erlanger Health System

Premier Healthcare

PATIENT INFORMATION

Last Name	First Name	Middle Name
Name you like to be called (*Nickname*)	Date of Birth	Social Security No.
Phone: Home Cell Work	Gender ( ) Male ( ) Female	Email
Address/ City/State/ Zip Code		Mother's Maiden Name *(ID Purpose Only)*
Emergency Contact Name	Emergency Contact Number ( )	Relationship to Patient
Language Spoken (mark all that apply) [ ] English [ ] Spanish [ ] Other_____	Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Divorced	Contact Preference [ ] Ok to leave confidential message [ ] Do not leave confidential message
Homeless Status [ ] Not Homeless [ ] Doubling up [ ] Shelter [ ] Street [ ] Transitional Other_____	Housing Status [ ] Public Housing [ ] Not in Public Housing	Student Status [ ] Full Time [ ] Part Time [ ] Not a Student
Employer	Address	Phone Number

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	Ethnicity	Interpreter Status
[ ] Asian [ ] American Indian/Alaska Native [ ] Black\African-American [ ] Native-Hawaiian [ ] More than one race [ ] White\Caucasian [ ] Other Pacific Islander [ ] Other _____	[ ] Hispanic or Latino [ ] Not Hispanic or Latino	[ ] Yes [ ] No
Veteran Status [ ] YES [ ] NO [ ] N\A	How did you hear about us? [ ] Relative\Friend [ ] Church [ ] Health Fair [ ] Hospital [ ] Newspaper [ ] Other _____	
Do you have an Advance Directive? *(Living Will)* [ ] YES [ ] NO	Smoker [ ] YES [ ] NO	

SIGNATURE_____ DATE_____

erlanger Health System

Premier Healthcare

RESPONSIBLE PARTY INFORMATION

Person to be billed, if other than the patient

RELATIONSHIP TO PATIENT [ ] Self (skip to next section) [ ] Spouse [ ] Parent [ ] Other _____

Last Name	First Name	Middle Name
SSN	**Date of Birth**	**Gender** [ ] Male [ ] Female
Address (if different from above)	**City** **State**	**Zip Code**
Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )
Employer	**Employer Name**	**Employer Phone**

INCOME INFORMATION

State your household income in one of the following categories listed below

Weekly _____ Monthly _____ Yearly/Annual _____

[ ] Decline to provide household income Signature _____ Date _____

OFFICE USE ONLY

Qualify for sliding fee discounts? [ ] YES [ ] NO

[ ] 100% & below [ ] 101-133% [ ] 134-175% [ ] 176-200%

INSURANCE INFORMATION

PLEASE PRESENT ALL ACTIVE INSURANCE INFORMATION & A COPY OF INSURANCE CARDS

PRIMARY INSURANCE

[ ] No Insurance [ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)

PATIENTS RELATIONSHIP TO INSURED PARTY

[ ] Self [ ] Spouse [ ] Child [ ] Other _____

Plan Name	Policy Number	Group Number
Insured Name	**Insured SSN**	**Insured Date of Birth**
Effective Date (if known)	**Co-Pay Amount $**	
Employer	**Employer Address**	**Employer Phone** ( )

SECONDARY INSURANCE

[ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)

PATIENTS RELATIONSHIP TO INSURED PARTY

[ ] Self [ ] Spouse [ ] Child [ ] Other _____

Plan Name	Policy Number	Group Number
INSURED NAME	**Insured SSN**	**Insured Date of Birth**
Employer	**Employer Address**	**Employer Phone** ( )

erlanger Health System

PATIENT FINANCIAL CONSENT FORM

Patient Name: _____ Patient 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 Medicap 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 health care, Erlanger Health System, 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 Health System 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 Health System will comply if possible, However, Erlanger Health System 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 Health System 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 Health System 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 Health System. Also, I may obtain a current copy of this notice at **www.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 health care operations. If I do not consent, Erlanger Health System may refuse to provide me health care services unless applicable state or federal laws require Erlanger Health System 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 health care operations. I further understand Erlanger Health System is not required to agree to the requested restriction but that, if it does agree, ii 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 that the CPSO.

