ACKNOWLEDGMENT OF FINANCIAL OBLIGATIONS

You are being admitted today for an ☐INPATIENT ☐OUTPATIENT ☐OBSERVATION admission. This is explained in the Inpatient, Outpatient, & Observation fact sheet we reviewed with you. **Your admission type may change. Be sure to ask your doctor.**

Assignment of Insurance Benefits: I hereby authorize my insurance benefits to be paid directly to the Hospital & its Affiliates. If I receive payment from my insurance plan for benefits due NYU Langone Hospitals for my care, other than as reimbursement for payments I already made, I agree to promptly sign the payment to NYU Langone Hospitals, or pay you that amount directly.

Release of Information I authorize NYU Langone Hospitals, the doctors who treat me, & their authorized representatives, to use & disclose my health information for any reason necessary for treatment, payment, & health care operations. These purposes include but are not limited to any release of information that my insurance company asks for & any information needed to plan my discharge.

Agreement to Pay: I know that I am financially responsible to pay the Hospital & its Affiliates for all charges not covered or paid by insurance or any other payer. I know that this includes all payments required under my insurance plan. I understand I may need to pay an estimate of my co-payment and co-insurance due at or before the time of service. I understand you will send me a final bill after discharge.

I understand I am expected to pay the bill in full within the stated reasonably expected time. If I am unable to pay or payment presents a hardship, I understand I could be eligible for help through NYU Langone Health's financial assistance program. I have been told I can see a Financial Counselor here or call 866-486-9847 toll-free for Tisch & NYU Langone Orthopedic Hospital, or 718-630-6252 for NYU Langone Hospital - Brooklyn or 516-576-5600 for NYU Langone Hospital - Long Island.

I understand that I am personally responsible to pay for my care at NYU Langone Hospitals, if I do not have insurance or my insurance does not pay for my care because:

- My health plan requires my own doctor (a Primary Care Physician or PCP) to give me a written referral before you treat me, & I did not get a referral
- My health plan denies payment for these services & leaves me responsible for payment
- My health plan decides that these services are not medically necessary and/or not covered by my Insurance plan. The same service might be covered at a different hospital or office
- My health plan coverage has lapsed or expired at the time I receive services at NYU Langone Hospitals, &/or
- I have chosen not to use my health plan coverage.

I understand you may be required by law to bill my spouse or parent if I am receiving public assistance services from the government.

Other Bills You may get more than one bill from NYU Langone Health, so read them carefully because they may be for hospital services or for different doctors who aren't paid by the hospital and are charging for specific services. These services might include anesthesia, radiology, pathology, psychology, or others. These are vital services & other doctors and professionals are involved in your care even though they may not be present at the time & you may not see them face-to-face. I authorize payment by my insurance plan directly to such physicians or practices. I agree to pay all charges due for such services after all benefits are paid on my behalf by any third party payer (insurance plan, etc.)

Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the 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.

Patient's Medicare # _____ Signature _____

I understand all the information listed above, which has been fully explained to me.

_____ _____ _____

Signature of Patient (or Financially Responsible Party) *Relationship to Patient* *Date*