NTMC
North Texas
Medical Center

* A E T O S *

AUTHORIZATION FOR EMERGENCY TREATMENT/OUTPATIENT SERVICES

1. **Consent for Medical Treatment:** I do hereby voluntarily consent to such hospital care encompassing diagnostic and therapeutic procedures and medical treatment, as may be ordered by my physician or other physicians as requested by him. I realize that physicians furnishing service to the patient. Including radiologist, pathologist, anesthesiologist and emergency physicians are independent contractors and are not employees or agents of the hospital. I understand that these independent contractors may not be contracted with all insurance companies. I understand I will be receiving a bill from these providers for their services. I understand that my condition may warrant my physician requesting consultation with other physicians and I agree to be responsible for their charges.
2. **Medicare Medicaid Patient's Certification:** Authorization to release information and payment request I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. If I am a recipient of Medicare I understand that I am responsible for the Medicare deductible and 20% co-insurance (Part B) relating to any professional charges which may be incurred.
3. **Pre-Certification Responsibility:** I understand that pre-certification/pre-authorization with my Insurance carrier is my responsibility and penalties may be assessed by my carrier as a result of failure to properly certify.
4. **Assignment of Insurance Benefits:** I hereby authorize payment directly to North Texas Medical Center of all hospital benefits otherwise payable to me Including major medical insurance and payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to the hospital and physician for charges not covered by this assignment. I shall provide completed, signed employee/member claim forms needed for proper insurance filing. Authorization is hereby further given for payment of Insurance Benefits directly to: Radiologist, Pathologist, Anesthesiologist, Attending Physician, Emergency Room Physician and Consulting Physician of all benefits otherwise payable to me for said services, but not exceed the total charges.
5. **Deposits:** I understand that NTMC has a schedule of deposits required to cover deductibles, co-insurance, co-pays and non-covered charges. These deposits are due at time of service.
6. **We accept checks under these conditions:** When you pay by check. you expressly authorize this merchant, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of $50 or legal limit plus any applicable sales tax. The use of a check for payment is your acknowledgement and acceptance of this policy and it's terms.
7. **Overpayment:** I understand that in the event of an overpayment on the account any refund due will be refunded to the appropriate party, except as follows: It is hospital policy to apply any credit balance that may exist as a result of this hospital stay to any other accounts for myself or a member of my family for whom I am legally responsible. In the event there are no other accounts, a prompt refund will be made.
8. **Financial Agreement and Payment Guarantee:** Both undersigned patient and the guarantor(s) agree that in consideration of the services to be rendered to the patent, they hereby individually obligate themselves to pay the charges of the hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
9. **Telephone Contacts:** I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls to my cellular telephone and any phone number provided during my registration process from NTMC or its affiliates and their agents including, without limitation, any account management companies and Independent contractors including any collection agents.
10. **Credit Reports:** I understand NTMC reserves the right to periodically report my credit standing to credit reporting agencies and I agree that NTMC may obtain credit reports about my credit standing for the purposes of establishing credit terms or collection of my account.
11. **Indigent/Charily Care:** NTMC has developed an eligibility system to assess patients who may be financially or medically indigent. To apply, contact Business Services. Care will be provided to those patients who qualify who present themselves for care without regard to race, creed, color, or national origin. By virtue of its exemption form federal and state taxes and as part of the hospital's mission to serve the health care of the community, indigent/charity care will be provided to patients without financial means.
12. **Authorization for Release of Medical Information:** The hospital and attending physician are authorized to furnish any medical information (including copies of records) requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care. A copy shall be as valid as the original.
13. I understand that health care services paid under Medicare. Medicaid, and maternal and child health programs are subject to review by the Professional Standards Review Organization.
14. **Patient Rights:** I hereby acknowledge receipt of a Patient Rights written statement regarding my rights as a patient, including, a mechanism for initiation, review and resolution of a complaint.
15. Obtaining this authorization will in no way interfere, hinder or delay the obligations and duties of NTMC under the Emergency Medical Treatment and Active Labor Ad.
16. I do ☐ or do not ☐ authorize NTMC to release the following information, if requested: (1) My name (2) My location in NTMC, (3) My condition described in general terms that does not communicate specific medical information, and (4) My religious affiliation (religious affiliation may only be released to clergy). If you choose to NOT authorize the release of information, you will be listed as a "No Information Patient," and all telephone calls, flowers and visitors will be refused on your behalf.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THE FOREGOING, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

Patient		Witness
PATADMIT		
Date	Responsible Party	Relationship to Patient