NC Elder Care

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AUTHORIZATION FOR MEDICAL TREATMENT AGREEMENT

NC ELDER CARE (A DIVISION OF HORIZON INTERNAL MEDICINE)

I, _____ A RESIDENT AT _____ HEREBY AUTHORIZE _____ AND/OR WHOMEVER MAY DESIGNATE AS AN ASSISTANT TO ADMINISTER SUCH TREATMENT OR PERFORM ANY DIAGNOSTIC OR THERAPEUTIC MEASURES TO BE UNDERTAKEN AT THE SAID FACILITY AS IS NECESSARY DURING MY STAY TO THE ABOVE SAID FACILITY. IN THE EVENT OF AN EMERGENCY, I CONSENT TO BE TREATED BY ANY ATTENDING PHYSICIAN IN ATTENDANCE AT THE LOCAL HOSPITAL OR ON THE BEHALF OF HORIZON INTERNAL MEDICINE.

I HEREBY AUTHORIZE AND DIRECT THE CENTERS FOR MEDICARE, MEDICAID SERVICES, AND PRIVATE INSURANCE PROVIDERS TO ISSUE PAYMENT OF BENEFITS DIRECTLY TO HORIZON INTERNAL MEDICINE OR ANY OF ITS ENTITIES. I ACCEPT RESPONSIBILITY FOR ANY UNPAID PORTIONS FROM SERVICES RENDERED.

I HEREBY AUTHORIZE ANY MEDICAL INFORMATION ABOUT ME OR ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES TO BE RELEASED BY HORIZON INTERNAL MEDICINE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND MY PRIVATE INSURANCE PROVIDERS.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION FOR MEDICAL TREATMENT.

_____

WITNESS/FACILITY REPRESENTATIVE DATE

_____

PRINTED NAME OF RESIDENT/RESPONSIBLE PARTY DATE

_____

SIGNATURE OF RESIDENT/RESPONSIBLE PARTY DATE