

PATIENT INFORMATION

Name: _____

Nickname: _____ DOB: _____ / _____ / _____ SS #: _____

Home #: _____ Cell #: _____ Work #: _____

Gender (circle): **Male** / **Female** Email Address: _____

Address: _____ City/State/Zip: _____

Mother's Maiden Name (JD Purpose Only): _____

Spoken Language (check all that apply): English / Spanish / Other: _____

Marital Status (circle): **Single** / **Married** / **Partnered** / **Widowed** / **Divorced**

Contact Preference (check): Ok to leave confidential message / Do not leave confidential message

Homeless Status (check): Not Homeless / Shelter / Transitional / Doubling Up / Street / Other: _____

Housing Status (check): Public Housing / Not in Public Housing Student Status (check): Full time / Part time / Not a Student

Employer: _____ Occupation: _____

Employer Phone #: _____ Employer Address: _____

Migrant/Seasonal Status:

Migrant (A person/dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment)

Seasonal (A person/dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)

Not a Farm Worker

Race (check): Asian / Black/African-American / American Indian/Alaska Native / Native-Hawaiian / White/Caucasian

More than one race / Other Pacific Islander / Other: _____

Ethnicity (check): Hispanic or Latino / Not Hispanic or Latino

Interpreter Status (circle): **Yes** / **No** Veteran Status (circle): **Yes** / **No** / **N/A** Smoker (circle): **Yes** / **No**

How did you hear about us? (check): Relative/Friend / Health Fair / Newspaper / Church / Hospital / Other: _____

Do you have an Advance Directive (living will)? (circle) **Yes** / **No**

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relation: _____

Signature: _____ Date: _____

RESPONSIBLE PARTY INFORMATION *(Person to be billed if different than the patient.)*

Relationship to Patient: Self (skip to next section) / Spouse / Parent / Other: _____

Name: _____

SS #: _____ DOB: ____/____/____ Gender (circle): **Male** / Female

Address (if different than above): _____ City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Employer Phone #: _____ Employer Address: _____

INCOME INFORMATION *(State your household income with one of the following categories below.)*

Weekly: _____ Monthly: _____ Yearly/Annual: _____

OFFICE USE ONLY

Quality for sliding fee Discounts?

100% & below 101-33% 134-175% 176-200%

INSURANCE *(Please provide all active insurance information & insurance card(s).)*

Primary Insurance: No Insurance / Medicaid/TennCare / Medicare / Other (Employer/Private/Commercial)

Patient's Relationship to Insured Party: Self / Spouse / Child / Other: _____

Plan Name: _____ Policy #: _____ Group #: _____

Insured Name: _____ DOB: ____/____/____ SS #: _____

Effective Date (if known): _____ Co-pay Amount: _____

Employer: _____ Occupation: _____

Employer Phone #: _____ Employer Address: _____

Secondary Insurance: Medicaid/TennCare / Medicare / Other (Employer/Private/Commercial)

Patient's Relationship to Insured Party: Self / Spouse / Child / Other: _____

Plan Name: _____ Policy #: _____ Group #: _____

Insured Name: _____ DOB: ____/____/____ SS #: _____

Employer: _____ Occupation: _____

Employer Phone #: _____ Employer Address: _____

PATIENT FINANCIAL CONSENT FORM

Patient Name: _____ DOB: ____/____/____

Patient MRN: _____

I authorize payments of medical benefits to the physician or suppliers for services rendered. I authorize the release of any medical information necessary to process insurance claims, and for physicians that the patient is referred to, and certify the information contained herein is correct.

Medicare patients: I authorize payments of Medigap benefits of Medigap insurer as listed be made on my behalf to the physician or group, for services rendered.

I voluntarily consent to examination and treatment of the patient listed above.

I am aware that I am ultimately responsible for payment of this account and any fees associated with the collection of this account.

MEDICARE & MEDICAID: The undersigned certifies that the information given in applying for benefits under Title XVII or XIX or the Social Security Act is true pertinent to this patient's /child's visit to be released to the physician or organization furnishing the services. The undersigned request that payment of authorized benefits be made to the undersigned or on his/her/their behalf. The physician or organization furnishing the services or authorizes such physician organization to submit a claim to Medicaid for payments to the undersigned.

Signature of Patient/Responsible Person: _____ Date: _____

Insurance card verified by: _____

Effective from: _____ Effective to: _____

I understand, that as, a part of my healthcare, Erlanger, receives, originates, maintains, discloses, and uses my protected health information, including, but not limited to, health records and other health information describing my health history, medication history, symptoms, examinations and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. Health information is maintained both in paper format and electronic media. I authorize Erlanger to use this information for the purpose of treatment, payment, or healthcare operations. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases included but not limited to blood-borne diseases. I understand that I may revoke this consent in writing and Erlanger will comply if possible, However, Erlanger will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

I have been provided a **Notice of Privacy Practices** that fully explains the uses and disclosures that Erlanger may make with respect to my protected health information. I understand that I have the right to review the Notice before signing this consent. I also understand that Erlanger reserves the right to change the **Notice of Privacy Practices** and should the privacy practices change, I will be notified of any changes upon my next visit to Erlanger. Also, I may obtain a current copy of this notice at **erlanger.org**.

