PROVIDENCE
a member of ASCENSION HEALTH

REGISTRATION FORM

(PLEASE PRINT)

Date_____ Home Phone (___) _____ Ref. Provider _____ PCP_____

~ PATIENT INFORMATION ~

Name_____ _____ SSN_____
Last Name First Name Middle Initial

Address_____ Cell (___) _____; Work (___)_____

City_____ State_____ Zip_____

Sex ☐M ☐F Age_____ DOB_____ ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for ____yrs

Race ☐American Indian or Alaska Native ☐ Asian ☐Native Hawaiian or other Pacific ☐Black or African American ☐White
☐Hispanic ☐Other Race ☐Other Pacific 1 Islander ☐Unreported/do not wish to report

Language ☐English ☐Indian (including Hindi & Tamil) ☐Spanish ☐Russian ☐Other

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refused to Report

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (___)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified? _____ Relationship_____ Phone (___) _____

~ PRIMARY INSURANCE ~

Person Responsible for Account _____
Last Name First Name Middle Initial

Relationship to Patient_____ DOB_____SSN_____

Address *(if different from patient's)* _____Phone (___)_____

Person Responsible Employed by_____Occupation_____

Business Address_____Business Phone (___)_____

Insurance Company_____ Contract #_____Group#_____ Subscriber#_____

Names of other dependents covered under this plan_____

~ ADDITIONAL INSURANCE ~

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name_____ Relation to Patient _____DOB_____ SSN_____

Address *(if different from patient's)* _____Phone (___)_____

Subscriber Employed by_____ Business Phone (___)_____

Insurance Company_____ Contract #_____Group#_____ Subscriber#_____

Names of other dependents covered under this plan_____

~ PHARMACY INFORMATION ~

Pharmacy Name _____

Address _____Phone (___)_____

We will be contacting you to remind you of appointments, for test results or to remind you of services you may need. Please circle your response below regarding communication with us:

How would you prefer to be contacted? (Please circle one option): Home Cell Text message
Could we leave a message about your medical care using your preferred contact information? Brief Message Extended Message
Preferred Language: (Please circle one) English Spanish
Preferred Time to call: (Circle one) Morning Afternoon Evening
Are you interested in emailing or contacting your doctor online about you medical care? Yes (email address) _____ No
Would you like to receive messages by email and educational information online? Yes No

Your Initials here acknowledge we will be contacting you regarding your medical care: Initials: _____

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PATIENT CONSENT TO CONDITIONS OF ADMISSION

1. Acknowledgement of Receipt of Notice of Privacy Practices: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

2. Release of Information: _____

I hereby authorize PROVIDENCE HOSPITAL, Providence Health Services and its agents, including but not limited to all physicians involved with my care, to release information from my medical record to include treatment of psychological or psychiatric impairment, substance abuse, alcoholism, AIDS, test for Human Immunodeficiency Virus (HIV), sexually transmitted diseases, sexual assault, criminal cases and photographs, unless otherwise specified herein, as may be required, to any person, corporation or agency legally responsible for processing and/or paying all or part of the hospital's charges and/or professional fees; and, to any entity which was contracted by an insurer to conduct utilization review or performance review.

3. Advance Directives: _____

I acknowledge that the office has made available written information concerning Advance Directives.

4. Prescription History: _____

We will use your pharmacy information to send any prescriptions needed electronically. Please call your pharmacy for prescription refills. We will review your prescription history to help with your medical care.
Your initials above acknowledge we will be accessing your prescription history.

5. Financial Agreement/Guarantee of Payment: _____

I/we agree to pay the established rate of Providence Hospital and its agents, for all services rendered. It is understood that my/our obligation will include any balance not covered by insurance. It is further understood that if my/our insurance does not pay within sixty (60) days of treatment of discharge I/we will become responsible for payment in full unless limited by contractual agreement or governmental regulation.
I understand that physicians, such as emergency room physicians, anesthesiologists, radiologists, pathologists etc. are independent contractors, not employees or agents of Providence Hospital, and that fees for professional services associated with my care at the Hospital will be billed directly to me by these physicians. I further understand that non-Hospital providers may also provide certain types of services, e.g. diagnostic and laboratory services, and thus billed separately.

6. Patients with Medicare, Medicaid or Medicaid HMO's: _____

I have been advised that this facility is owned and operated by Providence Hospital. I understand that I may receive two (2) bills - one from my doctor or other provider (for example: physician, nurse practitioner, physician's assistant, social worker, etc.), and another bill from the Hospital for the facility. I understand that I may incur a coinsurance liability for each bill. If I were to be treated at a location that is not hospital-based, my coinsurance payment may be less. Please contact us if you have trouble paying these fees.

This is an estimated amount of a coinsurance liability:

Since we do not know the exact type and extent of services that you may need, we are unable to provide you with an exact amount of your liability. However, the typical coinsurance liability incurred by a beneficiary based on all visits to our facilities normally ranges from $11.11-$100.00

~ ASSIGNMENT and RELEASE ~

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Providence Health Services all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Relationship to Patient