

PRE-REGISTRATION CONSENT FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

ESTIMATED DATE OF DELIVERY: _____

Initials

ASSIGNMENT OF BENEFITS: Authorizes the Insurance Company to reimburse Northside Hospital directly. This also states the patient is not relieved of any responsibility in paying charges not covered by insurance, medical care and treatment. 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/co-payments of specifically 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 within ninety (90) days of service with all conditions of the payment plan met.)** This also applies to any newborn child.

Initials

PRE-CERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expanded when justified. I understand that it is the utilization review program's responsibility to review proposed elective admission and anticipated courses of treatment. I understand that if the utilization review program determines that the 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 pre-certification 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 this admission should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial losses, I must review my obligations with my insurance company, utilization review program, and personal physician without delay.

Initials

ABOUT YOUR BILLING: In addition to the bill you receive from Northside Hospital, you may receive a bill directly from the physician or professional services rendered. Physicians are not employees of Northside Hospital but are independent contractors who have been granted the privilege of using the Hospital's facilities. The Hospital does not control the diagnosis and treatment of patients or the exercise of medical judgment by these physicians. If you receive services from physician groups including, but not limited to, Radiology, Anesthesiology, Neonatology, Perinatology, Emergency Medicine or Pathology, you will receive a bill for the professional component of your treatment. Although Northside Hospital may be a provider in your insurance network, the physician may or may not be a participating provider. This may affect your coverage level for professional services. Please contact your Member Services Representative with your plan for coverage determination.

When you receive your bill, please review the statement to determine where inquiries should be directed. The professional services listed below are not performed by Northside Hospital. Specific inquiries regarding professional billing for these services should be directed to the following offices:

- Northside Radiology Associates, P.C.: (770) 779-2175
- Northside Anesthesia (Sentinel): (770) 645-7889
- Pathology & Lab Medicine (PALM): (770) 458-6103
- Neonatology: (404) 252-9751
- Atlanta Psychiatric Clinic: (404) 285-9722
- Emergency Department Physician Services (770) 779-0015

Initials

PRIVATE ROOM REQUEST: Request the use of a:

() Private Room () Semi-Private Room

I understand that the hospital may not have the type of room requested. Private rooms are not guaranteed and are subject to availability. I understand that I will be expected to pay the Private Room differential per night upon discharge if I am in a private room.

Initials

SELF PAY: The patient understands that he/she is financially responsible for his/her hospital visit. 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/co-payments of specifically 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 within ninety (90) days of service with all conditions of the payment plan met.)** The patient does not have coverage under the Medicaid program, or has applied for Medicaid coverage and has not yet received a determination or eligibility.

Initials

If you have continuation of insurance from a prior employer, please complete this section.

COBRA: Previous employer information for:

() Patient () Guarantor (other than Patient)

Employer Name

Insurance Name

Address

Insurance Telephone No. _____

Phone No. _____

Group No. _____

Policy No. _____

PATIENT DATE

SIGNATURE OF INSURED/INSURANCE POLICY HOLDER DATE
(if different than the patient)

WITNESS DATE