I understand that I do not have to consent to the use or disclosure of my protected health information for treatment, payment, and healthcare operations. If I do not consent, Erlanger may refuse to provide me healthcare services unless applicable state or federal laws require Erlanger to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my protected health information to carry out treatment, payment, or healthcare operations. I further understand Erlanger is not required to agree to the requested restriction but that, if it does agree, it is bound by such agreement. If a request for restriction on the use or disclosure of individually identifiable health information is made the Corporate Privacy and Security Officer (CPSO) is to be notified immediately. No one is authorized to accept a request for restriction other than the CPSO.

I understand that I may revoke this authorization in writing and Erlanger will comply if possible. However, Erlanger will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

Signature of Patient/Legal Representative: _____

Relationship to Patient: _____ Date: _____

Signature of Witness: _____ Notice Effective Date: _____

I. CONSENT FOR ADMISSION/TREATMENT

I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician, and/or my physician's assistant or designee. I understand that these procedures and services may include but are not limited to emergency treatment or services, laboratory procedures) imaging services, nursing services, medical or surgical treatment or procedures, anesthesia or Erlanger services, I understand that other conditions may be diagnosed which may require additional treatment. This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency virus (HfV), if a physician orders such test(S) for diagnostic purposes. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of any treatment or examinations provided by Erlanger. I acknowledge that any supplies, medical devices or other goods sold or given to me are provided 'as is,' and that Erlanger disclaims any express or implied warranties related thereto.

II. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS

I hereby assign to Erlanger, and any practitioner providing care and treatment to me, my child, or any other person entitled to healthcare benefits for this admission or outpatient treatment, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, or any reimbursement from a pre-paid healthcare plan. This means that Erlanger and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to Erlanger any interest in any claims I may have to the extent necessary to fully reimburse Erlanger for rendering services to me. I understand that I may receive treatment from Erlanger-based physicians who do not have a current contract with my insurer and that I may receive a separate bill from such physician(s) for the amount not paid by my insurer. I certify that the insurance information I provided to Erlanger is accurate in every respect and I agree to be financially responsible for any and all charges relating to the services provided in the event the insurance information I provided is not accurate.

I understand and agree that my account is due in full upon rendering outpatient services or upon discharge for inpatients, with allowance made for insurance coverage approved and verified prior to discharge. In consideration of the services to be rendered, the undersigned (as patient, parent, guardian, spouse, guarantor, or agent) promises to pay Erlanger's account in accordance with Erlanger's Charge Master and payment terms. In the event an overpayment is received by Erlanger for this admission or outpatient treatment, the undersigned authorize(s) application of the overpayment to any unpaid balance for which patient/undersigned is responsible.

I consent and instruct that Erlanger can obtain my credit report at its discretion at any time and at its own expense and Erlanger may only provide the report to a third party for the sole purpose of aiding in collection evaluation and efforts on behalf of Erlanger. If my account is not paid in full within 30 days of the initial bill being sent to the last address I provided Erlanger, and Erlanger has not confirmed in writing that Erlanger has agreed to an acceptable payment plan, my account may be turned over for collection at Erlanger's option. If my account is turned over to an attorney for collection, I agree to pay 33 1/3% of the balance for attorneys' fees regardless of whether filing a lawsuit is necessary to collect the balance. In addition, I agree to pay all costs incurred to file a lawsuit, whether incurred by Erlanger or Erlanger's attorneys including but not limited to filing fees, court costs, process service fees, alias summons costs and all costs associated with post judgment proceedings including but not limited to post judgment interest, garnishment costs and execution fees. If my account is turned over to a collection agency I agree to pay the costs of collection in addition to the balance of the debt.

III. CONTACT

I agree that you may call me on whatever phone numbers I give Erlanger, including land lines, cell phones, Skype numbers, or anything else. The numbers I provide you may be used to communicate with me regarding my/personal information for whom I am consenting's, treatment services rendered, regarding any unpaid balance on my account, or for any other purpose.

IV. CONTINUING TREATMENT

I consent to have all the terms of this Agreement to authorize, govern and control all future treatment and financial obligations which I, or the person I am consenting for, receive in the future by Erlanger or any of its affiliates until I execute a new Consent for Admission/Outpatient Treatment.

V. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII or Title XIX 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 claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf. I understand that self-administered medications are not covered by Medicare and that I will be responsible for payment of charges relating to all self-administered medications.

