HEALTHCARE
MARYLAND
PATIENT INFORMATION AND AUTHORIZATION

PATIENT NAME: ______________________________ **PATIENT ACCT#:** SA0009049248

1. Insurance Certification and Assignment - I do hereby certify that the information given by me or by ________________________ acting on my behalf, in applying for payment under Titles XVIII and XIX of the Social Security Act, or by any other Third Party Payor, is correct. I do hereby assign to HealthCare all hospital or other health care service benefits due me under the terms of said policies and programs, but not to exceed 's regular charges for similar services. I assign payment to the physician(s) providing medical services to me, and I assign payment for the unpaid charges of the physician(s) for whom is authorized to bill in connection with its services.
2. Financial Agreement - I understand that I am fully responsible for all charges incurred by me that may not be reimbursable by insurance or third party payor. I understand that my insurance company may pay me directly for the services I have received, in which case I will immediately forward these monies to . Should my account be referred to an attorney/agency for collection, I shall be responsible for the payment of reasonable fees and collection expenses associated with these collection efforts.
3. Billing for Services - I understand that many of the providers of heathcare services may not be employees or agents of . I understand that I may receive separate billing from such providers.

Valuables Release - I acknowledge that assumes no responsibility for the loss or damage of any personal property or valuables belonging to me as a patient, inclusive of glasses, hearing aides and dentures. I understand that if I need to secure personal property/valuables at any time while at , that I may do so with the Protective Services Department until such time as I am discharged.

The following apply to inpatient admissions only:

5. Uterine Cytologic Examination for Cancer: If you are a woman 18 years or older and have not had a Pap Smear within the past year, do you desire that your doctor make arrangments for the taking of a Pap smear during your hopitalization? Yes______ No______

6. Advanced Directives - I have the following:

Advanced Directives Yes No Received: Yes No
Living Will Yes No
A Health Care Agent Yes No
Information about Advanced Directives given to patient: Yes No

have been given a statement of my rights regarding making health care decisions and information regarding advanced directives.

7. Acknowledgment of Receipt of Medicare Message my signature only acknowledges my receipt of this message from on 07/01/05 and does not waive any of my rights to request review of or make me liable for any payment.

____
Signature of Medicare beneficiary or person acting on behalf of beneficiary Date

8. This form has been fully explained to me, and I am satisfied that I understand it's contents and significance. I further understand that a photocopy of this authorization shall be as valid as the original on file.

9 Smoking Cessation Info Given: Yes No

______________________________ ______________________________

SIGNATURE OF PATIENT/LEGAL GUARDIAN **SIGNATURE OF WITNESS**

SIGNATURE DATE: __________________________