PAYMENT DISCLOSURE AND AGREEMENT

This Registration Agreement (this "Agreement") applies to all Emplify Health Locations

Patient Name: _____ Medical Record Number: _____ Date of Service: _____
Date of Birth: _____ Hospital Account Number: _____

Insurance carriers will only pay for services that it determines to be reasonable and necessary as determined by their guidelines. If your insurance carrier determines that a particular service is not covered or not reasonable and necessary under their guidelines, they will deny payment for that service.

☐ I understand that I am receiving a service that is **not covered by my Medicaid** coverage and **I will accept financial responsibility** for today's services.

☐ I understand that because I am **not able to obtain the necessary authorization from my insurance carrier** for _____ (indicate service) and all related services that is necessary for these services to be a covered benefit**, I will accept responsibility for all charges denied by my insurance carrier for this reason**.

☐ I understand that if I cancel my service, the **cost of the custom item(s) that were ordered** will be billed to my Insurance and **I will be financially responsible for any amounts my insurance does not pay.**

☐ I understand that I am receiving services that may **not be covered by my insurance** and **I will accept financial responsibility for charges denied by my insurance carrier.**

☐ I understand that I am being transferred to an **out-of-network hospital** and that my insurance benefits may be reduced. I acknowledge that I may incur higher out-of-pocket expenses and accept financial responsibility for any charges not covered by my insurance plan.

☐ Other; please specify: _____

PATIENT AGREEMENT

I have been notified that even though my physician feels my professional health care will be enhanced by its performance, the services provided are likely to be denied for payment from my insurance carrier. My signature serves as my acknowledgment that I will accept personal responsibility to Emplify Health for these services.

I hereby authorize to Emplify Health to provide either emergent, non-emergent, or elective procedure or treatment as considered necessary and/or appropriate.

Printed Name: _____

Signature: _____ **Date:** _____

If signed by someone other than the patient: ☐Parent/Legal Representative ☐Health Care Agent (Health Care Power of Attorney)

NOTE: Your Health Information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance carrier, your health information on this form may be shared with your insurance carrier.