bellinhealth

ADMREG

4/5/13 Revised 12/4/23

Patient Sticker
or

Printed Name _____

Date of Birth _____

HAR # _____ *E#* _____

BELLIN HEALTH SYSTEMS
REGISTRATION AGREEMENT

This Registration Agreement (this "Agreement") applies to Bellin Memorial Hospital, Inc.; Oconto Hospital & Medical Center, Inc. d/b/a Bellin Health Oconto Hospital; and Bellin Psychiatric Center, Inc. (each a, "Bellin Hospital"); and each of their outpatient primary care and specialty care clinics (each a, "Bellin Clinic" and together with Bellin Hospital, "Bellin Health").

If the services are provided in a Bellin Hospital, this Agreement applies to all services provided by the applicable Bellin Hospital on or after _____ (Todays Date) and remain in effect until such date when all treatment/hospital charges have been paid in full and there is a zero ($0) balance on my account.

If the services are provided in a Bellin Clinic, or if the services are provided by a Bellin Health provider in a non-Bellin Health facility, this Agreement applies to all services provided on or after the date this Agreement is signed below and remains in effect for a period of one (1) year thereafter.

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.

I understand that if I choose to consent to receive any specialized medical care and/or non-routine services from Bellin Health, I will have the opportunity to provide my consent for such specialized medical care and/or non-routine services separately from this Agreement.

RELATIONSHIP BETWEEN BELLIN HEALTH AND MEDICAL 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 granted clinical privileges to provide medical care and treatment to 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. I agree that Bellin Health is not liable for the actions, failures to act, or the instructions given by the independent physicians while I am at Bellin Health. I further understand that the fees of any independent health care provider are not included as a part of any bill I receive from 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. 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 all charges not covered by insurance. I understand a financial advisor is available to help me find the best payment plan. I also understand that if I receive health care services from a health care provider who is not employed by Bellin Health, I may receive a separate bill from such health care provider, and I agree to be responsible for all such charges.

I authorize Bellin Health 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 may request and receive any and all information that would be provided to me. Bellin Health 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 unless I otherwise provide specific written directions.

COMMUNICATIONS FROM BELLIN HEALTH. I authorize Bellin Health and its contractors to contact me for various purposes, including but not limited to, appointment reminders and collection of payment for services rendered, at the current or future numbers I provide for my landline telephone, cellular telephone or any wireless device. I further consent to Bellin Health's use of automated dialing equipment or prerecorded voice or text messages delivered to the current or future numbers and email addresses I provide. I understand standard messaging rates may apply to any such communications from Bellin Health.

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

I have **declined** a copy of the Bellin Health Systems 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)

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