CARTHAGE AREA HOSPITAL

1001 West Street Carthage, New York 13619 Phone: 315-493-1000

Last Name: ______ First: ______ MI: ____ ☐ Jr ☐ Sr ☐ Other: ______

Date of Birth: ______ Age: ____ Sex: ____ SS#: ______ Marital Status: ______

Mailing Address: ______ County: ______

Physical Address: ______ County: ______

Home Phone: ______ Cell Phone: ______ Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work

Pharmacy Name: ______ Phone: ______

Patient Employer: ______ Phone: ______ Occupation: ______

Emergency Contact: ______ Relationship: ______ Phone: ______

Race: ______ Primary Language: ______ Translator Needed? ☐ Yes ☐ No

SPOUSE/GUARDIAN INFORMATION

Last Name: ______ First: ______ MI: ____ ☐ Jr ☐ Sr ☐ Other: ______

Mailing Address *(if different that above)*: ______

SS#: ______ Contact Number: ______ ☐ Home ☐ Work ☐ Cell

Employer: ______ Phone: ______ Occupation: ______

INSURANCE INFORMATION

MEDICARE ID #: ______ Disability/Retirement Date: ______

Are you entitled to Veteran Benefits? ☐ Yes ☐ No *If so, what?* ______

PRIMARY INSURANCE

Name: ______ ID#: ______ Group #: ______

Insurance Address: ______

Subscriber's Name: ______ Date of Birth: ______ Relationship: ______ SS#: ______

SECONDARY INSURANCE

Name: ______ ID#: ______ Group #: ______

Insurance Address: ______

Subscriber's Name: ______ Date of Birth: ______ Relationship: ______ SS#: ______

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize Carthage Area Hospital to release any information needed to my insurance carriers to determine benefits payable for related services. I hereby assign to Carthage Area Hospital all payments for medical/surgical services rendered to me and/or my dependents. I authorize and direct any holder of medical information regarding my medical history, symptoms, treatment, examination results or diagnosis to release ALL Information to Carthage Area Hospital. I also give my permission for records FROM any physician, hospital or any other medical provider to be released BY Carthage Area Hospital as pertains to their care of me. This authorization shall remain in full force and effect until revoked in writing by myself. A photocopy of this authorization shall be considered as valid as original.

Patient/Guardian Signature: ______ Date: ______

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General Consent for Association to Hospital for Diagnosis and Treatment, Authorization and Assignment of Benefits, Release or Records or Information

General Consent for Treatment

I/the patient, ______________________________, enter Carthage Hospital voluntarily for the purpose of diagnostic and medical treatment, I hereby consent to such diagnostic procedures, hospital care, medical and X-ray treatments, and injection of pharmaceutical products or medications as may be deemed necessary by my physician, his assistants, or designees, both for myself/the patient (and my newborn, if applicable).

______________________________	______________________________	____________________
Patient/Relative/Guardian	Relationship to Patient	Date

I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the result of diagnosis, treatment, tests or examinations performed at Carthage Area Hospital. I acknowledge that the Hospital has the authority to dispose of specimens taken for laboratory or pathological examination. I give my permission for the Hospital to use my name in the general course of treatment, to identify me/my room number on patient boards/treatment schedules. I also agree to allow the Information Desk to identify me/my room number in order to allow visitation and personal telephone calls.

Authorization for Release of Information

The Hospital may disclose all or any part of my/the patient's record to any person or corporation which is or may be liable under contract to the Hospital for all or part of the Hospital's charges, including but not limited to hospital or medical service companies, billing, insurance companies, workers' compensation carriers, welfare funds or my/the patient's employer, or the Hospital's health service caring for any Hospital employees injured while rendering care to me for payment or for review or evaluation of patient care. The Hospital may disclose my Social Security number to any State or Federal government agencies, as required by law. The hospital may also release information necessary to implement proper discharge planning.

Assignment of Benefits/Payment Guarantee

I assign and instruct my insurance company(ies) to pay Carthage Area Hospital directly for hospital services. I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for charges not covered by this assignment, including collection costs. I also agree that any overpayment may be applied to any hospital account owed by me or my immediate family members. I will notify my insurance company of my emergency room visit and/or admission if such notification is required. I have obtained prior authorization according to my insurance contract for radiological and/or therapy services and may be billed accordingly.

Medicare Certification

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers, any information needed for this claim. I request that payment or authorization benefits made on my behalf.

Release from Liability

I agree that the Hospital shall not be liable for loss or damage to any personal property, including eyeglasses or dentures, which have been retained by me in my/the patient's room. Items having a monetary value that are not placed on admission, in facilities provided by the Hospital for safekeeping shall remain my/the patient's obligation and responsibility.

Receipt of Information

I confirm that I have read and understand the Patient's Bill of Rights brochure and information regarding advance directive/ Health Care Proxy and Patient's Bill of Rights. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction.

