Erlanger Health System Pre-registration Form

Expected Date of Delivery: _____
Date of Last Menstrual Period: _____

Please Print

Patients Legal Name: _____
Last First Middle Maiden

Address: _____
Number Street City County State Zip Code

Home Phone Number: (_____) _____-_____
Marital Status: *(Circle one)* Single / Married / Divorced / Separated / Widowed
Social Security: _____/ _____/ _____
Date of Birth: _____/ _____/ _____
Age: _____ Race: _____ Ethnicity / Nationality: _____ Religion: _____
Family Practitioner: _____
OB/GYN: _____
Email Address: _____
Military Status: _____ Branch: _____ *(Circle one)* Patient / Spouse
Are you a eChart member? *(Circle one)* Yes/ No

- If No would you like to receive an email with information? *(Circle one)* Yes/ No

Employer Information

Employer: _____ *(Circle one)* Full time / Part time

Address: _____
Number Street City State Zip Code

Phone number: (_____) _____-_____

In Case Of Emergency

Name: _____
Phone Number: (_____) _____-_____
Relationship: *(Circle one)* Spouse / Friend / Significant Other / Relative *(specify)*: _____
Address: _____
Number Street City State Zip Code

Insurance Information

Name of person responsible for insurance: _____

Address: _____
Number Street City State Zip Code

Social Security Number of Responsible Party: _____/ _____/ _____
Date of Birth: _____/ _____/ _____
Relationship: *(Circle one)* Spouse / Friend / Significant Other / Relative *(specify)*: _____
Employer: _____ *(Circle one)* Full time / Part time
Contact Number: (_____) _____-_____

TennCare or Medicaid Identification Number: _____

- Do you have an advance directive? _____ if so please be prepared to present a copy at the time of admission.
- You may call Erlanger's Pre-registration Department at (423) 778-5241 or 1-800-825-7002 Ext. 5241 if you have any questions concerning your pre-registration.

Formulario de preinscripción del Sistema de Salud de Erlanger

Fecha prevista de entrega: _____
Fecha de la última menstruación: _____

Por favor, Imprimir

Nombre Legal Del Paciente: _____
Apellido Primera nombre Segundo nombre Soltera

Dirección: _____
Número Calle Ciuda Condado Estado Código postal

Número de teléfono de casa: (_____) _____-_____
Estado civil: *(Circule uno)* único / Casado / Divorciados / viudos/ separados
Número De Seguro social: _____/_____/_____
Dia dc Cumpleañs: _____/_____/_____
Edad: _____ Raza: _____ Religión: _____
Médico de Familia: _____
Ginecology: _____
Email: _____
Estado militar: _____ Sucursal: _____ (Circule uno) Paciente / Esposo
¿Es usted un miembro De eChart? *(Circule uno)* Sí /No

- Si no le gustaría recibir un correo electrónico con la información? *(Circule uno)* Sí/No

Información de la empresa

Empleador: _____ *(Circule uno) Tiempo completo / Tiempo*

Dirección: _____
Número Calle Ciuda Condado Estado Código postal

Número de teléfono: (_____) _____-_____

En caso de emergencia

Nombre: _____ Número de teléfono: (_____) _____-_____
Relación: *(Circule uno)* Esposola / familia / Amigo / OTROS: _____
Dirección: _____
Número Street Ciudad Estado Código postal

Información sobre seguros

Nombre de la persona responsable de los seguros: _____
Dirección: _____
Número Street Ciudad Estado Código postal
Número de Seguro Social de la parte responsable: _____/_____/_____
Dia dc Cumpleañs: _____/_____/_____
Relación: *(Circule uno)* Esposola / familia / Amigo / OTROS: _____
Empleador: _____ *(Circule uno) Tiempo completo / Tiempo Parcial*
Número de contacto: (_____) _____-_____

TennCare / Número de identificación de Medicaid: _____

- ¿Tiene una directriz anticipada? _____ Si es así, por favor esté preparado para presentar una copia en el momento de la admisión.
- Usted puede llamar Erlanger Del Departamento de pre-inscripción al (423) 778-5241 o 1-800-825-7002 ext. 5241 Si tiene alguna pregunta relativa a su pre-inscripción.

