PATIENT REGISTRATION FORM

Read carefully & complete

Post Office Box 660 · 85 Sierra Park Road · Mammoth Lakes, CA 93546 · 760-934-3311 · Fax 760-924-4029 · www.mammothhospital.com

PATIENT INFORMATION Have you ever been a patient at any Mammoth Hospital facility? Y N

Last Name: ______ First Name: ______ Middle Name: ______

E-mail address ______ Cell Phone # (____) ______

Street Address/City/State/Zip ______

Mailing Address (if different than above) ______ Phone(____) ______

City ______ State ______ Zip ______ County ______ Country ______

Birth Date ______ Age ______ Sex ______

Marital Status M S D W Social Security #: ______ Refused *please initial* ______

Any changes in the above section? Yes No Initials ______

Race: ______ *or (circle)* White Native American Other Black Asian Unknown Pacific Islander

Any changes in the above section? Yes No Refused *please initial* ______

Ethnicity: ______ *or (circle)* Hispanic Non-Hispanic Unknown

Any changes in the above section? Yes No Refused *please initial* ______

Primary Language: ______

Employer's Name ______ Phone ____ ______

Employer's Address ______

Occupation ______ Full Time Part Time Self Employed Retired Student

If visiting the area, please leave a local phone # & location where you can be reached: ______

______

INSURANCE INFORMATION

Primary Insurance: ______

Group Policy ***OR*** *Individual Policy*

Address: ______

Telephone # (____) ______

ID # ______ Group # ______

Insured's Name: ______

Address: ______

Birth Date: ______ Gender M F

Employer's name: ______

Address: ______

FT PT Seasonal Retired/Date ______

Occupation ______

Relationship to Patient: ______

Secondary Insurance: ______

Group Policy ***OR*** *Individual Policy*

Address: ______

Telephone # (____) ______

ID # ______ Group # ______

Insured's Name: ______

Address: ______

Birth Date: ______ Gender M F

Employer's name: ______

Address: ______

FT PT Seasonal Retired/Date ______

Occupation ______

Relationship to Patient: ______

Third Insurance (If any) ______

*** *A copy of your insurance card and other ID is required for billing*

Any changes in the above section? Yes No Initials ______

EMERGENCY CONTACT (preferably someone outside of the home) Relationship to patient ______

Name ______

Mailing Address ______ City ______ State ______ Zip ______

Home Phone # (____) ______ Work Phone # (____) ______

CONSENT FOR TREATMENT

M.R. # ______________________

Patient Name ______________________ Date of Birth ______________________

Medical and Surgical Consent: The patient is under the control of his/her attending physicians and the Hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physicians. The undersigned recognizes that all medical doctors furnishing services to the patient, including radiologists, pathologists, anesthetists and the like are independent contractors and are not employees or agents of the Hospital.

General Duty Nursing: The Hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal from the patient. If the patient is in such condition as to need continuous or special duty-nursing care, it is understood that such care must be arranged by the patient, or his/her legal representative, or his/her physicians, and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability which may or might arise from the fact that the undersigned patient is not provided with such additional care.

Personal Valuables: It is understood and agreed that the Hospital maintains a safe for the safekeeping of money and valuables and the Hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.

Financial Agreement: The undersigned agrees, whether he/she signs as the patient or as agent, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the account of the Hospital in accordance with its financial terms (attached). Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Medicare Assignment of Benefits: If applicable, I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Assignment of Benefits: I hereby authorize payment directly to Mammoth Hospital of insurance benefits otherwise payable to me for payment of this hospitalization, but not to exceed the Hospital's regular charges. It is agreed that payment to the Hospital pursuant to this authorization by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the Hospital does not accept responsibility for collecting my insurance proceeds or negotiating a settlement on a disputed claim. It is also understood that I am financially responsible for charges not covered by this assignment.

I UNDERSTAND THAT ONCE THIS CONSENT FOR TREATMENT IS SIGNED, IT WILL REMAIN IN EFFECT FOR ALL FUTURE CLINIC VISITS UNTIL REVOKED IN WRITING.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, THE PATIENTS LEGAL GUARDIAN OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AGREEMENT AND ACCEPTS ITS TERMS.

______________________ ______________________
Signature of patient/patient's legal representative Date

____
If signed by other than patient, indicate relationship

MAMMOTH HOSPITAL Southern Mono
Healthcare District

FINANCIAL POLICY

Thank You for choosing Mammoth Hospital's Sierra Park Clinics for your health care needs.

The following is a general statement explaining our financial policies.

FINANCIAL AGREEMENT The financial agreement is a contract between you, the patient or responsible party, and the hospital.

