PIEDMONT STONE CENTER, PLLC FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

PATIENT NAME_____ Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION

I, hereby authorize Piedmont Stone Center, PLLC and/or the attending and consulting physicians to release information concerning examination, testing and treatment of the above Patient to any third party payor requesting the same for purposes of determining eligibility for payment of insurance benefits to Piedmont Stone Center, PLLC ("Provider: including any physicians and/or allied health professionals under contract with or in employment with Piedmont Stone Center, PLLC"), and any external inspectors or regulatory agencies. I also authorize release of information concerning examination, testing, and treatment subsequent to my lithotripsy treatment by the hospital, ASC or other heathcare provider.

NORTH CAROLINA HEALTH INFORMATION EXCHANGE (NCHIE)

If my healthcare plan is North Carolina Medicaid or other North Carolina state funded health plan (such as for teachers or fireman or other state employees), I consent to opt-in to NC HealthConnex, the North Carolina Health Information Exchange (NCHIE). I understand that participation in the NCHIE enables my patient record to be viewed by healthcare providers that participate in NCHIE.

If I do not wish to participate in NC HealthConnex, then I will complete the NCHealthConnex Patient Opt-Out Form and mail it to the address provided on the form. Educational information about the NCHIE is provided on the "North Carolina Health Information Exchange Authority Patient Opt-Out Information" form, which is included in the patient packet.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and convey any and all third party payor payments made on the behalf or for the benefit of Patient to Provider.

STATEMENT OF FINANCIAL RESPONSIBILITY

The undersigned agrees whether he signed as agent or Patient, that in consideration of the items and services to be rendered to the Patient, he individually obligates himself to pay the account in accordance with the rates charged by the Provider. I understand that services for extracorporeal shockwave lithotripsy (ESL) are billed in two parts, one for the professional component for the physician who treated the Patient and the other for the technical component of the ESL service. These services may or may not be billed separately to you by Piedmont Stone Center, PLLC and the hospital where Patient received the ESL service. In addition, Patient may receive separate bills from other providers including radiology, anesthesiology or other professional or hospital services. I further understand agree that Provider may or may not be a participating Provider with the Patient's insurer and that, in the event Provider does not participate with the Patient's insurer, the Patient will be financially responsible for charges not covered by the Patient's insurer. I understand that, should the account be referred to collections whether it be a collection agency or an attorney, Provider reserves the right to collect and Patient shall pay Provider or its Agent the reasonable costs and fees of collection. Should litigation result, the Patient agrees to pay Provider or Provider's agent all collection costs and further agrees that the court may access additional charges against Patient. Patients without insurance should contact Piedmont Stone Center's business office at 1-888-373-6328 to make financial arrangements.

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf directly to Provider. I authorize any holder of medical records or other information about me to release such records or information to Provider, the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER

I request that payment of authorized Medigap benefits be made on my behalf to the Provider for any medical services furnished to me by that Provider, I authorize any holder of medical records or other information about me to release to the Provider or the Medigap insurance carrier and its agents any information needed to determine these benefit or benefits for related services.

TRICARE/CHAMPVA

I certify that to the best of my knowledge and benefit the TRICARE/CHAMPVA eligibility information provided is complete and correct. I further authorize the release of any medical information necessary to adjudicate and process this claim to the Federal Government including the TRICARE Contractor. I also authorize the release of, or obtaining of, medical and/or other coverage information to and from any other organization with which I have another medical benefits plan or health insurance coverage.

The TRICARE Management Authority and TRICARE Contractors use the information to control and process medical claims for payment; for control and approval of medical treatments and interface with providers of medical care to control and accomplish reviews of utilization; for review of claims related to possible third party liability cases and initiation of recovery actions; for referral to Peer Review Committees or similar professional review organizations to control and review providers medical care; for disclosure to third party contracts, without the consent of the individual to whom the information pertains, in situations where the party to be contracted has or is expected to have, information necessary to establish the validity of evidence or to verify the accuracy of information presented by the individual concerning the individual's eligibility for benefits under TRICARE/CHAMPVA, the amount of benefit payments, any review of suspected abuse or fraud, or any concern for program integrity or quality appraisal; for the issuance of deductible certificates; to respond to inquiries from Congressional offices made at the request of the individual covered by the system; for referral to the Secretary of the Department of Health, Education, and Welfare and/or to the Administrator of the Veteran's Administration consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; for referral to the Department of Justice and/or foreign law enforcement agencies for investigation and possible criminal prosecution; and for referral to the Department of Justice for representation of the Security of Defense in civil actions. The information must be provided if the beneficiary/patient (or sponsor) desires to have a portion of the charges paid by the government. Failure to provide information will result in denial of or delay in payment of the claim.

IMPORTANT: READ CAREFULLY

Federal Laws (18 U.S.C. §§ 287 and 1001) and other federal laws provide for criminal and/or civil penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Many state laws provide for similar criminal and/or civil penalties for claims submitted to state funded payors such as Medicaid. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of Medicare and/or state claims. I have received a copy of Piedmont Stone Center, PLLC's **Notice of Privacy Practices**.

_____ _____ (Seal)
Date **Patient's Signature (Parent if Minor)**

_____ _____ (Seal)
Witness **Insured and Guarantor If Other Than Patient**

_____ _____
Time **Legal Relationship to Patient**