

Pre-registration Form

Patient Identification Information					
Any Allergies to MEDICATIONS: YES NO					
Name -					
FIRST		MIDDLE		LAST	
Address -					
City -		State -		Zip Code -	
Phone # -		Date Of Birth -		*Social Security # - <small>This information is used for identification purposes only. And will be kept confidential.</small>	
Sex - MALE FEMALE		Race - WHITE BLACK INDIAN ASAIN HISPANIC NATIVE HAWAIIAN MULTIRACIAL		Marital Status - MARRIED SINGLE DIVORCED WIDOWED SEPARATED	
Previous/Maiden Name:				Primary Care or Family Doctor	
Patient Employment Information					
Employer Name -					
Address -			City & State -		Zip Code -
Phone # -			Employment Status - FULLTIME PARTTIME RETIRED UNEMPLOYED		
Is your illness or injury related to an accident? - YES or NO <small>If yes: AUTOMOBILE EMPLOYMENT HOUSEHOLD</small>			Accident Date and Time - / / :		
Insurance Subscriber					
*Only complete the following if the PATIENT IS NOT the insurance policy holder <small>(Person who carries the insurance in their name or is responsible for the bill)</small>					
Name -			Relationship to Patient - SPOUSE PARENT OTHER <small>Please circle</small>		
Address - <small>If different from patients address</small>			City & State -		Zip Code -
Phone # -		Date Of Birth -		Social Security # -	
Sex - MALE FEMALE		Race - WHITE BLACK INDIAN OTHER			
Employer Name -					
Address -			City & State -		Zip Code -
Phone # -			Employment Status - FULLTIME PARTTIME RETIRED UNEMPLOYED		

The purpose of this form is to reduce your time spent waiting on registration for routine outpatient visits and to ensure account accuracy. All information is required to ensure timely and accurate insurance filing. This information will be kept active on your file for this visit only. **You must complete a new form for each visit.** Chesapeake Regional Medical Center, and our family of providers, value your time and appreciate the time you spend with us as we deliver your healthcare needs. We strive to provide you with excellent treatment during your visit. If you are not satisfied, please contact a member of management for the department that you are visiting by calling 757-312-8121. Thank You.

CHESAPEAKE REGIONAL MEDICAL CENTER

CONSENT FOR TREATMENT, RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

The person named below (hereinafter called "Patient" has been received for services including but not limited to, outpatient diagnostic testing, surgery, emergency/urgent treatment, and/or admitted, or is the legal parent of a newborn delivered in the facility, on _____, 20____. The Guarantor listed for Patient has been accepted as the guarantor of payment by Chesapeake Regional Medical Center or Chesapeake Health (hereinafter called "Hospital"), or other service providers.

AUTHORIZATION FOR TREATMENT: Patient consents to the following: That the attending physician, the clinical and technical employees of the hospital, any consulting physicians or any assistants, whom they may call to their aid, may administer any treatment deemed advisable in the care and treatment of the Patient. Patient also consents to all procedures that, whether for diagnosis or treatment prior to or during the procedure may be deemed advisable in their care and treatment. Patient further understands that no guarantee of assurance has been made as to the results that may be obtained.

ASSIGNMENT OF BENEFITS: The Patient and/or the insured requests that payment of any authorized insurance benefits are made on their behalf to all providers of service. Patient understands that it is necessary for the hospital to release certain medical information in order to receive payment of its debt from third party insurers or governmental "providers". Accordingly, patient will not in any way interfere with the hospital's and other service providers' attempts to collect insurance or governmental proceeds due and will furthermore not make any attempt to revoke this authorization.

TERMS FOR FINANCIAL AGREEMENT: *The Patient/Guarantor agrees to pay all charges made by the Hospital or other service providers for services rendered for this date. Any portion of the bill not covered by insurance or other benefit is due in full at the time of service or discharge unless prior arrangements are made.*

Any unpaid balance, whether covered by insurance or other benefit, will be subject to a FINANCE CHARGE OF 1.0% PER MONTH, commencing thirty (30) days after the discharge date. THIS IS AN ANNUAL PERCENTAGE RATE OF 12%. It is further agreed that the hospital or other service providers shall have the right to proceed against either the patient, spouse, or responsible party without making a request for payment or taking any action, or proceeding against the other. EACH OF THE UNDERSIGNED WAIVES THE BENEFITS OF THE HOMESTEAD EXEMPTION AS TO THIS DEBT. EACH FURTHER AGREES TO PAY ALL COSTS OF COLLECTION, INCLUDING AN ATTORNEY'S FEE OR COLLECTION FEE OF TWENTY-FIVE (25) PERCENT OF THE UNPAID BILL, IF SUCH EXPENSES ARE INCURRED. Any overpayments that would otherwise be eligible for refund to the Guarantor will be applied to outstanding balances on other accounts that are the responsibility of the same Guarantor.

INSURANCE AGREEMENT: Patient and/or Guarantor understand that insurance is a contract between the subscriber and the insurance company and that the Hospital and other service providers will bill the insurance carrier as a courtesy to the patient. All required authorizations, pre-certifications, and/or referral forms are the responsibility of the Patient. If required procedures are not followed to the satisfaction of the HMO or PPO, payment for certain services will become the responsibility of the Patient.

