of Information for State Financial Assistance Programs

I authorize the Financial Counseling staff of Cone Health to represent and assist me in the processing of an application for benefits, including but not limited to Medical Assistance (Medicaid), TANF, or Special Assistance, initiated by me or on my behalf within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I or my representatives would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor orally via telephone or by photocopy or facsimile. I authorize referral to the County Department of Social Services for benefits by use of an appropriate referral form, including but not limited to the DMA-5020. I request that the final disposition of my application for benefits, along with an explanation of any denial, be attached to and returned with the appropriate referral form.

HIPAA 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. Cone Health, physicians, and other health care professionals involved in providing my care at Cone Health are authorized to obtain and release such medical information (except for drug and alcohol treatment and psychotherapy notes) obtained or needed for purposes of treatment, payment, and health care operations as stated in the Cone Health Notice of Privacy Practices. The Notice of Privacy Practices is located on the Cone Health website and a printed version is available at all registration sites, where I may obtain a copy without asking anyone.

I understand that HIPAA and other regulations allow me to place certain restrictions on how my Protected Health Information is used. I will specify those restrictions on a HIPAA restriction form.

Release of Liability for Valuables:

Cone Health 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 (seal): _____ Date: _____

Patient or Legal Guardian / Power of Attorney (if patient unable to sign)

Consent to Diagnosis and Treatment Obtained by Telephone

Treatment / Procedure: _____

Authorized Person Giving Consent: _____

Telephone #: _____ Relationship to Patient: _____

Witness: _____ Date & Time: _____