UMC

UNCOMPAHGRE MEDICAL CENTER

Uncompahgre Medical Center Agreement Information

Payment of Services Agreement:

I agree to pay for medical/dental services provided by Uncompahgre Medical Center (UMC). I also agree to pay for radiology and/or laboratory services, which may be billed separately by Western Radiology, LabCorp or their designees, should these services be deemed necessary in the opinion of the medical provider at UMC. Bills for all services shall be due and payable upon receipt.

Authorization for Release of Information:

I hereby authorize the release of medical/dental records to any person or entity which is liable under a contract for payment of any charges incurred by me as a part of medical/dental treatment provided or ordered by UMC. I understand that following the release of any medical/dental records, UMC, or its designees, will no longer be responsible for maintaining confidentiality.

Assignment of Insurance Benefits:

I hereby authorize any third party responsible for any portion of the patient's covered medical/dental services to be made directly to UMC or its designees. I acknowledge that this assignment of benefits is irrevocable and assigns to the medical/dental provider all rights under my insurance policies. I further understand that I am financially responsible to UMC, or its assignees, for charges not covered by any insurance or third party payer.

Medicare, Title XVIII and Medicaid, Title XIX

I certify the information I have given for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

Education

For the purpose of advancing medical knowledge, I consent to the admittance of medical/dental residents and other para-medical observers in accordance with ordinary practices of Uncompahgre Medical Center and under the supervision of a staff physician. I also consent for the purpose of education to the occasional taking of photographs, the preparation of drawings, similar illustrative graphic materials, and the use of such photographs and material for scientific purposes.

The undersigned herby certifies that he/she has read and understands the above stated conditions of the consent and payment of services agreement and that they have been fully explained. Patient also agrees that he/she has read the Patient Bill of Rights and Responsibilities.

_____

Print Patient Name

_____ _____

Patient's Signature or Guarantor/Representative Date

_____ _____

Witness' Signature Date