syracuse AREA HEALTH
2731 Healthcare Drive
Syracuse, NE 68446
402.269.2011
syracuseareahealth.com

RELEASE OF INFORMATION

I understand that Syracuse Area Health may disclose all or any part of my medical record to any person or entity which is or may be liable for all or part of the charges incurred-for example, to verify coverage or benefits, to authorize or pay for a Medicare or Medicaid claim, or for any other purpose related to payment of benefits. I understand that the Clinic may release my medical records to any physician or other health care professional who may require health information in connection with my current or subsequent health care. I also understand that the Clinic may disclose health care information to a party designated by my employer when services are related to a workers' compensation claim.

ASSIGNMENT OF INSURANCE BENEFITS

I assign to Syracuse Area Health, for services provided by the Clinic and its employees or others working under contract or arrangement with the Clinic, any and all coverage and benefits available under any government program, any insurance policy or plan, or any other benefit program, and I direct that all benefits be paid directly to the Clinic. Any credit balance resulting from benefit payment or other sources may be applied to any other account owed by me or by the undersigned. The benefits assigned include, but are not limited to, all benefits for all medical and hospitalization insurance; accident insurance; disability or loss-of-time insurance; Medicare, Medicaid, and CHAMPUS; benefits payable by alternative delivery systems such as HMOs or PPOs or arising from workers' compensation or occupational disease claims; and proceeds to which I am, or my estate is, entitled because of any judgment, settlement, or other claim or cause of action for damages against any person or organization if I was or am injured. This assignment cannot be revoked as to services provided during this visit, or corresponding course of diagnosis and treatment.

PAYMENT OF CHARGES

I agree to promptly and fully pay all charges for services and supplies provided by the Clinic, physicians, and others providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the patient's spouse, the minor patient's parent, or the minor patient's legal guardian, for payment of all such charges at the regular rates to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I agree to pay balances under 500 within 6 months and balances 501+ within 1 year. I understand that it is my responsibility to obtain any prior approvals required by an insurer, and to take all other steps to quality for insurance coverage. I will determine whether my insurer requires pre-certification before I receive Clinic services. No extension or forbearance, nor attempt to obtain payment from insurance or other sources, nor delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder. Syracuse Area Health has a Financial Counselor who is available to help me set up a payment plan and/or to determine whether the patient is eligible for charity care, and I understand that I can request to meet with the Financial Counselor if the patient has limited insurance or is uninsured.

The undersigned, who is a person other than the patient or patient's spouse/parent, individually agrees to be personally responsible for the financial obligations set forth herein, and guarantee payment of this account.

I have read this form (or have had it read to me) and understand it. I agree that by signing this form I am bound by what is says, whether I am the patient or someone acting on the patient's behalf.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE

WITNESS

PRINT NAME, IF SIGNED BY OTHER THAN PATIENT