NORTHSIDE HOSPITAL

English - Spanish	Pa	atient Full Name
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FINANCIAL ACKNOWLEDGEMENT		
medical providers all hospital and medical provider benefits prights and remedies due under the insurance policies or benefit including but not limited to all rights and remedies pursuant to Hospital and other medical providers applicable under ERISA an administrative review of fiduciary duties involving administ Department of Insurance. I authorize and direct the insurance understand that assignment does not relieve me of any respon	ayable under my in the plans that I have to applicable state, a, federal or state in tration of benefits company to pay a sibility I may have	Northside Hospital, I hereby assign and transfer to the Hospital and other nsurance policies or benefit plans. I hereby assign and transfer all related identified or will identify in connection with all services rendered, federal and ERISA regulation. I hereby assign and transfer all rights to the egulation to pursue any benefit denial, limitation of coverage or request for by the U. S. Dept of Labor, the Department of Community Health or the ll such benefits to the Hospital and appropriate medical providers. I e for payment of charges not paid by the insurance company, unless my and the Hospital. If admission is for pregnancy, assignment of benefits
care benefit funds are expended when justified. I understand admissions and anticipated courses of treatment. I understand appropriate and issues certification, the benefits of my health certification is denied, health care benefits may be withheld. responsible party and his or her physician. I understand that I may be financially responsible for all hospital charges the admission is appropriate, or should the certification effort	I that it is the utiliand that if the utilize plan will be made I understand that Northside Hospitalicurred as a result occur too late to	compliance with a utilization review program to make certain that health zation review program's responsibility to review proposed elective ration review program determines that admission is necessary and a available to me in accordance with the terms of my policy. However, if a precertification may be the responsibility of the patient or financially ral is willing to admit as requested by my physician. I also understand to of admission should the utilization review program refuse to certify that be valid. I understand that to protect myself from unnecessary personal aw my obligations with my insurance company, utilization review program,
treatment. Although Northside Hospital may be a provider in	an insurance network care, the insurance	orthside Hospital, a bill will be received for the professional component of work, the physician or professional service group may or may not be a se carrier will process the claim(s) on an outpatient basis. Outpatient arance policy benefits.
Physician Practice Locations — If services are received in a insurance benefits will be processed as a physician office visit		e, which is <u>not</u> a provider-based outpatient location of Northside Hospital,
interest at the rate of 8 percent a year. This interest does not a (Accounts under an agreed alternate payment contract w with Northside Hospital's Payment Installment Agreemer Plan established, with all conditions of the payment plan estimated co-insurance prior to any elective services unless a prior to any elective services unless alternate arrangements are emergency screening and stabilizing treatment as required by	apply to deductibl ill not be conside at Plan up to one met.) Insured patilternate arrangement made. This prove federal law.	rvices are received. Accounts more than 30 days past due will accrue es/copayments of Medicare/Medicaid or other governmental programs. red past due, provided the plan is accepted in writing in accordance hundred eighty (180) days of service, depending upon the Payment ents are required to pay identified co-pay, unsatisfied deductible, and ents are made. Uninsured patients are required to make payment in full vision does not apply, and payment will not be requested, prior to
By signing below, I acknowledge and agree that I have read	l or had this form	read to me and I understand and agree to its contents.
PATIENT / REPRESENTATIVE	DATE	RELATIONSHIP TO PATIENT
	m Northside Hosp Il and the Northsio	oital, Inc. and the Northside Hospital medical staff. The Notice of Privacy de Hospital medical staff members may use and disclose my health
I understand that Northside Hospital and its Medical Staff m joint notice of privacy practices. Although the Hospital and of complying with privacy laws, some or all of the health ca	nembers operate a Medical Staff men re professionals p t contractors. Inde	s an "organized health care arrangement" and have presented me with a mbers have established an organized health care arrangement for purposes erforming services in this hospital or its outpatient centers are not pendent contractors are responsible for their own actions and Northside contractors.
I understand that the Notice of Privacy Practices is subject to Notice at Northside's website (www.northside.com).	o change. If North	side Hospital changes its notice, I may obtain a copy of the revised
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