bellinhealth

ADMREG ADMREG

4/5/13 Revised 1/14/20

Patient Sticker
or

Printed Name _____

Date of Birth _____

HAR # _____ *E #* _____

BELLIN HEALTH SYSTEM REGISTRATION AGREEMENT

CONSENT TO CARE: I understand that by signing this agreement, I consent to all general medical care and/or routine services, including evaluation, therapies, nursing care, and diagnostic testing provided under the general or specific instruction of my physician(s) and other health care providers, in person or via telemedicine. I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician(s) or other authorized health care providers.

NATURE OF FACILITY'S RELATIONSHIP TO STAFF: I understand there may be physicians or other health care providers who provide services at Bellin Health who are not employees or agents of Bellin Health, but rather are independent health care providers who have been given the privilege of caring and treating for their patients at a Bellin Health facility. I understand that Bellin Health's employees, agents, and representatives may follow the instructions of these independent physicians and other health care providers. I agree that Bellin Health is not liable for the actions, failures to act, or the instructions given by the independent physicians or other health care providers who treat and care for me while I am at Bellin Health.

PERSONAL VALUABLES (inpatient only): I understand I am responsible for all personal belongings during my visit. Bellin Health maintains a small safe or locked cabinet for storage of patient valuables that will be made available to me, upon request. I understand and agree that Bellin Health does not assume responsibility for any loss or damage to valuables not deposited into the safe.

SIGNATURE FOR PAYMENT: I request that payment of authorized insurance benefits be made to Bellin Health for any services provided to me by Bellin Health System. I give permission to Bellin Health to release any medical information about me to Medicare or other insurer and its agents for the purpose of deciding benefits and processing claims. I agree to be responsible for charges not covered by insurance. A financial advisor is available to help you find the best payment plan.

If I am a patient seeing a Bellin provider in a non-Bellin facility, I understand this agreement shall be in effect for the duration of one year.

I authorize Bellin Health System to act on my behalf as my authorized representative regarding all claims and appeals for the purpose of reimbursement. This may include but is not limited to: requesting prior authorization or appealing denied claims. Bellin Health System may request and receive any and all information that would be provided to me. Bellin Health System may act for me in providing information to the insurance plan that relates to claims or appeals for coverage or benefits under the plan. The insurance plan will direct all information and/or notification regarding my claim or appeal to Bellin Health System unless I otherwise provide specific written directions.

I give my permission to Bellin Health System, along with any billing service, collection agency or attorney who may work on collecting monies on Bellin's behalf, to contact me on my cell phone, home and/or work phone using prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by e-mail, text messaging, or by any other form of electronic communication.

HIPAA PRIVACY NOTICE: I have **received** a copy of the Bellin Health System Notice of Privacy Practices. Initials _____

I have **declined** a copy of the Bellin Health System Notice of Privacy Practices. Initials _____

For Bellin Health Staff Only:

☐ Documented in Epic, patient has received or declined Notice of Privacy Practices

Patient Rights & Responsibilities Brochure:

I have been **offered** a written copy of the Patient Rights & Responsibilities brochure. Initials _____

By signing this form, I understand and agree with the above printed content.

Signature: _____ Relationship: _____ Date: _____
(Patient or person legally authorized to sign for patient)

Printed Name: _____ Relationship: _____ Date: _____

AN ELECTRONIC OR PHOTOCOPY VERSION OF THIS FORM IS CONSIDERED AS VALID AS THE ORIGINAL.