A Northside Network Provider

English - Spanish - French - Korean - Vietnamese

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
Patient Agrees that Practice may also rely on patient's expressed preference when making the appointment

We require a minimum of 24 hour notice for cancellations. Failure to do so may result in a charge for the missed appointment.

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 _____

*By providing a phone number or email address, you understand that communication by email and text may be an unsecure form of communication and you expressly consent and authorize Northside and its affiliates to contact you via phone calls (through the use of any dialing equipment such as artificial or pre-recorded voice technology and/or automated telephone dialing systems), texts, and/or emails, including for appointment reminders, payment-related messages, quality improvement communications such as surveys, and invitations to join our secure patient portal, if available.

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		
Policy Holder Name and Date of Birth		
Policy Holder Relationship to Patient		
Policy/Member ID Number		
Group/Plan Number		

Patient/Guarantor Signature _____ **Date/Time** _____

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Piedmont Graphics Rev. 11/11/2024

PATIENT REGISTRATION FORM

A Northside Network Provider

English - Spanish - Korean - Vietnamese - Simplified Chinese

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, 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. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

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 annually. 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.

COMMUNICATION: By providing my email address and/or phone number to Northside Hospital at any time, I authorize Northside Hospital or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, including mobile phone numbers, email addresses, or other contact points that have been or may be provided by me or on my behalf) in connection with any matter relating to my treatment or payment, including appointment reminders, quality improvement communications, patient-portal related messages, debt collection issues, patient surveys, prescription notifications, and other similar types of messages. I understand that text and e-mail messages may be an unsecure method of transmitting information and I accept the risks of agreeing to receive communications by text and/or email. I also understand that standard message and data rates may apply for text messages and that phone calls or text messages may use dialing equipment such as artificial or prerecorded voice technology or automated dialing systems. I understand that providing a mobile phone number or email address is not required in order to receive health care services at a Northside Hospital facility. I further understand that is my responsibility to notify Northside Hospital immediately of any change in my telephone number or email address. I understand that I may revoke my consent to receive such communications by changing my notification preferences in my patient portal account or using the opt-out method that may be identified in the applicable communication, but that providing my phone number or email or agreeing to such communications at a later date will override any such opt-out and I will be required to opt-out again if such communications are no longer desired.

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.

Witness' Signature _____ Date/Time _____

Print Witness' Name _____

Interpreter's Signature _____ Date/Time _____
Note: If remote interpretation used (phone/iPad), record interpreter name, ID#
Interpreter comments (optional): _____

Signature of Patient or Legal Representative _____ Date/Time _____

Relationship to Patient If Not the Patient _____

Reason Patient Unable to Sign _____

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).

Witness' Signature _____ Date/Time _____

Print Witness' Name _____

Interpreter's Signature _____ Date/Time _____
Note: If remote interpretation used (phone/iPad), record interpreter name, ID#
Interpreter comments (optional): _____

Signature of Patient or Legal Representative _____ Date/Time _____

Relationship to Patient If Not the Patient _____

Reason Patient Unable to Sign _____

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** _____

A Northside Network Provider

English - Spanish - Simplified Chinese - Korean - Vietnamese

AFFIX PATIENT LABEL HERE

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____

Why You Are Reading This Form

This form gives Northside permission to provide routine medical care while you are a patient at this practice or with any Northside Network provider.

What is Routine Medical Care?

Routine medical care includes things like:

- Getting medicine or vaccines
- Taking medicine by mouth
- Blood draws
- Physical exams
- X-rays or scans
- Physical therapy
- Placing small tubes or lines in a vein or artery
- Putting tubes into the body
- Removing small tissue samples for testing
- Other small procedures that use numbing medicine (local anesthesia), such as taking a bone marrow sample or removing skin tags

Routine medical care is usually safe, but there are still risks. There is a chance something might go wrong, such as an infection, soreness, loss of a body part or how it works, damage to the body or medical devices, paralysis, or death. Ask questions if you are unsure. Doctors, advanced practice providers, nurses, or other healthcare workers may give you medical care.

Samples or Items Removed from Your Body

Northside or a lab used by the practice may keep tissue samples, medical devices, or other items removed from your body. These may be tested, used for teaching or research, kept, or thrown away as allowed by law.

If you do not agree, you must tell us in writing before your procedure.

If the tissue includes pregnancy tissue or fetal remains, the lab may test and dispose of them as required.

If you have a request about how to handle these items, tell your nurse. If you ask for an item back, you must pick it up within 14 days. If not picked up, it may be thrown away.

Medication Records

Each practice may get your medicine history from your pharmacy or other sources. This may include health plans and other healthcare providers. This information may be added to your medical record to help your care team work together and care for you.

This may include medicines used for mental health, sexually transmitted diseases, substance use disorders, and HIV/AIDS.

If you do not want the practice to get this information, tell the practice in writing. Your request will not take effect until the practice receives and confirms it in writing. The request will not apply to any actions already taken.

If you do not allow this, your doctor may still check prescription records through the Georgia Drug Monitoring Program for controlled substances.