Erlanger Health System's
Consent For Admission / Outpatient Treatment

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 Health System ("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 (HIV), 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 to 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 health care 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 health care 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 Health System any interest in any claims I may have to the extent necessary to fully reimburse Erlanger Health System for rendering services to me. I certify that the insurance information I provided to Erlanger is accurate in every respect, and I agree to be financially respons ble for any and all charges relating to the services provided in the event the insurance information I provided is not accurate.

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Notice Regarding Potential Out-of-Network Charges

I understand that I may receive treatment or services from Erlanger-based physicians who may be out-of-network and do not have a current contract with my insurer. I understand that the physicians and other healthcare providers that may treat me at Erlanger may not be employed by Erlanger and may not participate in my insurance network. I agree to receive medical services by an out-of-network healthcare provider.
Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by Erlanger. Services provided by those specialists, among others, will be billed separately.

Before receiving services, I should check with my insurance carrier to find out if my providers are in-network. Otherwise, I may be at risk of higher out-of-network charges.

Erlanger has a contract with the following physician groups to provide the following services:

Anesthesia Services:
Ace Anesthesiology
Phone: (423) 778-7608
www.aceanesthesia.com

Pathology Services:
Path Group
Phone: (423) 305-0227
www.pathgroup.com/resources/patient-resources/patient-service-centers

Adult Emergency Services:
Tennessee River Physicians, PLLC
Phone: 1 (888) 568-5443
www.quickpayportal.com

Children's Emergency Services:
Pediatric Emergency Medicine Associates, LLC
Phone: 678-344-1960
www.pema-llc.com

Radiology Services:
Tennessee Interventional and Imaging Associates (TIIA)
Phone: (423) 778-7234
www.tiiarad.com

Lab Services:
LabCorp
Phone: (423) 634-1162
www.labcorp.com/contact-us

If Erlanger is out-of-network with my insurance carrier, I agree to receive medical services by Erlanger and I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility.

If I am admitted to Erlanger, or have a scheduled medical procedure, I acknowledge that I will be billed for additional charges, including any out-of-network charges, if I am provided medical services by a healthcare provider that is not in-network. In particular, I should ask Erlanger if I will be provided any medical services by anesthesiologists, radiologists, emergency room physicians, or pathologists who are not in my insurance network.

I understand I may be transferred to another facility during the course of my care and treatment. If I am transferred to an out-of-network facility, I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility. I understand that Erlanger will provide information about a transfer to a facility that is in my insurance network, if the in-network facility has similar treatment available to me and will not risk my health.

By signing this form, I acknowledge I may receive a bill for up to 100 percent (100%) of billed charges for any amount unpaid by my insurer for out-of-network healthcare services.

I will receive a separate estimate/ statement of Erlanger charges for items and services in accordance with my health benefits coverage. This estimate/ statement will be provided once healthcare providers determine what treatment and services I require.

Additional Financial Agreements

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 to paying all costs incurred in filing a suit, including but not limited to filing fees, court costs, process service fees, alias summons and costs associated with post judgment proceedings including but not limited to post judgment interest and garnishment 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/ person 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. SOCIAL SECURITY AND OTHER BENEFITS

I have applied, or intend to apply, for benefits under all Titles of the Social Security Act for which I may be eligible (e.g. Titles II, XVI, XVIII, XIX), as well as for any benefits that may be available to me.

VI. 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 may be responsible for payment of charges relating to all self-administered medications.