______________________________	______________________________	____________________
Patient/Relative/Guardian	Relationship to Patient	Date
______________________________	____________________	
Witness	Date	

Authorization for Release of Medical Information

Carthage Area Hospital

The Place for Personal Care

1001 West Street Road, Carthage, New York 13619 (315) 493-1000

Patient Name	Birth Date	Security Number Number	MR#

Address	Phone Number

I hereby authorize ______________________________ to disclose personal health information from the medical record of the above named patient to:

____

Name & Address of Person/Organization to which disclosure is to be made

For the following purpose: ______________________________

For the following dates of service *(must be completed)*: ______________________________

Types of Access Requested		**Select Portions Requested**	
☐ Copies of Records	☐ Entire Record (dates)	☐ Labs	☐ Operative Report
OR	☐ Emergency Room Visit	☐ Imaging/Radiology	☐ Pathology Report
☐ View Record Only	☐ History & Physical	☐ Cardiac/EKG	☐ Physician Progress Notes
	☐ Consultations	☐ Discharge Summary	☐ Other: __________

I authorize Carthage Area Hospital to discuss my medical condition and/or instructions regarding same, until such time

I state otherwise in writing, with the following individuals(s): ______________________________

____

This authorization expires ______________________________ or unless otherwise specified, 90 days from the date signed below and covers only treatment for the dates specified.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn by me by notifying Carthage Area Hospital's Medical Records Department in writing at any time, except to the extent that action has been taken in reliance upon it. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Medical Information."

______________ ______________________________ ______________

Date | Signature of Patient/Parent/Guardian/Healthcare Proxy | Relationship/Authority

____

Print Name

All fees/charges will comply with all laws and regulations applicable to release of information. Although information should not be re-disclosed, it may be dispersed by another entity during routine treatment, payment, or operations and therefore, would not be covered by Federal Regulations, Federal Register, Department of Health & Human Services, 45 CFR, Standards for Privacy of Individually-Identifiable Health Information, Section 164.524.

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APPOINTMENT POLICY

Now that you have been accepted for medical treatment, you should be aware of the following appointment policies.

All patients are treated on appointment basis only and every attempt is made to see the patient on time. Please be prompt for all scheduled appointments. If possible the patient should arrive a few minutes early to fill out necessary paperwork.

LATE SHOW

Patients who arrive late for appointments limit the amount of treatment time that can be provided for that visit. If it is determined that treatment cannot be rendered in the remaining time scheduled, the patient will be rescheduled without receiving treatment that day.

CANCELLATIONS

Patients are requested to notify the clinic 24 hours in advance if an appointment cannot be kept. This will allow us to fill the time slot with another patient that may need to be seen. Appointments cancelled with less than 24 hours notice will be regarded as a *broken appointment*.

BROKEN APPOINTMENTS

Failure to keep an appointment without 24 hours notification will be called a *broken appointment*. A patient who occurs 2 broken appointments will be place on the clinic's waiting list. Likewise, if multiple appointments have been scheduled with the Provider and 2 of the appointments were broken without notification, then the following appointments will be cancelled and the patient will be put on the waiting list. Carthage Area Hospital policy states that any patient that misses 3 or more appointments within a year will be discharged from the practice.

SCHEDULING FAMILIES

When possible, the clinic will schedule 2 patients from the same family in consecutive slots. If patients are continually late or break appointments, only 1 family member will be scheduled at a time.

Exceptions to the policies may be made is special circumstances, but only after careful consideration.

Patient's Signature: ____ Date: _____________

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FINANCIAL POLICY

Self Pay

If you do not have insurance, our staff will help you find an insurance program that best fits your needs. Our staff will tell you about Child Health Plus and Medicaid and help you apply if you meet the qualifications. Without insurance, you are responsible for payment in full at the time of service unless prior arrangements are made with our billing department. To be considered for a discount fee, you need to complete an application and show proof of income and proof of address. During this application process, you will be responsible for $50 of the day's charges at the time of service. When your application is approved and we know the percentage that you qualified for, we will adjust accordingly.

Medicaid

You are responsible for providing your card at every appointment. This card indicates the identification number, which begins with 2 alpha letters followed by 5 numbers and ending with 1 letter. If Medicaid rejects the claim for any reason, the patient will be billed directly. Adult patients are responsible for the required co-pay at the time of the visit.

Participating Insurance

Carthage Area Hospital will be happy to provide you with a list of insurance's with whom we participate. However, you are ultimately responsible for your bill regardless of insurance coverage. Co-pays are due at the time of visit. Some companies do not cover the entire cost. Deductibles and non-covered charges are the patient's responsibility.

Co-Payments

Your co-payments and other uncovered charges are **due at the time of service**. However, no patient will be turned away due to inability to pay. Additional fees may be added to your account if we have to bill you for balances after 30 days. We accept cash, check, or credit cards (Visa/MasterCard).

Non-Participating Insurance

Payment in full is due at the time of service, unless prior arrangements are made. We will gladly assist you with the information for your insurance forms if you bring them with you. You must bring all necessary information with you, including employer information. You are requested to authorize the insurance payments to come directly to Carthage Area Hospital to be more efficient in payment turnaround time. You will be responsible for following up the your insurance company.

I understand that I am responsible for all charges, regardless of insurance coverage. I hereby authorize Carthage Area Hospital to release information acquired in the course of my examination or treatment to my insurance company. I hereby authorize insurance payment to be made directly to Carthage Area Hospital for treatment, as permitted by my carrier. I also agree to pay any collection costs as outlined above.

Patient's
(legal guardian)
Signature: ______________________________ Date: ______________

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JOINT NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that we have offered you a copy of our Notice of Privacy Practices.

Patient Name (print): ____

Patient/Guardian Signature: ____

Date: ___________________

Effective Date: June 1, 2005