Patient Registration Form

Full Name: _____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____ City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐cell _____

*Email_____

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown/Declined

Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Unknown/Declined

Preferred Language ☐English ☐Spanish ☐Chinese(Cantonese) ☐Chinese(Mandarin) ☐French ☐German ☐Italian ☐Japanese ☐Portuguese ☐Russian ☐Other

Employer _____ Employer Phone _____

Preferred Communication for Appointment Reminders: ☐Phone Call ☐Automated Text ☒Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐yes ☐ no.

Pharmacy Information

Pharmacy Name_____ Phone_____ Fax_____

Pharmacy Address_____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name_____ Date of Birth _____Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐cell _____ *Email_____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Referring Physician Information:

Physician Name_____ Specialty_____ Office Name_____

Address_____ Phone_____ Fax_____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty_____ Office Name_____

Address: _____ Phone_____ Fax_____

Does your insurance require a referral? ____YES ____NO; **if yes**, please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Name of Policy Holder		
Date of Birth of Policy Holder		
Policy/Member ID Number		
Group/Plan Number		
Phone Number		
Effective Date of Policy		

Patient/Guarantor Signature_____ **Date**_____

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

{Name of Medical Practice}

Patient Name:_____ Date of Birth _____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals The Minor Procedures are performed by a physician or qualified midlevel provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to the Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source . I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice;

The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;

I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and

If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____ _____

Witness Date Time Signature of Patient or Legal representative Date Time

_____ _____

Interpreter (Note: if phone interpretation used, record interpreter ID#) Relationship to patient reason patient can't sign

ADDRESSOGRAPH

NH2500

NORTHSIDE HOSPITAL

Ebola Virus Disease (EVD) Screening

Outpatient Settings - Patient Access

In order to keep our patients and staff safe, we would like to ask you some questions about recent travel to areas where Ebola has been found.

1. Have you traveled to West Africa (Guinea, Liberia, Mali or Sierra Leone) within the 21 days (3weeks) of symptom onset or had any exposure to anyone with suspected or confirmed Ebola?Yes _____ No_____

AND

2. Do you have any of the following symptoms: fever, headache, joint and muscle aches,weakness, fatigue, diarrhea, vomiting, stomach pain or lack of appetite, and in some casesbleeding? Yes _____ No_____

If "Yes" to BOTH questions: IMMEDIATELY

(1) PROVIDE* patient with a surgical or isolation mask and
a gown (or blanket) with instruction for them to apply
(2) CALL clinic Manager/Supervisor
(3) NOTIFY patient's physician
(4) CALL Georgia Department of Public Health (DPH) at 1-866-PUB-HLTH (1-866-782-4584)
NOTE: After the call is placed to DPH, the Medical Epidemiologist will call back to triage and advise on next steps, and arrange for EMS transport to an appropriate treatment facility if necessary.
DO NOT CALL 911 unless there is a medical emergency.

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Staff Name _____ Signature _____ Date/Time_____

Healthcare workers should not touch patient without application of their own Personal Protective Equipment (gowns, gloves, mask, goggles, etc.)

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

English - Spanish

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: In consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child.

PRECERTIFICATION: **I understand** that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent a year. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ **I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.**

_____ **I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues**

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____

Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____

Note: If phone interpretation used, record interpreter ID #

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

English - Spanish

YOUR WELL BEING AND HEALING ARE OUR PRIMARY CONCERN. WE BELIEVE THAT A POSITIVE HOSPITAL EXPERIENCE IS A RESPONSIBILITY THAT IS SHARED BY YOU AND YOUR HEALTH CARE PROVIDERS.

YOUR RIGHTS

- You have the right to request and receive information on patient rights, responsibilities and ethics.
- You have the right to request considerate and respectful care that recognizes your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences.
- You have the right to identify a surrogate decision-maker, as allowed by law, when you cannot make decisions about your own care, treatment, and service.
- You, your family, and/or surrogate decision maker have the right to request, as appropriate and as allowed by law, to be involved in care, treatment, and service decisions, including the assessment and treatment of your pain.
- You have the right to request an environment that preserves dignity and contributes to a positive self-image, including room accommodations as available, reasonable and medically appropriate.
- You have the right to request privacy and confidentiality as reasonable and appropriate under the circumstances.
- You have the right to request visitor, telephone and mail services, as reasonable, available and appropriate within the hospital setting and patient population.
- You have the right to request free qualified medical interpretation services as reasonable if you have special communication needs due to vision, speech, hearing, language, or cognitive barriers or impairments.
- You have the right to request, in a timely manner, the name of the physician primarily responsible for your care, treatment, and services and the name of the physician (or other practitioner) performing your care, treatment and services.
- You have the right to request consultation with another physician or specialist, including a pain specialist.
- You have the right to informed consent for certain care, treatment and services provided to you, and the right to refuse participation in research programs and recording and filming for internal and/or external purposes.
- You have the right to rescind consent for care, treatment, and services provided, including your participation in research programs and recording or filming for internal and/or external purposes.
- You and, when appropriate, your family have the right to be informed about the outcomes of care, treatment, and services, including unanticipated outcomes.
- You or your surrogate decision-maker have the right to accept or refuse medical or surgical treatment for you to the extent permitted by law and hospital policy, including foregoing or withdrawing life-sustaining treatment or withholding resuscitative services, in accordance with law and regulation.
- You have the right to execute, review and revise an advance directive, and, upon admission, receive information on the extent to which the organization is able, unable or unwilling to honor advance directives. (The existence or lack of an advance directive does not determine an individual's access to care, treatment and services.)
- You have the right to request access, request amendment to, and receive an accounting of disclosures regarding your own health information as permitted under applicable law, including current information concerning your diagnosis, treatment and prognosis (Health Information Portability & Accountability Act 1996).