Vaccines

By law, vaccines are reported to the Georgia immunization database (GRITS).

If you do not want your information shared, you must opt out with the Georgia Department of Public Health. Tell your provider that you have done this at the same time you get a vaccine.

Medicines You Take

Tell your doctor about all medicines you take, including vitamins and herbal products. If you bring medicine to the practice to be given to you, staff may examine it so it can be added to your medical record. The practice is not responsible for keeping the medicine safe or for giving it to you correctly.

ANNUAL ACKNOWLEDGMENT – CONSENT TO TREAT

AFFIX PATIENT LABEL HERE

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____

Video Visits (Telehealth)

You agree that care may be given by video if needed. You may say no at any time. Sound and video may be recorded. Unless you say no, someone may be in the room to help with equipment.

If you do not agree, some services may not be available at all Northside locations. You may still choose in-person care. If you set up or join a telehealth visit, you agree to get care that way.

Healthcare Students

The practice helps train future doctors, nurses, and other medical workers. Students may help with your care while supervised.

If you do not want students to take part in or watch your care, tell your doctor or care team at your visit.

Blood Testing

If a healthcare worker is exposed to your blood, your blood may be tested for diseases like HIV. Pregnant patients may also be tested when required.

If you do not want to be tested, tell your doctor.

Some testing is required by law even if you say no.

Photos and Recordings

Photos or recordings may be taken for care, safety, training, or quality improvement. Photos, recordings, or information may be used to help with medical learning or research. Your name will not be shared for teaching or research.

Talk to your doctor if you have questions about photos or recordings.

If you do not want photos or recordings taken, tell your doctor or care team at your visit.

Northside may take photos or record video in public areas to help keep everyone safe.

Your Privacy

Northside follows privacy laws. Your information may be shared with family unless you say no. Your information may be shared with your doctors or other providers. Do not take photos or videos of others.

Sharing Your Information

Northside may share your health information with other health care providers through secure systems to help coordinate care.

This may include sensitive information like mental health, HIV/AIDS, genetic information, and pregnancy information.

You may opt out by completing the form on Northside's website. www.northside.com/hie.

Technology

Your healthcare team may use technology that helps them do their work (such as AI).

Licensed Clinical Social Workers

The practice may have a Licensed Clinical Social Worker (LCSW) or similar staff. They learn about your needs, share this information with your care team, and connect you with support services.

Notes from the LCSW are part of your medical record. They are not psychotherapy notes. They are not protected the same way as therapy records.

Independent Providers

Some providers are not Northside employees. They are responsible for their own actions. Northside is not responsible if they make a mistake or do something wrong.

AFFIX PATIENT LABEL HERE

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____

Your Consent

By signing this form, you agree that:

- Medicine is not an exact science. No one has promised you that any treatment or exam at the practice will have a certain result.
- Your care team may use the information you give them to guide care.
- Northside's employees and other doctors and medical workers who are not Northside employees may take care of you.
- Providers may test your blood if exposed.
- You received patient rights information.
- You have read this form, or someone has read it to you.
- You understand this form.
- If you are signing for someone else, you confirm you are allowed to sign.

Witness' Signature Date/Time

Print Witness' Name

Interpreter's Signature Date/Time

Note: If remote interpretation used (phone/iPad), record interpreter name and ID#

Interpreter Comments (optional): _____

Signature of Patient or Legal Representative Date/Time

Relationship to Patient If Not the Patient

Reason Patient Unable to Sign

NOTICE OF NON-DISCRIMINATION

Northside Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 404-845- 5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee); 678-312-4399 (Gwinnett/Duluth)

Northside Hospital cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee); 678-312-4399 (Gwinnett/Duluth)

Northside Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee); 678-312-4399 (Gwinnett/Duluth)

A Northside Network Provider

English - Spanish - French - Korean - Traditional Chinese - Vietnamese

CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

AFFIX PATIENT LABEL HERE

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date: _____

Federal law allows a health care provider to discuss your health information related to your care or payment for your care with your family members and close personal friends who are involved in your care if you authorize us to do so. This form allows you to designate family members, friends or others with whom the practice listed above can share your health information and communicate with about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to discuss your health information with the individuals that you have listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form authorizes the practice to verbally communicate with the individuals you have listed below but does not entitle them to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Electing not to complete this form will not impact your care provided at this practice.

This form can be revoked by submitting a written request to the physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you expressly revoke it in writing. Completing a new Consent to Communicate form or electronically changing your communication preferences does not revoke any previous Consent to Communicate forms that you have completed, which the Practice may continue to rely on unless you elect to revoke the form.

First and Last Name	Relationship	Phone Number

_____ _____

Signature of Patient or Legal Representative Date/Time Reason Patient Unable to Sign

_____

Relationship to Patient If Not the Patient

_____

Interpreter's Signature Date/Time

Note: If remote interpretation used (phone/iPad), record interpreter name and ID#

Interpreter Comments (optional): _____

_____

Please complete this form and return it to the Practice

NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS