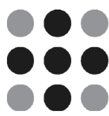

Randolph Health ASHEBORO, NORTH CAROLINA 27203

REGISTRATION FORM

PATIENT NAME AND ADDRESS	ACCOUNT NO.	ROOM/BED	TYPE	LOCATION	UNIT NO./ MEDICAL RECORD NO.
	DATE OF BIRTH	AGE	SEX	M.S.	RELIGION / RACE
PHONE	PERSON TO NOTIFY		PHONE		RELATIONSHIP
EMPLOYER	NEXT OF KIN NAME AND ADDRESS				RELATIONSHIP
GUARANTOR NAME AND ADDRESS				PHONE	
PHONE RELATIONSHIP EMP.					
FINANCIAL CLASS					

INSURANCE NAME

OCCURENCE INFORMATION	REASON FOR VISIT		
OCCURNECE DATE/TIME	COMMENTS		
ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	USER
			DISCHARGE DATE/TIME

VISIT DIAGNOSIS

1. -
2. -
3. -
4. -
5. -
6. -

VERBAL CONSENT FOR MEDICAL TREATMENT and DIAGNOSIS: Knowing that I am suffering from a condition requiring hospital care, I/we do hereby voluntarily consent to such hospital care encompassing routine diagnostic procedures and medical treatment by my physician, his assistants or his designees as is necessary in his judgment. The hospital maintains personnel and facilities to assist my providers in providing me medical care, and I/we authorize the personnel to perform on the care ordered by my providers. I/we understand that Randolph Health system has contracted with certain independent professional groups for such groups to provide certain services, and these groups are independent contractors and are not employees of Randolph Health System. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital. This consent has been fully explained to me and I certify that I understand its contents. I/we do consent to receive services by telemedicine (using interactive audio, video, or data communicated to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient) if appropriate for my condition. I/we do understand the risks, benefits, and alternatives of doing so. I/we choose to receive the service if my insurance plan may not cover or continue to cover specific services including the specific services rendered during the admission.

ASSIGNMENT OF INSURANCE BENEFITS: I/we hereby assign all my rights to Randolph Health under any policy of insurance, including but not limited to major medical insurance, hospital benefits, sick benefits, injury benefits due to me because of the liability of a third party. This assignment includes payment of hospital, surgical, medical benefits to all providers and professional groups contracted by Randolph Health and affiliates for professional services they may perform for me. I hereby give my permission for representatives of Randolph Health to represent me, and act on my behalf in the appeal process related to a denial from my Insurance provider for services related to this date of service. I give representatives of Randolph Health authority to represent my interest in a First and Second Level Review and in all possible appeals. I further understand that the person(s) that I have given permission to receive my PHI are subject to federal health information privacy laws, and that my information will be protected by federal health information privacy laws. I hereby authorize payment directly to Randolph Health of benefits otherwise payable to me, including major medical insurance, and payment of surgical or medical benefits, including major medical, directly to the attending physician, but not to exceed regular charges for these services. I understand that I am financially responsible to the hospital and physician for charges not covered by this assignment. I further agree that in the even benefits paid under this assignment or any other amounts patient by me/us or on my/our behalf exceed the amounts due Randolph Health system, my providers, or those entities for services in connection with this hospitalization, any such excess amount may be applied to any indebtedness that I or my spouse or any child for who I am financially responsible may have to the health system.

MEDICARE/MEDICAID PATIENT'S CERTIFICATION: Authorization to release information and payment request. I certify that the information given by me is applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The hospital and attending physician are authorized to release any medical information required in the processing of applications, financial coverage for services rendered during this treatment, and/or admission, and to other facilities to provide information necessary for continuity of care. In the event a medical device used in my care may require tracking by the FDA, for the purpose of complying with Federal law, the hospital is authorized to release my Social Security Number for this purpose.

RANDOLPH HEALTH IS A TOBACCO-FREE CAMPUS: Tobacco-use of any kind will not be permitted on any hospital grounds or at those facilities owned and operated by the hospital.

MONEY AND VALUABLES RELEASE: This is to certify that I have been advised by the Admitting Officer to deposit all my funds and valuables with the cashier of the hospital for safekeeping in the institution's safe. Contrary to this advice I desire to keep my money and valuables in my own custody while in the hospital and I hereby release and absolve the Hospital and its personnel from any responsibility in case a loss occurs.

COMMUNICATIONS: You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Verbal Consent to Diagnosis and Treatment Obtained from Patient

Patient Giving Verbal Consent: ______________________

Guarantor Giving Verbal Consent: ______________________ Relationship to Patient: ______________________

Witness: ______________________ DATE: ______________ TIME: ______________