AANDA

NMC health

PO Box 308 | Newton, KS 67114

AUTHORIZATIONS AND AGREEMENTS

INSURANCE REQUIREMENTS: Health insurance plans often have special requirements or limitations. I understand my insurance may refuse to pay for part of my entire bill because:

- The requirements of my insurance were not met,
- My insurance decided the tests or services provided to me were not medically necessary according to its criteria, and/or
- The services were not covered under my insurance plan.
- I did not obtain referral

If my insurance limits or denies payment, I understand I will be responsible for that payment.

MEDICARE DRUG DENIAL: Medicare does not pay for drugs and biologicals given to outpatients. If I have Medicare, I understand I will be responsible for payment of medications I receive as an outpatient.

MEDICARE/MEDICAID BENEFITS: Medicare, Medicaid, the Social Security Administration of their representatives including peer review organizations may request to review my medical records. I understand Newton Healthcare Corporation will release my records as requested.

HEALTH SHARE PLANS: I understand that if I am a part of health sharing plan, I will be responsible for submitting my bill to the sharing plan for reimbursement unless otherwise notified.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Newton Healthcare Corporation to release medical and/or billing information in the following situations:

- To those who provide medical care and/or services to me,
- To pay insurance claims for the services I receive,
- To any third party who has agreed to pay for the services I receive, or
- As needed for health care operations.

Further details about the release of information practices and the methods used to protect the privacy of your health information are found in the Newton Healthcare Corporation, HIPAA Notice of Privacy Practices.

DIRECT PAYMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND MEDICAID: I authorize insurance payments for services provided to me at NMC Health Clinics to be paid directly to NMC Healthcare Corporation and to physicians and specialists who may be doing their own billing.

AGREEMENT TO PAY FOR SERVICES: I agree that as the patient, or agent of the patient, I will pay the charges of Newton Healthcare Corporation according to its regular rates and terms. *As posted at NMC Heathcare corporation, any patients presenting for services to the emergency department or in labor will have a medical screening examination performed regardless of the ability to pay the bill.*

NMC Healthcare Corporation is not responsible for valuables and personal items. Please leave valuable such as jewelry, cash, and other personal items at home or with a family member.

AS THE PERSON SIGNING BELOW, I CERTIFY THAT I AM THE PATIENT OR THE AUTHORIZED REPRESENTATIVE OF THE PATIENT. I AGREE TO THESE TERMS UNLESS SPECIFIED IN WRITING.

Patient Signature: _____ Date: _____

Agent/Representative/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____

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