VI. RELEASE OF INFORMATION

I understand and acknowledge that Erlanger may use protected health information (PHI) collected about me for the provision of treatment, collection of payment, and performance of hospital operations without additional consent. I understand and acknowledge that Erlanger participates in health information exchanges with other healthcare facilities and providers ("Exchange Participants"). I understand that when I seek treatment from Erlanger or Exchange Participants, my health information may be shared electronically between Erlanger and Exchange Participants in order to provide care and services to me/the patient, and I authorize Erlanger to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychological notes) or communicable diseases (including HIV or AIDS) and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.

VII. LEGAL RELATIONSHIP BETWEEN ERLANGER AND PHYSICIAN

I am under the care and supervision of my attending physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or Erlanger services rendered to me under general and special instructions of my physician, I understand that there will be a separate charge for professional services, such as physician services. I understand that Erlanger does bill for some professional fees; otherwise the professional fees will not be included in Erlanger's bill, and I will receive a separate bill. My physician may or may not be an employee of Erlanger, and Erlanger is not responsible for the acts or omissions of any physicians not employed by Erlanger.

VIII. RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I understand and acknowledge that Erlanger does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my Erlanger room during my stay, such as but not limited to jewelry, eyeglasses, dentures or hearing aids. Personal property should not be brought into the Erlanger and I understand and agree that Erlanger shall not be liable for loss or damage to any personal property.

IX. TEACHING AND RESEARCH HOSPITAL

Erlanger is a teaching and research institution, and I understand and acknowledge that medical residents, students, and Erlanger approved observers engaged in an educational or research purpose, may be involved in or observe my care under the direct supervision of a privileged provider or staff member.

Unless required or permitted by law; it is Erlanger's policy to obtain approval by Administration before agreeing to any external disclosure of de-identified health information. Erlanger Administration agrees to obtain written authorization from me or my authorized representative prior to any external disclosure if Administration deems authorization necessary to preserve my dignity and privacy, Any medical information used or disclosed outside of Erlanger for education and training of health care professionals, including students, residents and instructors, must be de-identified and should be presented with my dignity in mind, even if I become incapacitated or deceased.

X. VIDEO MONITORING

I understand and acknowledge that Erlanger uses video monitoring for security purposes, and for diagnosis, care and treatment of patients and that video monitoring occurs in both public and non-public areas of Erlanger including direct care areas and patient rooms. By signing below, I, for myself and/or for the patient, acknowledge and agree that I and/or the patient have no expectation of privacy in such areas of Erlanger, and that Erlanger is not liable for any demands, causes of action and suits, including but not limited to claims for invasion of privacy, unreasonable search and seizure, defamation, breach of contract or any other breach of duty arising out of or related to video monitoring.

XI. WEAPONS / EXPLOSIVES / DRUGS

I understand and agree that if the Erlanger at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Erlanger may search my room and my belongings, confiscate any of the above items that are found and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

XII. PHOTOGRAPHS, SPECIMENS, AND TISSUE

I authorize the Erlanger to retain, preserve, and/or use for medical documentation, scientific and/or teaching purposes any photographs, specimens and/or tissues taken as part of any procedure performed. I understand these will be properly discarded according to Erlanger policy.

I certify that I have read and fully understand this Consent For Admission/Outpatient Treatment ("Consent"), and I have signed this Consent knowingly; freely; and voluntarily. If signing on behalf of a minor child or another adult, I represent that I have legal authority to give consent for their treatment, and the consent of no other person is required by agreement, court order or otherwise for such treatment. I certify that I have received no promises, assurances, or guarantees from anyone as to the results that maybe obtained by any medical treatment or services. I understand that I am personally responsible for payment for any and all items or services not covered by insurance or other third party.

Signature of Patient/Responsible Party (Relationship to Patient): _____

Relationship to Patient: _____ Time: _____ Date: _____

Erlanger Representative: _____ Time: _____ Date: _____

Signature of Interpreter/Provider Using Translation Services: _____ Time: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF DOCUMENTS AND CONSENT

INITIAL I received Erlanger's Patient Bill of Rights and Notice of Privacy Practices.

INITIAL I received Erlanger's Plain Language Summary of the Erlanger's Financial Assistance Policy, and I have been verbally advised about Erlanger's Financial Assistance Policy.

INITIAL I consent to my name being listed in Erlanger's directory for this visit. *Choosing not to include your name in the directory means Erlanger information desk will not acknowledge your presence as a patient, except as required by law, to anyone wishing to visit or call. Additionally, all flowers or gifts will be returned to the florist, undeliverable.*

INITIAL I consent to my name being provided to clergy.

Patient's Print Name: _____

Signature of Patient/Patient's Representative: _____ Time: _____ Date: _____

SLIDING FEE SCALE QUESTIONNAIRE

Patient Name: _____ DOB: ____/____/____

Family Household Gross Income:

Monthly: _____ Yearly/Annual: _____

Family Household Size (count yourself, spouse, and any dependents under 18 years): _____

I attest that the above information is true and any false information could prohibit me from being eligible for further assistance:

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Date: _____

Photo ID and proof of income required.

Internal Use Only

Add Rated Category = (V, W, X, Y, Z, Full Charge)