VII. MEDICATION AND MEDICAL DEVICE ASSISTANCE PROGRAM

In some cases, Erlanger may be able to obtain reimbursement for some of your medications or medical devices from the companies that manufacture them. If this occurs, the charge for the medication or medical device is removed from your bill. Most of these programs require your signature on the applications for reimbursement. To avoid you or your authorized representative having to sign this application for each medication or device, Erlanger requests that you or your authorized representative allow a Pharmacy Healthcare Solutions (PHS) representative to sign these forms on your behalf. By signing this form, you or your authorized representative are appointing PHS to carry out in your name the application forms required for PHS to obtain reimbursement for your medications or medical devices from the manufacturers. The authorization to sign on your behalf will be in full force and effect from the date you or your authorized representative sign this form.

VIII. 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 as detailed in Erlanger's Joint Notice of Privacy Practices (NPP). I understand and acknowledge that Erlanger participates in health information exchanges with other health care 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 understand I can opt out of having my information shared with Exchange Participants by following the process in Erlanger's NPP. 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. I understand and acknowledge that I may request a restriction on how my information may be used/shared by contacting Erlanger's HIM department and that I can obtain more information on this upon request and from Erlanger's NPP.

IX. 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.

Additional Financial Agreements

X. RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I understand and acknowledge that Erlanger does not assume the respons bility 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.

XI. 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.

XII. 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.

XIII. 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 .

XIV. 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 may be 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)	**Time**	**Date**
Erlanger Health System Representative	**Time**	**Date**
Signature of Interpreter/Provider Using Translation Services	**Time**	**Date**

ACKNOWLEGMENT OF RECEIPT OF DOCUMENTS AND CONSENT

I acknowledge that I have been offered a copy of Erlanger Health System's **Patient Bill of Rights** and **Notice of Privacy Practices**

_____
Initials

I have declined to receive a copy of Erlanger's Joint Notice of Privacy Practices

_____
Initials

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

_____
Initials

I consent to my name being listed in Erlanger Health System's directory for this visit. *Choosing not to include your name in the directory means Erlanger's 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/gifts will be returned to the florist, undeliverable.*

_____
Initials

I consent to my name being provided to clergy.

_____
Initials

_____
Patient's Printed Name

_____ _____ _____
Signature of Patient (or Patient's Representative) Time Date

Appointment of Representative

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form approved OMB
No. 0938-0950

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
STREET ADDRESS		PHONE NUMBER (with area code)
CITY	STATE	ZIP CODE

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:
I, Jill Forgey RN, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I AM (A) / AN Registered Nurse
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE Jill Forgey RN BSN		DATE
STREET ADDRESS		PHONE NUMBER (with area code)
CITY	STATE	ZIP CODE

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.) I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE Jill Forgey RN BSN	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under Section 1879(a)(2) of the act is at issue.

SIGNATURE Jill Forgey RN BSN	DATE

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You, the patient, have the right to:

- Competent, safe, considerate, respectful and dignified care.
- Be informed of your condition (diagnosis, recommended treatment and prognosis).
- Be involved in care planning and treatment.
- Have family, representative of choice, and/or your own physician notified promptly on your admission to the hospital.
- Choose your own visitors.
- Know visitation guidelines relating to visitor limitation and reasons for limitation (such as L&D, ICU, Special Precautions—Isolation, Patient Safety).
- Consent to all treatment, and be informed with understanding of risks, benefits and alternatives to treatment.
- Refuse treatment and drugs and refuse any experimental treatment and drugs in regards to your care.
- A second opinion.
- Formulate and have honored an Advance Directive.
- Know about the Do Not Resuscitate policy.
- Privacy in treatment and personal care.
- Confidentiality - including your medical record.
- Review your medical records and have them explained to you by your physician.
- Know hospital rules.
- Know about hospital resources including patient representatives, the Ethics Committee and other ways to voice concerns.
- Be aware of the complaint and grievance resolution process.
- Wear appropriate personal clothing, religious or other symbolic items, which do not interfere with prescribed treatment or procedures.
- Receive care in a safe setting and to be free from mental or physical abuse or harassment.
- Have your guardian or legal designee exercise your rights when you are unable to do so, or if you are a minor.
- Have your pain assessed and managed when you are admitted and throughout your hospital stay.
- Have access to your health information (Protected Health Information) and options to modify such information under the Health Insurance Portability and Accountability Act (HIPAA).

