PATIENT CONSENT TO TREAT AND FINANCIAL AGREEMENT

Patient Name: ____ Date of Birth: ________________

Consent to Treat:

I authorize Greater Baltimore Medical Center, Inc., GBMC Physicians, LLC, and their successors and assigns ("GBMC"), through their physicians and clinical staff, to provide medical treatment for me/the patient named on this consent form.

I understand GBMC is partnering with Sheppard Pratt Physicians, P.A. ("Sheppard Pratt," a provider of mental health treatment) and Mosaic Community Services, Inc. ("Mosaic," a provider of mental health and substance use disorder treatment). When medically appropriate in the GBMC treating physician's opinion, GBMC may, with my below authorization, refer me/the patient to the Sheppard Pratt or Mosaic Community Services ("Treating Partners").

I agree that GBMC may share contact information with the Treating Partners and consent to treatment at GBMC by the Treating Partners when recommended by the GBMC treating physician. I understand and agree that, if I am treated by Sheppard Pratt at GBMC, Sheppard Pratt will document treatment provided in the GBMC medical record and GBMC is the custodian of that record. Access to the medical record is explained in the GBMC Notice of Privacy Practices (NOPP). Mosaic will document in their own medical records, and should be contacted directly for access to those records.

______I decline to have information shared and decline treatment by Treating Partners.

E-Prescribe:

I have read the Welcome to GBMC Health Partners packet and understand the benefits of E-Prescribing and would like my provider to e-prescribe my prescriptions. I certify that I have had the chance to ask questions and all my questions have been answered to my satisfaction.

______ I decline to participate with the E-Prescribe Program.

Assignments of Insurance Benefits and Third-Party Claims: I hereby authorize payment directly to GBMC Inc. of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third-party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal

rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause.

I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

Medicare/Medicaid Patient Certification (for Medicare/Medicaid patients only): I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

I certify that I have read, understood, and agree to the above terms.

X____

Signature of Patient (Print Name) Date Time

X____

Signature of Authorized Patient Representative (Print Name) Date Time

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(Relationship to Patient)