Five-Town Health Alliance, Inc
Mountain Health Dental Care/Mountain Health Center
Patient Billing Agreement

CONSENT TO RELEASE OF INFORMATION

I authorize Mountain Health Center/Mountain Health Dental Care (MHDC) to give copies of my medical records for services provided by Mountain Health Center/Mountain Health Dental Care providers to any of the following: (a) my insurance company or any other third party reimburser (including Medicaid), (b) my continuing care facility, (c) any organization involved in planning my discharge from Mountain Health Center/MHDC, (d) any organization performing utilization review pursuant to state or federal law, and (e) any health care agency authorized by law. Patient acknowledges that the medical records covered by this consent may include information concerning conditions of mental illness, substance or alcohol abuse and worker's compensation.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

Patient (or the policyholder if the patient is not the policyholder) authorizes and directs that all medical and dental benefits payable to or for the benefit of Patient under the terms of any applicable insurance policy, be paid directly to the providers affiliated with Mountain Health Center/MHDC. Patients agree to sign any additional assignment of benefits form requested by Mountain Health Center/MHDC or any insurance company from time to time. Patients understand that he/she is liable to providers at Mountain Health Center/MHDC for all related charges, whether or not covered by insurance.

AUTHORIZATION OF MEDICARE BENEFITS

I request payment of authorized Medicare benefits for me or on my behalf for any services furnished me by the providers of Mountain Health Center/MHDC including non-physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

AGREEMENT TO PAY MOUNTAIN HEALTH CENTER/MOUNTAIN HEALTH DENTAL CENTER CHARGES

Patient and guarantor (where applicable) agree that in consideration of the services to be rendered by or through Mountain Health Center/MHDC providers, each personally promises and obligates himself/herself to pay the amount of Mountain Health Center/MHDC charges in accordance with its regular rates and terms. In the event of non-payment, patient and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney fees.

CONSENT TO TREAT

I (or my legal guardian or parents) authorize Mountain Health Center/MHDC to provide medical/dental care reasonable by today's standards. I also authorize Mountain Health Center/MHDC to share my health information with other providers that are treating me.

Signature of Patient or Guardian: _____ Relationship to Patient: _____

Print Patient Name: _____ Date: _____

Updated: 9/20/2018