PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Patient Name: TEST, MEMORIAL	☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status : **M**	
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?	Birthdate: **10/02/1980**	Age / Sex: **45yo / M**
Street or Mailing Address: **1234 NO LANE LAS CRUCES, NM 88007**		Home Phone Number: **(575) 522-0000**	
Cell Phone #:	E-Mail (To be used for appointment reminders):	SSN#:	
Occupation	Employer:	Employer Phone Number :	

Employment Status: ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military
Student Status: ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N - Not a Student
Race: White
Ethnicity: Hispanic or Latino
Language: English

Pharmacy:	Do you have a living will? ☐ YES ☐ NO

Referred By (Please check one box)
☐ Dr. ______________ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Other ________
Other Family Members Seen Here

PCP Name	Phone #

RESPONSIBLE PARTY INFORMATION **(information used for patient balance statements)**

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self ☐ Check here if information is same as patient			
Name		Address	Home Phone Number
Birth Date		E-Mail Address	
Occupation	Employer	Employer Address	Employer Phone Number

INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC) ☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA)	ACCIDENT DATE:	CASE NUMBER:

Does the patient have healthcare coverage? ☐ YES ☐ NO			Insurance Name: ***SELF PAY***		
Name of Insured:	Social Security Number:	Date of Birth:	Effective Date:	Group ID:	Subscriber ID (Policy Number):
Patient Relationship to Insured:					Primary Insurance Phone Number:
Name of Secondary Insurance:	Name of Insured:	Date of Birth:	Group ID:		Subscriber ID (Policy Number):
Patient Relationship to Insured:					Secondary Insurance Phone Number:

EMERGENCY CONTACT

Name: LCPP	Relationship to Patient: **SPOUSE**	Home Phone #: **(575) 800-7432**	Other Phone #:	

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).
Have you or someone you have been in contact with traveled outside of the country or been in an airport in the last 30 days? ☐ YES ☐ NO

Patient/ Guardian Signature Date

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

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9. **INFECTION CONTROL CONSENT: To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS. HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.**

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, per individual state regulations, most physician assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask my Health Care Provider to verify if they are a Hospital employee or an independent contractor.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

    I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S):** I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

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☐ I object to having my name, location and general condition listed in the facility directory.

15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

17. **CONSENT TO RECORDING:** I consent to photographs, video images, and/or audio monitoring/recordings as it may be used to document patient care, security, or for the purposes of healthcare operations. I hereby consent to the use of such technologies in the course of my treatment and medical condition and understand that such recordings may be kept as a part of my medical record.

18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.
    ☐ I have executed an Advance Directive
    ☐ I have not executed an Advance Directive
    ☐ I would like to formulate an Advance Directive and receive additional information

19. **OTHER ACKNOWLEDGEMENTS:**
    a. Personal Valuables: I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.

    b. Smoke Free Facility Policy: The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

    c. Weapons / Explosives / Drugs: I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

20. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

21. **KENTUCKY ONLY:** In compliance with KRS214, the undersigned has received AIDS information.
    ☐ Yes ☐ No

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient or Legal Representative for Health Care Hospital Services if Other Than Patient	Date and Time
Relationship to Patient	
Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent	
Signature of Witness	Date and Time