CMH
Columbia Memorial Health

An affiliate of ALBANY MED

columbiamemorialhealth.org

FAMILY CARE CENTERS OF COLUMBIA MEMORIAL HEALTH

UNIFORM ASSIGNMENT, RELEASE OF INFORMATION AND GUARANTY

Patient Name: _____ Date: _____ DOB: _____

RELEASE OF INFORMATION:

I, the undersigned, hereby authorize Columbia Memorial Hospital to release any medical records or other information about me to any insurance carrier, agent or governmental agency responsible for payment in respect to any hospital and medical care which I have received at the Family Care Center.

ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned, authorize my insurance carrier to pay benefits to which I am entitled directly to Columbia Memorial Hospital.

GUARANTEE OF PAYMENT:

I, the undersigned, do hereby guarantee full payment to Columbia Memorial Hospital for the hospital and medical services rendered. Payment shall be due in full upon presentation of a statement of the charge(s) owed.

When it has been determined that insurance will no longer provider coverage, we are obligated by law to notify the patient. In this case, it will be necessary for you to make alternate arrangements for payment. Every effort will be made by the hospital to assist you through our Patient Accounts Office.

You do have a right to request a review through your insurance carrier to appeal any determination. When Medicare is the primary insurance carrier, the hospital may be subject to retroactive denial of payment from Medicare.

_____ _____

Patient or Responsible Party/Relationship to patient Witness