SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

☐ ____ **1. CONSENT FOR RELEASE OF MEDICAL INFORMATION:** I permit Saint Peter's University Hospital to give information and/or medical records from my file, or from the person I appoint, to the insurance company or its agents, in order to process a claim for payment. Only information that is reasonable or necessary to process the claim can be released.

☐ ____ **2. GUARANTEE OF PAYMENT:** I want Saint Peter's University Hospital and all my doctors to be paid directly for any benefits that may be payable to me, but not to go above the hospital's regular charges for this period of service. I understand that I have to pay the hospital and/or doctors for any charges not covered or allowed by any third party payer. I know that I must pay all bills when I get them. I state that the insurance information I gave is complete and correct as far as I know. I also understand that I am responsible for any liens or wage garnishments imposed on me, and any legal fees, costs, late charges, collection fees, or court costs that may be incurred by Saint Peter's in its collection efforts.

☐ ____ **3. CREDIT/VERIFICATION AUTHORIZATION:** I permit Saint Peter's University Hospital and its affiliates and contractors to use all legal methods to locate me, my sources of income and/or my assets to collect on my account should it become overdue for payment. This may include but is not limited to, credit bureau inquiries. I may receive care at Saint Peter's University Hospital without this Credit/Verification Authorization; however, it may be lawful for Saint Peter's University Hospital to do these things even if I do not provide this authorization. A photocopy of this authorization shall be equal to the original.

☐ ____ **4.** I was given the Saint Peter's University Hospital Patient brochure about Patient Rights and Responsibilities or a copy of the Patient and Family Guide which has the content on Patient Rights and Responsibilities.

☐ ____ **5.** I have received a copy of the Saint Peter's University Hospital Notice of Privacy Practices (NPP), and a short summary of same. [Note to staff: If the patient will not accept the NPP OR will not initial and sign that they have received the NPP document your good faith efforts to provide the NPP and/or obtain the patient's initials or signature here: _____

☐ ____ **6.** I was given the notice called **THE AVAILABILITY OF NEW JERSEY HOSPITAL CARE ASSISTANCE OR REDUCED HOSPITAL CARE FOR INDIGENT PATIENTS.**

☐ ____ **7. AN IMPORTANT MESSAGE FROM MEDICARE (HMO/MANAGED CARE PLAN)**
HMO NAME: _____ I understand that my signature only says that I have received this message from Saint Peter's University Hospital on the date below. It does not mean that I cannot request a review or make me responsible for any payment.

☐ ____ **8. AN IMPORTANT MESSAGE FROM MEDICARE.** I understand that my signature only says that I have received this message from Saint Peter's University Hospital on the date below. It does not mean that I cannot request a review or make me responsible for any payment.

☐ ____ 9. **AUTHORIZATION TO PAY INSURANCE BENEFITS: MEDICARE.** The information that I gave when I applied for payment under Title XVIII of the Social Security Act is correct as far as I know. I permit any holder of medical or other information about me to release it to the Social Security Administration (or its intermediaries or carriers) if it is needed for this or a related claim. I want Saint Peter's University Hospital and all of my doctors to be paid directly for any benefits that may be payable to me. I permit these doctors and the hospital to file a claim to Medicare for payment.

☐ ____ **10. PERMISSION TO PAY INSURANCE BENEFITS: MEDICAID.** I state that I received the services for this claim and want payment for these services to be paid for me. I want Saint Peter's University Hospital and all of my doctors to be paid directly for any benefits that may be payable to me. I permit these doctors and the hospital to file a claim to Medicaid for payment. The information I gave when I applied for payment under Title XIX of Medicaid is correct as far as I know. I permit any holder of medical or other information about me to release it to the Division of Medical Assistance and Health Services (or its intermediaries or carriers) if it is needed for this or a related claim.

☐ ____ **11. PERSONAL PROPERTY/VALUABLES:** It is understood that the hospital is not responsible for personal property or valuables retained by the patient, including dentures, eyeglasses, prosthesis or items of sentimental value, but will exercise due care in the protection of same during a patient's hospitalization.

☐ ____ **12.** This consent or permission is valid unless I cancel it. I know that I cannot cancel this consent or permission if a claim is already being processed.

☐ ____ **13.** I understand that the following Physicians are **NOT** Employees of Saint Peter's University Hospital and if you should need their services, you will be receiving separate billing statements from their offices: Emergency Room Physicians, Radiologists, Pathologists and/or other Specialists.

_____ Witness to Signature

_____ Signature of Patient or Responsible Party

_____ Date and Time

_____ Relationship to Patient Translator Reader