

**EMERGENT MEDICAL ASSOCIATES
DECLARATION OF FINANCIAL RESPONSIBILITY
AND
AUTHORIZATION TO PAY BENEFITS**

Federal legislation know as COBRA/EMTALA allows any patient who comes to the Emergency Department to be seen, treated, and stabilized by an Emergency Department physician regardless of their ability to pay.

PATIENT NAME: _____

I understand that Emergency Department Physician charges are billed separately from Hospital charges and that I am financially responsible (will be billed later) for the Emergency Department Physician charges.

The Emergency Physicians' Group will participate with the Hospital as a provider in many Health Plans. These include governmental programs such as Medicare and Medi-Cal. However, there are certain plans that the Emergency Physicians' Group is **non participating**. For these plans Emergent Medical Associates will accept reasonable reimbursement.

I understand that having health insurance represents a contractual arrangement between the health insurance company I have chosen and myself. It does not guarantee payments to the physicians. I understand that my insurance company may not issue reimbursement for certain procedures and/or codes and that there may be co-payments and deductibles in my policy that I may have to pay personally. Should Emergent Medical Associates bill my insurance on my behalf, I hereby authorize my insurance company to pay directly to Chino Emergency Medical Associates benefits accruing to me under my policy. I further agree that if my insurance company (this does not include Medicare or Medi-Cal) has not reimbursed Emergent Medical Associates after three billings (90 days) I will assume full responsibility for the outstanding bills. I understand that at that point in time it is my responsibility to turn to my insurance company for direct payment.

I hereby authorize Emergent Medical Associates to release information to my insurance company that may be requested regarding my illness or injury in order to determine liability for payment and to obtain reimbursement.

In the event of any legal action, by either party, to enforce the terms of this assignment or the collection of fees due under this agreement, the prevailing party shall recover reasonable attorney's fees and costs. All accounts not paid in full within 90 days shall bear interest at the legal rate allowed by law.

Signature of Patient or Representative

/ /

Date

Please circle one:
Person who signed above is:
patient /self, spouse, parent / guardian, relative,
other _____

Addressograph