If Patient is covered by Medicare and receiving inpatient services, the Patient certifies that they have received a copy of the "Important Message from Medicare" concerning their rights to coverage and appeals for non-coverage.

The Patient understands that all physicians furnishing services to the Patient, including radiologists, anesthesiologist, and the like, are independent contractors and are neither employees nor agents of the Hospital. A separate billing will be rendered for services provided by them. The undersigned patient, spouse, and/or responsible party, agree that they will pay any physician's charges in accordance with regular terms and charges.

IMPORTANT - THIS CONSENT IS CONTINUED ON THE REVERSE SIDE **READ THE SECOND PAGE OF THIS CONSENT PRIOR TO SIGNING**

DECLARATION OF UNDERSTANDING: The signature below certifies that I have read, or have had read to me, this entire form, including the reverse side of this consent which contains additional information about what health information can legally be released by Chesapeake Regional Medical Center and I certify that I understand its contents and been given the opportunity to request further information. This printed contract is intended as the complete agreement between the Patient/Guarantor and the Hospital, and Chesapeake Regional Medical Center/Chesapeake Health shall not be bound by any verbal agreement or modification of the terms of such printed contract. Any modification or amendment to this agreement shall be in writing signed by both parties in the presence of witnesses.

PATIENT SIGNATURE

DATE

GUARANTOR/INSURED SIGNATURE

DATE

WITNESS SIGNATURE

DATE

WITNESS SIGNATURE

DATE

ACCT#

DOB

MR#

CHESAPEAKE
GENERAL HOSPITAL

ACCT

PT

MR#



CONTINUED FROM FRONT SIDE - READ BOTH SIDES PRIOR TO SIGNING

SAFETY: It is understood and agree that the hospital will maintain facilities for the safe keeping of money, valuables, and other personal property small enough to fit into the Hospital safe. The Hospital strongly encourages the patient to not bring valuables or personal property with them and the Hospital shall not be liable for the loss of, or damage to: valuables, money, personal possessions, dentures, etc. not deposited with Patient Access Services for safe keeping.

The Patient also understands that close proximity to their assigned unit is necessary to provide immediate care and ensure safety; however, if the Patient decides to leave their assigned unit, they assume all responsibility for injuries or complications that may result. The Patient understands that Chesapeake Regional Medical Center is a smoke-free facility.

The Patient certifies that, if receiving services as an inpatient, that they have received information regarding Advance Directives. Upon request, additional information may be provided to the Patient by their health care provider or physician.

The Patient/Guarantor signature on the reverse side of this consent form certifies that the Patient/Guarantor has received the pamphlet "Notice of Privacy Practices" describing how medical information about the Patient may be used and disclosed in accordance with federal regulations. Patient certifies that they have had an opportunity to review the "Notice of Privacy Practices" and offered additional information if requested.

ACKNOWLEDGMENT FOR HIV/HBV/HCV TESTING: The code of Virginia (32.1-45.1) authorizes health care providers to test patients for HIV (human immunodeficiency virus) hepatitis B virus and hepatitis C virus, when a health care provider is exposed to the blood or body fluids of a patient in a manner which may transmit the viruses. In the event of such exposure, the Patient will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who has been exposed. The Patient will be offered the opportunity for face to face disclosure of the test results and counseling if conscious. In the event, the Patient is unconscious, the Legal Representative of the Patient or Surrogate will be deemed to have consented to the testing. If the patient remains unconscious, the test results may be released to the legal representative, or surrogate only in the event the surrogate is the spouse.

RELEASE OF INFORMATION: Patient grants permission to the Hospital, agent, or testing physicians to release psychiatric, substance abuse, AIDS/HIV-related or medical/surgical information to any insurance company having insurance in force on the Patient, as may be required or requested from the respective provider's files. The Patient authorizes the Hospital or other service providers to release information from their medical records to the Social Security Administration, its intermediaries, or carriers, and to any utilization and/or quality review organization affiliated with their insurers for use in utilization management, any information needed for this, or a related Medicare or Medicaid claim. The Patient further authorizes the Hospital or other service providers to provide from its own records pertinent medical information to other health related agencies and facilities involved in their continuing care after hospital discharge for up to ninety days. Patient also agrees that their medical records may be reviewed as part of an internal quality assurance process, including our agents.

Chesapeake Regional Medical Center is required by law to maintain the privacy of your health information (Protected Health Information or PHI). The permissible uses and disclosures of your PHI without your written authorization include:

- PHI used to treat you, obtain payment for services and conduct our "health care operations"
- PHI provided to other health care providers when required to treat you
- Using your name, location in Chesapeake Regional Medical Center, general health condition, and religious affiliation in a patient directory unless you object
- Disclosing information to a family member, other relative or a close friend or any other person identified by you when you are present
- Contacting you to request a tax-deductible contribution to support activities of Chesapeake Regional Medical Center or our institutionally related foundation (Chesapeake Health Foundation)
- Reporting child abuse, communicable diseases or other public health activities

FOR FURTHER INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services for which, upon request, the address can be provided to you by the Director of Health Information Systems Department of Chesapeake Regional Medical Center.

You may contact the Health Information Services/Privacy Office at:

Health Information Services / Privacy Office
Chesapeake Regional Medical Center
736 Battlefield Boulevard, North
Chesapeake, VA 23320
Telephone Number (757) 312-6114