

PRE-REGISTRATION CONSENT FORM

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

ESTIMATED DATE OF DELIVERY: \_\_\_\_\_

\_\_\_\_\_  
Initials

**ASSIGNMENT OF BENEFITS:** In consideration of the services provided at Northside Hospital to the patient identified above, I hereby assign and transfer to the Hospital all hospital and medical provider benefits payable and related rights existing under the insurance policies that I have identified or will identify in connection with this admission (but not to exceed the amount of the Hospital's charges for this period of hospitalization or other amounts as may be provided by an agreement between the Hospital and my insurance company). I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that this 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. Accounts more than 30 days past due will bear interest at the rate of 8 percent a year. **(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.

\_\_\_\_\_  
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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 Room Services: (800)599-0167

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**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.

\_\_\_\_\_  
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**SELF PAY:** I understand that I am financially responsible for charges or any unpaid balances for the patient account listed above. Accounts more than 30 days past due will bear interest at the rate of 8 percent a year. **(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.)** Please check one of the following statements:

( ) I acknowledge that the above named patient has no known existing coverage under the Medicaid program.

( ) I acknowledge that the above named patient has applied for medical coverage under the Medicaid program and had not received a determination of eligibility from the Department of Medical Assistance.

**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 (if different than the patient) DATE \_\_\_\_\_

\_\_\_\_\_  
WITNESS \_\_\_\_\_ DATE \_\_\_\_\_