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LOURDES

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# Conditions of Admission

**Patient Name:** _____ **DOB:** _____

**MR#:**_____ **Social Security Number:** _____

**Date of Service:** _____ **Account #:**_____

**HIPAA Information**
Visitors ☐Yes ☐No
Directory ☐Yes ☐No
Clergy ☐Yes ☐No

**Patient presented with:** ☐ **Photo ID:** _____ ☐ **Other ID:**_____ ☐ **No ID**

☐ **Consent to Hospital Admission or ☐ Medical / Dental Treatment:**

**I hereby** consent to medical care and treatment to include routine diagnostic and therapeutic procedures by Our Lady of Lourdes Memorial Hospital Inc.. **I have been** informed that Our Lady of Lourdes Memorial Hospital, Inc. and its medical staff are participating in the educational programs for Medical students, nursing students and allied health personnel approved by the State of New York. As part of these programs, students will be participating in the care of patients at Lourdes Hospital when approved by the attending physician. I understand that I will have the right to express to my provider at the time of any of my visits my wishes to consent to the participation of students in my care.

**I consent** to the Hospital to dispose of all specimens taken for laboratory or pathological examinations.

**I consent** to photographing or recording/filming, which will be used for internal purposes only.

**I understand** that I have the right to rescind consent before photographs/video recordings are actually used.

☐ **Assignment of Benefits:** In consideration of the services provided by Our Lady of Lourdes Memorial Hospital, Inc. 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 or medical treatment (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 consent to 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. This also applies to any newborn child.

☐ **Consent of Release Claim Information:** I hereby consent to Our Lady of Lourdes Memorial Hospital, Inc., its associates and agents, and members of its Medical Staff to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) hospitalization or medical care and treatment to any appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public, Title XVIII of the Social Security Act (Medicare/Medicaid), or private reimbursement, which may have a bearing on the benefits payable by or on behalf of any such person. I hereby give consent for Our Lady of Lourdes Memorial Hospital, Inc., its associates and agents to act on my behalf in completing claims forms.

☐ **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 expended when justified.

**I understand** that it is the utilization review program's responsibility to review proposed elective admissions 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.

**Pre-Certification (continued): I understand** that pre-certification may be the responsibility of the patient or financially responsible party and his or her physician.

**I understand** that Our Lady of Lourdes Memorial Hospital, Inc. is willing to admit as requested by my physician**.**

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**I also understand** that I may be financially responsible for all hospital charges incurred as a result of this admission should the utilization review program refuse to certify that the admission is appropriate, or 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 program, and personal physician without delay.

☐ **About Your Billing:** In addition to the bill you receive from Our Lady of Lourdes Memorial Hospital, Inc., you may receive a bill directly from the physician for professional services rendered. If you receive services from Radiology, Anesthesiology, or Pathology, you will receive a bill for the professional component of your treatment. Although Our Lady of Lourdes Memorial Hospital, Inc. 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 Members Services Representative with your plan for coverage determination.

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 Our Lady of Lourdes Memorial Hospital, Inc. Specific inquiries regarding professional billing for these services should be directed to the following offices:

- Millenium Medical Imaging, PC (800) 235-0045
- Riverside Associates in Anesthesia PC (607) 722-7264
- Twin Tier Pathology (607) 798-5219
- Exigence (ED) (800) 611-0750

☐ **Self-Pay:** I understand that I am financially responsible for charges or any unpaid balances for the patient account listed above. 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 has not received a determination of eligibility from the Department of Medical Assistance.

☐ **I hereby** release Our Lady of Lourdes Memorial Hospital, Inc. from all liability resulting from loss or damage to any personal effects retained by me on admission or subsequently received by me while I am a patient in this Hospital/Emergency Department. This includes prosthetic devices (denture, limbs, etc.), jewelry, eyeglasses, electrical devices, clothing, and any other personal items.

☐ **I acknowledge** that the insurance information I have provided is correct and in force at the time of this service. I understand this does not guarantee payment for services rendered.

_____

Patient Signature or Patient Representative (State Relationship to Patient) Date Time

_____

Name or Signature of Insurance Policy Holder Date Time

_____

Witness Date Time

(If required) Interpreter:_____

(Signature) (Print Name with Date /Time)