Labor and Delivery Pre-Registration Form

Dear Patient,

Thank you for choosing to Pre-Register with Southern Tennessee Medical Center. We look forward to serving you on your upcoming visit to our facility. To help ease the process of registering for your delivery, we ask that you complete the questionnaire and Consent for Services form and return it. By doing so, it will ensure that we have the correct information, therefore, simplifying the insurance and billing process. Again, thank you for choosing Southern Tennessee Medical Medical Center.

Save time and get paperwork our of the way. You may download, print, and fill out the following forms.

OB Pre-Registration form. Please fill out the form completely.

All Patients must sign a consent form prior to admission. Download the Consent form.

Please print this document, review, sign and initial where indicated. Then bring the forms, along with your insurance cards to: Southern Tennessee Medical Center Admitting Department

For assistance with your pre-registration please dial Admitting Department 931-967-8272

SOUTHERN TENNESSEE MEDICAL CENTER

DATE:_______________

INFORMATION

IT IS VERY IMPORTANT THAT THIS INFORMATION BE COMPLETED TO ITS ENTIRETY.

PATIENT INFORMATION **SOC SEC #**____________________

PATIENT NAME:____
(LAST) (FIRST) (MIDDLE)
DATE OF BIRTH____________________ AGE______________ SEX ______________
ADDRESS______________________________ TELEPHONE # (____)____________________
CTY/ST/ZIP ____
RACE __________ RELIGION____________ MARITAL STATUS __________ DO YOU SMOKE?________
EXPECTED DATE OF DELIVERY____________________ **LAST MENSTRUAL CYCLE**______________

PATIENTS EMPLOYER
EMPLOYER NAME________________________________ EMP STATUS ______________
ADDRESS________________________________ OCCUPATION______________
CTY/ST/ZIP____________________________ TELEPHONE # (____) ________

PERSON TO NOTIFY IN CASE OF EMERGENCY
NAME____________________________ RELATIONSHIP______________
HM TELEPHONE (____)______________ WK TELEPHONE (____)______________
ADDRESS________________________ CTY/ST/ZIP______________

GUARANTOR INFORMATION **SOC SEC #**______________
NAME____________________________ RELATIONSHIP______________
HM TELEPHONE (____)______________ WK TELEPHONE (____)______________
ADDRESS________________________ CTY/ST/ZIP______________

GUARANTOR'S EMPLOYER
EMPLOYER NAME____________________________ RELATIONSHIP ______________
ADDRESS________________________________ OCCUPATION______________
CTY/ST/ZIP____________________________ TELEPHONE # (____) ________

INSURANCE INFORMATION ****COPY OF INSURANCE CARD REQUIRED****
INSURANCE CO. NAME ____
SECONDARY INSURANCE
INSURANCE CO. NAME ____

VISIT INFORMATION

PCP:____________________ REFERRING PHYSICIAN:____________________
FAMILY PHYSICIAN:____________________ SERVICE DATE:____________________

I UNDERSTAND AND AGREE, (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR THE SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE QUESTIONS. I CERTIFY THAT THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOFITY YOU OF ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE______________________________DATE______________
PARENT (IF MINOR)______________________DATE______________

EXTENDED SIGNATURE AUTHORIZATION

I REQUEST THAT MY PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND ANY OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON BEHALF TO SOUTHERN TENNESSEE MEDICAL CENTER. I AUTHORIZE MY MEDICAL INFORMATION TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND/OR ITS AGNETS FOR ANY INFORAMTION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

______________________ ______________
SIGNATURE DATE

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY AND SIGN THE NECESSARY AUTHORIZATIONS, RELEASES AND AGREEMENTS SO THAT WE MAY PROCEED WITH THE CARE AND TREATMENT ORDERED BY YOUR PHYSICIAN.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I have no objection to doctors in training or other hospital approved persons assisting in or observing my treatment when the purpose of this is to advance medical education.

3. **PERSONAL VALUABLES:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, or other prosthetic devices.

4. **PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holders of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefit be made on my behalf.

5. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the hospital in accordance with its regular rates and terms and, if the amount is referred to an attorney or agency for collection, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the hospital insurance benefits for hospital services. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

6. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS.** I understand that, unless informed otherwise:

   a. **Physicians providing care at this hospital are <u>not employees or agents of the hospital</u>**. The physicians are independent medical practitioners who have privileges to practice medicine at this hospital. These physicians include, but are not limited to: emergency room physicians, radiologists, anesthesiologists, pathologists, and hospitalists.

   _____ Initials of patient / patient representative

   b. **The following types of health care providers <u>also are not employees or agents of the hospital:</u>** Physician Assistants (P.A.'s), Nurse Practitioners (N.P.'s), and Certified Registered Nurse Anesthetists (C.R.N.A.'s).

   _____ Initials of patient / patient representative

   I understand that these physicians may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

7. **NOTICE OF PRIVACY**

   I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

   ☐ I decline the Notice of Privacy

Southern Tennessee MEDICAL CENTER Winchester, TN

Emerald Hodgson HOSPITAL Sewanee, TN

Patient ID Label

ADMCONS

8. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, my name, location within the facility and general condition will be included in the patient directory.

☐ I object to having my name, location and general condition listed in the patient directory.

☐ Yes I would like to be visited by a member of the hospital clergy. My specific religious preference is ______________________. I understand that visitation by a clergy member of this denomination is not guaranteed.

9. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

10. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

11. **SMOKING POLICY:** Smoking is not permitted inslde the facility. I understand that while I am a patient at the Hospital I may be offered nicotine patches as well as information and options on smoking cessation.

12. **CONSENT TO PHOTOGRAPH:** Photography still and/or video may be deemed medically necessary by your physician before, during, or after a procedure. This is to provide documentation and will be kept as a part of your medical record.

☐ I refuse to be photographed and/or videoed

13. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law:

_______ I have executed an Advance Directive, if applicable
Initial

_______ I have not executed an Advance Directive
Initial

_______ I would like to formulate an Advance Directive / receive additional information
Initial

14. **TEST RESULTS/PHI.** I would like to designate ______________________________________ who is to receive my test results/PHI, Radiology films or who could assist me with any billing questions.

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

_______ I acknowledge I have received a Patient Handbook
Initial

______________________________________ ____________ ____________
Signature of Patient, Legal representative for health care Hospital Services if other than Patient | Date | Time

______________________ ______________________________
Relationship of Representative | Reason individual is Unable to Sign, i.e., Minor or Legally incompetent

______________________________________ ____________ ____________
Signature of Witness | Date | Time

Patient ID Label

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