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

Signature of Patient or Legal Representative _____

Relationship to Patient _____

Date: _____

Notice Effective Date: _____

Signature of Witness: _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT IDENTIFICATION

Comprendo que como parte de mi cuidado de la salud, el Sistema de Salud Erlanger recibe, origina, mantiene informa y usa mi informacion de salud protegida, incluyendo, pero no limitandose a los informes de mi salud y otra informacion de la salud que describe mi historial medico, historical de medicamentos, sintomas, resultados de examenes y pruebas, diagnosticos, tratamiento, planes de tratamiento y la informacion acerca del seguro medico y la facturacion. La informacion de la salud es mantenida sobre papel y medios electronicos. Yo autorizo al Sistema de la Salud Erlanger para que use esta informacion con el proposito de efectuar el tratamiento, pago u operaciones para el cuidado de la salud. Esta autorizacion especificamente incluye la liberacion de informacion medica concerniente a condiciones relacionadas con el uso de drogas, alcoholismo, condiciones psicologicas, condiciones psiquiatricas y/o enfermedades infecciosas que incluyen pero no se limitan a las enfermedades de la sangre. Comprendo que puedo revocar este consentimiento por escrito y el Sistema de Salud Erlanger cumpliria con esto si fuera posible. Sin embargo, el Sistema de la Salud Erlanger no se responsabiliza por cualquier accion o informacion que se haya dado antes de la revocacion de esta autorizacion.

Se me ha suministrado una ***Notificacion de las Practicas de la Informacion*** que explica completamente los usos y la liberacion de informacion que el Sistema de Salud Erlanger pueda hacer con respecto a mi informacion de salud protegida. Comprendo que tengo el derecho de revisar la ***Notificacion*** antes de firmar este consentimiento. Tambien entiendo que el Sistema de Salud Erlanger se reserva el derecho de cambiar la ***Notificacion de las Practicas de la Informacion*** y si las practicas de la informacion cambian, yo sere notificado/a de los cambios durante mi proxima visita al Sistema de Salud Erlanger. Tambien, puedo obtener una copia actualizada de esta notificacion en el **www.erlanger.org**.

Entiendo que no tengo la obligacion de consentir al usa y la liberacion de mi informacion de salud protegida para el tratamiento, pago y operaciones del cuidado de la salud. Si no consiento, el Sistema de Salud Erlanger puede rehusarse a suministrarme los servicios de cuidado de la salud a menos que se apliquen las leyes federales o del estado que requieren que el Sistema de Salud Erlanger me suministre estos servicios.

Entiendo que tengo el derecho de pedir restricciones sabre la liberacion de mi informacion de la salud protegida para llevar a cabo tratamiento, pago, u operaciones del cuidado de la salud. Tambien comprendo que el Sistema de Salud Erlanger no necesita acordar la restriccion pedida, pero si esta de acuerdo, esta sujeta a ese acuerdo. Si hay un pedido de restriccion sabre el uso o liberacion de informacion de la salud individualmente identificable, se debe de notificar al Oficial en Jefe de la Privacidad (CPO) de inmediato. La unica persona que esta autorizada para aceptar un pedido de restriccion es el CPO.

Comprendo que puedo revocar esta autorizacion par escrito y el Sistema de Salud Erlanger debera cumplir si es posible. Sin embargo, el Sistema de Salud Erlanger no sera responsable par las acciones o liberacion de informacion que se hayan llevado a cabo antes de la revocacion de esta autorizacion.

Firma del Paciente o Representante Legal _____

Parentesco con el Paciente _____

Fecha: _____

Fecha Efectiva de la Notification: _____

Firma Del Testigo: _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

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HD1801

PATIENT IDENTIFICATION

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 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

ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS AND CONSENT

I received Erlanger Health System's **Patient Bill of Rights** and **Notice of Privacy Practices.**

Initials

I received Erlanger Health System's **Plain Language Summary of the 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

CONSENT FOR ADMISSION / OUTPATIENT TREATMENT

erlanger

PATIENT IDENTIFICATION

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 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 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/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. 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 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 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.

Additional sections on back are incorporated by reference herein.

CONSENT FOR ADMISSION / OUTPATIENT TREATMENT

erlanger

CA8700

PATIENT IDENTIFICATION

erlanger Health System

SOUTHSIDE, DODSON AVENUE & PREMIER COMMUNITY HEALTH CENTER
SLIDING FEE SCALE QUESTIONAIRE
Cuestionario Para Calcular Honorarios en Proporcion a la Habilidad de Pago

Patient's Name: _____

Nombre del Paciente: _____

Patient's Date of Birth: _____

Fecha de Nacimiento: _____

Family Household Gross Income Monthly: _____ Annual: _____

Ingreso Brutos de la Familia Mensual: _____ Por Año: _____

Family Household Size (Count yourself, spouse and any dependents under 18 years)

_____

Tamaño de la Familia (Coutandose Ud, su esposo(a), y niños dependientes menores de 18 años)

_____

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

Claro que las informacion arriba mencionada es veridica y que cualquier falso informacion podria causar que prohiban darne mas ayuda.

_____ _____

Patient's Signature (Firma del Paciente) **Date (Fecha)**

_____ _____

Representative's Signature (Firma del Representante) Date (Fecha)

(Internal Use Only)
Add Rated Category = (V, W, X, Y, Z, Full Charge)
Agreguan Categoria = (V, W, X, Y, Z, Carga completa)