AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **Mount Sinai Beth Israel and/or Mount Sinai Brooklyn** ("Mount Sinai") with respect to such services and care unless the contract between Mount Sinai and my insurance company provides otherwise and/or unless otherwise provided by law. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to Mount Sinai, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of a Mount Sinai bill, I agree to immediately pay all amounts not covered by insurance unless otherwise provided by law. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to Mount Sinai for services rendered to me, I hereby give my consent to have an authorized representative of Mount Sinai contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by Mount Sinai which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize Mount Sinai, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of Mount Sinai charges and/or professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only Part A and Part B providers)

I certify that the information given by me in applying for payment under Title XVIII 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 and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or Mount Sinai Services to the physician (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that Mount Sinai is a participating provider in many health plan networks, and that a list of the plans that Mount Sinai participates in can be found at www.mountsinaihealth.org/insuranceinfo

I understand that physicians and other providers who render services at Mount Sinai may be employed or contracted by Mount Sinai, or may be independent practitioners who are **not** employed or contracted by Mount Sinai. I further understand that charges for physicians' and providers' "professional services" that I receive at Mount Sinai are **not** included in Mount Sinai's charges, and that physicians/providers may bill for their "professional services" separately from Mount Sinai.

I understand that physicians who provide services at Mount Sinai may not participate in the same health plans as Mount Sinai (even if they are employed or contracted by Mount Sinai). I understand that I can determine the health plans participated in by the physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinaihealth.org/insuranceinfo.

I understand that I can check with the physician(s) arranging for my hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician/practice whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by Mount Sinai to provide services (including anesthesiology, pathology and/or radiology) are reasonably anticipated to be provided to me. I further understand that I can determine the health care plans participated in by physicians/practices who are reasonably anticipated to provide services to me at Mount Sinai who are employees of or are contracted by Mount Sinai to provide such services (including anesthesiology, radiology, and/or pathology) by visiting http://www.mountsinaihealth.org/insuranceinfo. I further understand that I can check with the physician(s) arranging for my hospital services to obtain the contact information for any physicians/practices whose services may be needed in connection with my hospital care, and that I can contact those physicians/practices directly to obtain information regarding their health plan participation.

5. Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services, in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring action against my health plan.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATED

RELATIONSHIP TO PATIENT

WITNESS TO SIGNATURE