To help us keep our promises to you and to help us with your care, please:

- Cooperate to the best of your ability with your plan of care as developed by your healthcare providers.
- Provide honest and complete information about your health status.
- Give us feedback (questions, comments or concerns) about your met or unmet needs for further evaluation.
- Follow hospital guidelines to protect yourself and others.
- Keep your scheduled appointments as able, or notify your healthcare provider of any changes.
- Know that financial information may be required and that you may ask about financial assistance.
- Respect others.

Erlanger Health System ("Erlanger") employees and medical staff are committed to providing quality care in a safe environment to all patients that we serve. Erlanger encourages the involvement of patients and their authorized representatives in all aspects of their health care experience. In fact, feedback about how we are doing is very important to the staff at Erlanger. It not only helps with our ongoing quality improvement initiatives, it helps us to recognize those who have provided outstanding quality of care and service. Please feel free to share your compliments and concerns (complaints/grievance) with the staff delivering your care, the department manager or Erlanger's House Supervisor at (423) 778-6168.

If you have a concern regarding the quality of your care or about patient safety, and our management staff has been unable to help you resolve that concern, you may contact The Joint Commission, Office of Quality Monitoring, One Renaissance Blvd., Oakbrook Terrace, IL 60181; phone 1-800-944-6610; fax 1-630-792-5636; email complaint@jointcommission.org; and/or the Tennessee Department of Health, Office for Investigation, Heritage Place, Metro Center, 227 French Landing, Suite 201, Nashville, TN 37243; phone 1-800-852-2187.

Note: The Chattanooga-Hamilton County Hospital Authority complies with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. No individual shall, on grounds of race, sex, color, creed, national origin, age or handicap be kept from participating, be denied the benefits of , or be otherwise discriminated against under any programs or services offered by the Authority.

If you have a complaint regarding Title VI regulations, please contact Human Resources at (423) 778 -7969.

Advance Directives

Advance Directives are documents that express your wishes if you are very ill or unconscious and can not speak for yourself. By completing an advance directive before you are very ill or injured, you let your doctor and family know what you want.
Your right to stop or prevent treatment if you do not believe it is beneficial is communicated in these instructions known as an Advance Directive. An Advance Directive should be written and discussed with your family and medical team.

Advance Directives may include end-of-life treatment choices that provide direction to your family and medical team to assure that your care is provided with dignity, comfort, and the support of your loved ones. For further information about Advance Directives, contact Care Management Office at (423) 778-7654.

Organ Donation

You can save lives, through organ and tissue donation. To learn more, contact Tennessee Donor Services at (423) 756-5736 or donatelifetn.org.

Updated 6/11

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Ud., el paciente tiene el derecho de:

- Recibir cuidado competente, seguro, considerado, respetuoso y digno.
- Informarse acerca de su condición (diagnostico, tratamiento recomendado y pronostico).
- Conocer todo acerca de la planificación de su cuidado y tratamiento.
- Pedir que el hospital avise inmediatamente a su familia, representante de su preferencia, y/o su médico de cabecera sobre su hospitalización.
- Escoger quienes pueden visitarlo.
- Conocer las directrices para visitantes en cuanto a límites en comportamiento para visitantes y razones para los límites (Como las reglas especiales en el departamento de maternidad, ICU, precauciones especiales, aislamiento, y seguridad del paciente).
- Dar su consentimiento para todo el tratamiento, y estar informado, con entendimiento, de los riesgos, beneficios, y alternativos al tratamiento.
- Rechazar el tratamiento y drogas y rechazar cualquier tratamiento experimental y drogas que le puedan dar.
- Una segunda opinión.
- Formular y honrar una Directiva Avanzada.
- Conocer la política de "No Resucitar".
- Tener privacidad para su tratamiento y cuidado personal.
- Confiabilidad - incluyendo su historia medica.
- Revisar su historia medica y conseguir que un medico le explique la misma.
- Conocer los reglamentos del hospital.
- Conocer los recursos del hospital incluyendo los representantes del paciente, el Comité de Ética y otras maneras de hacer saber sus preocupaciones.
- Ser conciente del procedimiento para presentar quejas e injusticias para su resolución.
- Ponerse ropa apropiada, símbolos religiosos y otros emblemas que no interfieran con el tratamiento recetado o los procedimientos.
- Recibir cuidado seguro en un ambiente libre de abuso mental o físico o acoso.
- Conseguir que su guardián o persona designada ejercite sus derechos cuando no lo puede hacer Ud. mismo o si Ud. es menor de edad.
- Conseguir que asesoren y manejen su dolor cuando es admitido y durante toda su estadía en el hospital.
- Tener acceso a la información acerca de su salud (Información Protegida de la Salud) y las opciones que puedan modificar esta información bajo el Acta de Practicas de la Privacidad (HIPAA).

