



Insurance Benefit Assignment/Guarantee of Payment/Use of PHI/Consent for Treatment/  
Power of Attorney/Acknowledgment

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Insurance Assignment and Medicare/Medicaid Certification:**

I, the undersigned, hereby authorize payment of health insurance benefits that I am entitled to per my benefits contract with my insurer to be paid to Randolph Health Medical Group. This authorization will include those major medical benefits payable to the physician who rendered care on my behalf.

As a Medicare/Medicaid patient (if applicable), I hereby authorize payment of all claims filed by the above referenced provider of healthcare services, which are otherwise payable to me. I hereby authorize the provider of healthcare services to release any health information that may from time to time be required by Medicare/Medicaid in order to make final determination of payment of claims submitted by the provider for all medically necessary services rendered to me. I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct.

As the signer below, I attest that RHMG has been requested to maintain my signature on file for the purpose of filing claims permitted by the assignment.

**Guarantee of Payment:**

I, the undersigned, hereby acknowledge that I am the guarantor on this account and, as such, will be responsible for payment of charges not covered by my health insurer. Once my healthcare insurer makes a final claims determination as reflected on their Explanation of Benefits received by my healthcare provider, I understand payment of the remaining balance is immediately due. RHMG does not discriminate based on ability to pay.

RHMG, as a tax deferred entity, is required by IRS code to offer patients with legitimate financial need a sliding fee schedule. Upon your request, RHMG will require specific documents from you in order to determine if you qualify for our sliding fee schedule based on your income. You, our patient and/or guarantor on the account, have the ultimate responsibility of making a request for sliding fee scale consideration and will be expected to provide RHMG with any and all documentation required to make an accurate determination of income. The amount of discount afforded the patient/guarantor will vary and be based on income as determined by RHMG.

**Reasons we may use and disclose Protective Health Information (PHI) without your authorization:**

RHMG, as the provider of healthcare services, is authorized to release, without prior authorization, any PHI required to:

1. Provide health care treatment to you, including communicating with other health care providers to coordinate and manage your health care
2. Obtain payment for services rendered
3. Perform business activities known as "health care operations" in order to collect information for such purposes as: improving the quality, efficiency and cost of care that we provide.

Other circumstances for providing PHI without your authorization include, but are not limited to, public health activities or when required by law. See our Notice of Privacy Policies for further details.

**Consent for Medical Treatment**

I, the undersigned am knowingly requesting general medical services from RHMG and I am requesting these services willingly and voluntarily. By my signature below, I attest that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis (as applicable) and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and understand the reasons for the procedure. I understand that I have the right to refuse such care, except in an emergency.

**Power of Attorney Regarding Healthcare Services Rendered to a Minor:**

As the legal guardian of the patient who is under the age of eighteen (18) years of age and who does not possess statutory authority to make his/her own decisions regarding healthcare services rendered, I authorize the following persons to make these decisions in my absence and convey in listing them the legal authority to make such decisions.

Power of Attorney, as described herein, is hereby granted to the following individuals:

_____	_____	_____
Name	Relationship to Patient	Date
_____	_____	_____
Name	Relationship to Patient	Date
_____	_____	_____
Name	Relationship to Patient	Date

**Acknowledgement as Signer on the Account:**

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. In doing so, I convey and acknowledge a full understanding of my rights and obligations as a patient of RHMG. Should the patient be a legal minor as defined in the State of North Carolina Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

X

_____	_____
Signature of Patient/Guarantor on the Account	Date

_____	_____
Relationship if Other than Patient	Date

_____
Reason Patient Cannot Sign

_____	_____
Witness	Date