- You and your family have the right to request an ethics consultation to assist in resolving any ethical issues, concerns or dilemmas regarding your care, treatment and services.
- You have the right to request pastoral care and other spiritual care services while you are a patient in this hospital.
- You have the right to request to be considered as a candidate for organ/tissue/eyes donation.
- You have the right to have your wishes concerning organ donation honored, within the limits of the law or organizational capacity.
- You have the right to reasonable personal safety while you are a patient in this hospital, including access to protective services, as allowable by law and as reasonable under the circumstances.
- You have the right to request to be informed of hospital rules and regulations that apply to you as a patient, and to speak to a Patient Relations Representative to have complaints, suggestions for improvements or concerns heard.
- All patients have the right to be free from physical or mental abuse, and corporal punishment.
- All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time.
- You have the right to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.
- You have the right not to be transferred to another facility or organization, except in an emergency, without your consent to the transfer, including a complete explanation and alternatives to a transfer. (The other facility and you must accept the transfer.)
- You have the right to request an itemized and detailed explanation of hospital charges for services rendered, and to be provided with financial counseling free of charge, as appropriate.
- Northside Hospital strives to provide satisfactory care, however if you have a concern that you feel was not satisfactorily addressed, you have the right to contact a Patient Relations representative. You also have the right to file a concern with the Georgia Department of Resources. You may reach them at 404-657-5728 or by mail at 2 Peachtree Street, NE, 33rd Floor, Atlanta, GA 30303. You may also contact the Joint Commission on Accreditation of Healthcare Organizations at: Office of Quality Monitoring, One Renaissance Blvd., Oakbrook Terrace, IL 60181.

YOUR RESPONSIBILITIES

In order to create a partnership that will improve your care, we ask that you give careful consideration to your responsibilities to:

- Provide, to the best of your knowledge, accurate and complete information about your health history, current condition and current medication and adverse reactions.
- Ask questions if you do not understand any aspect of the care, treatment, or services provided for you.
- Cooperate with your doctor, nurse, and other caregivers.
- Follow the recommended treatment plan.
- Report changes in your condition or anything you think might be a risk to you.
- Ask the doctor or nurse what to expect regarding pain and pain management.
- Take responsibility for the outcome if you decline or refuse the recommended treatment.
- Communicate your wishes regarding end of life decisions, including advance directives, with your family, physician, personal attorney and spiritual advisor.
- Discuss your wishes regarding organ/tissue/eye donation with your family, physician, personal attorney, and spiritual advisor.
- Show respect and consideration of others.
- Respect the privacy rights of others. Photographs, films, videos, and voice recordings of other patients or staff are not permitted.
- Follow the hospital's policies and regulations.
- Fulfill the financial obligations of receiving care, including accepting financial responsibility for any consultations with physicians or specialists, including pain specialists.
- Request interpretation services when necessary
- Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you.
- If you have a test, don't assume no news is good news. Always ask for the results of all tests

ADDRESSOGRAPH

NH2499

NORTHSIDE HOSPITAL
PHYSICIAN OFFICE PRACTICE

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

The Northside Hospital Physician Office Practice identified above is hereby authorized to **(Please mark appropriate box):**
☐ **Release to** <u>OR</u> ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) **(Please identify by name or general description and provide address, if known):** _____

_____

_____

The following protected health information regarding the patient **(Please mark appropriate box(es)):** ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐EKG only
☐ Other **(Please specify clearly)** _____
For the following dates of service: _____

<u>Unless you state otherwise</u>, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

<u>Unless you state otherwise by marking one or both boxes below</u>, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I <u>object</u> to the release of **HIV/AIDS** confidential information.
☐ I <u>object</u> to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is **(Please describe each purpose of the requested use or disclosure):** _____

_____

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates: **(a)** _____ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit);** (b) the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient <u>OR</u> (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Witness

_____ AM/PM _____
Date Time

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Signature of Patient or Legally Authorized Representative, Including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print name: _____

Relationship to patient: _____

Reason patient unable to sign: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

White - Medical Records
Yellow - Patient