BERKSHIRE HEALTH SYSTEMS
FINANCIAL CONSENT

PLACE PATIENT LABEL HERE

PATIENT NAME_____

PATIENT NUMBER_____ PLACE FORM ID LABEL HERE

This is a ***lifetime financial consent concerning outpatient service records,*** which shall continue in effect unless, and until I revoke it by written request to the Admitting Department at Berkshire Medical Center or Fairview Hospital. (in either case, the "Hospital"). Inpatient services, outpatient invasive procedures and emergency services will require that I sign an additional consent for each date of service.

I authorize payment directly to the Hospital and all hospital based physicians any benefits payable under the terms of my insurance/third party payer. I understand that I am financially responsible for any appropriate charges or remaining balances not covered by my insurance/third party payer, subject to any agreement the Hospital has with my carriers. If questions arise concerning my bill, I understand I can contact the Hospital's Customer Service Representatives for resolution.

I authorize the Hospital to release all pertinent medical and financial information for purposes of obtaining payment for services rendered, reviewing or evaluating patient care, and/or preparing continuing care, including any treatment for alcohol or drug abuse and psychiatric conditions. This may include furnishing photocopies of my medical record as requested. I understand that I may revoke this authorization at any time, but only by written request to the Medical Record Department of the Hospital.

I authorize my insurance companies, representatives of local, state or federal agencies or other organizations/entities holding pertinent identifying or benefit/coverage information about me to release upon request any such information to the above named hospitals and hospital based physicians.

MEDICARE BILLING

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 or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to the Hospital for hospital services. I further assign payment for unpaid charges for certain in-hospital physician services furnished by specialists, and by physicians for whom the Hospital (or its affiliates) is authorized to bill. I understand that I am responsible for any insurance deductible and co-insurance.

MEDICARE INPATIENT ONLY

I authorize the Hospital to utilize my sixty lifetime reserve days after expiration of my regular Medicare benefits. I understand that if reserve benefits are used, there may be co-insurance due, and that once used, reserve days are permanently reduced by the number of used days.

Witness_____ Signed _____

Date_____ Relationship_____

New 01/14/99
Revised 07/28/99 Reviewed11/28/00
Revised 07/31/01 Reviewed 02/02/06