Para ayudarnos a mantener nuestras promesas con Ud. y ayudarlo con su cuidado:

- Coopere lo mejor que pueda con el plan de cuidado desarrollado por los cuidadores de su salud.
- De información honesta e informativa acerca del estado de su salud.
- Dénos información (preguntas, comentarios o preocupaciones) acerca de lo que necesita o no necesita para proseguir con su evaluación.
- Siga las reglas del hospital para protegerse y para proteger a los demás.
- Mantenga las citas programadas que pueda o notifique a la persona que cuida de su salud si necesita hacer cambios.
- Sepa que puede ser que necesiten información financiera y que puede preguntar acerca de ayuda financiera.
- Respete a los demás.

Los empleados del Sistema de Salud Erlanger ("Erlanger") y el personal medico están comprometidos para dar cuidado de calidad en un ambiente seguro a todos los pacientes. Erlanger fomenta el interés de los pacientes y los representantes autorizados para enterarse de todos los aspectos de la experiencia del cuidado de la salud. Es un hecho, que la información acerca de cómo hacemos todo esto es muy importante para el personal de Erlanger. No solamente nos ayuda en nuestra meta de mejorar todas las iniciativas, sino que nos ayuda a reconocer las personas que han dado un servicio y cuidado de calidad.Por favor sientase libre de compartir sus cumplidos y preocupaciones con el personal que le da su cuidado, el gerente del departamento o el Supervisor Residente de Erlanger (423-778-6168).

Si tiene una preocupación acerca de la calidad del cuidado o acerca de la seguridad del paciente, y si la gerencia del personal no ha podido resolver su preocupación, Ud. puede comunicarse con la Comisión Conjunta, Oficina de Control de Calidad, One Renaissance Blvd., Oakbrook Terrace, IL, 60181; teléfono 1-800-944-6610; fax 1-630-792-5636; email complaint@jointcommission.org; y/o el el Departamento de Salud de Tennessee, Oficina de Investigaciones, Heritage Place, Metro Center, 227 French Landing, Suite 201, Nashville, TN 37243; phone 1-800-852-2187.

Nota: La Autoridad del Hospital del Condado de Chattanooga-Hamilton, cumple con el Titulo VI del Acta de Derechos Civiles de 1964, sección 504 del Acta de Rehabilitación de 1973, y el Acta de Discriminación por Edad de 1975. Ningún individuo se vera, debido a su raza, sexo, color, credo, origen nacional, edad o su discapacidad, evitado de participar, negado beneficios o discriminado bajo cualquier programa o servicio ofrecido por la Autoridad.

Si tuviera alguna queja acerca de las reglamentaciones del Titulo VI, por favor comuníquese con Recursos Humanos al (423) 778-7969.

Updated 6/11

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1 **Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 **Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ ☐ Yes No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ ☐ Yes No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ ☐ Yes No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ ☐ Yes No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ ☐ Yes No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ ☐ Yes No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ ☐ Yes No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ ☐ Yes No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.