USUAL AND CUSTOMARY RATES Fees charged at Mammoth Hospital are usual and customary for our area. You are responsible for payment in full regardless of rate reductions made by your insurance company based on their fee schedule.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Some services provided at Mammoth Hospital may not be deemed reasonable by your insurance company and may therefore be considered "non-covered". Mammoth Hospital will bill your insurance carrier as a courtesy when provided with complete and accurate information. It is YOUR responsibility to make the necessary calls to ensure your insurance company will pay for your treatment. If you are enrolled with an HMO or are assigned to a Primary Care Physician (PCP) or Primary Medical Group (PMG), it is critical that you notify them of your treatment at Mammoth Hospital. READ your insurance card or booklet for specific instructions.

NON-COVERED ITEMS

Non-covered items are services and/or supplies which may be determined by Medi-Cal, CMSP, Medicare or other insurance carriers as not medically necessary for the symptoms, diagnosis and/or treatment of a medical condition. You are financially responsible for ALL services and supplies rendered.

DENIED SERVICES

In the event that all or any portion of an insurance claim is denied by the insurance carrier, the patient/financially responsible party shall be responsible for all charges incurred.

LIMITED COVERAGE If your coverage is for emergency, accident or pregnancy. related services only, you may be responsible for emergency department charges not meeting coverage criteria.

DEFINITION OF EMERGENCY CONDITION

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical care could reasonably be expected to place the health of the individual or unborn child in serious jeopardy, impairment to bodily functions, or dysfunction of any bodily organ or part.

If you have received services such as anesthesia, emergency physician services, physician specialist consultation, had laboratory or pathology services that were sent to an outside laboratory, or arrived at the hospital via Mono County Paramedics, you will receive a separate bill from those providers. Independent physicians and service providers are not covered by Mammoth Hospital insurance contracts.

NOTE: Medicare recipients may have additional rights not outlined above.

I acknowledge receipt of Mammoth Hospital's Notice of Privacy Practices. This document provides information about how Mammoth Hospital may use and disclose my protected health information.

<u>Once this financial policy is signed, the financial responsibility will remain in effect for all future admissions until revoked in writing.</u>

I have read and understand the above statements. I acknowledge that I am fully responsible for all charges incurred.

______________________________	______________________________
Signature of Patient/Financially Responsible Party	Date
______________________________	______________________________
Patient Name	If signed by other than patient, indicate relationship

Patient Intake

MAMMOTH HOSPITAL
Southern Mono Healthcare District

__Right Handed
__Left Handed

Past Medical Information	Date	Family History	
List medical conditions:		Has anyone **in your family** had:	
1.		Heart disease	yes no
2.		Cancer	yes no
3.		Stroke	yes no
4.		High blood pressure	yes no
Current medications:		Diabetes	yes no
1.		Migraine headaches	yes no
2.		Dementia	yes no
3.		Parkinsonism	yes no
4.		Epilepsy	yes no
Allergies:		Mental illness	yes no
		Peripheral neuropathy	yes no

Surgical History	Date	Social History	
1.		Alcohol use	yes no
2.		Tobacco use	yes no
3.		Drug use	yes no
4.			

Review of Systems

Have **you** had: (please circle yes or no)

CONSTITUTIONAL		heart attack	yes no
recent fever	yes no	high blood pressure	yes no
recent weight loss	yes no	chest pain	yes no
recent weight gain	yes no	palpitations	yes no
SKIN		ankle swelling	yes no
rash	yes no	heart murmur	yes no
change in skin color	yes no	rheumatic fever	yes no
skin lumps or sores	yes no	abnormal EKG	yes no
EYES		pain in legs when walking	yes no
cataract	yes no	varicose veins	yes no
glaucoma	yes no	blood clots	yes no
dry eyes	yes no	RESPIRATORY	
excessive tearing	yes no	shortness of breath	yes no
EARS		cough	yes no
hearing loss	yes no	wheezing	yes no
ringing in ears	yes no	asthma	yes no
vertigo	yes no	bronchitis	yes no
CARDIOVASCULAR		pneumonia	yes no
heart failure	yes no	abnormal chest X-ray	yes no

Patient Signature: ______________________ Patient Name: ______________________

Medical Record #- ____________________

__Right Handed
__Left Handed

GASTROINTESTINAL		goiter	yes no
difficulty swallowing	yes no	diabetes mellitus	yes no
heartburn	yes no	high cholesterol	yes no
nausea	yes no	heat intolerance	yes no
vomiting	yes no	cold intolerance	yes no
vomiting blood	yes no	excessive sweating	yes no
black/bloody stools	yes no	excessive thirst	yes no
constipation	yes no	excessive hunger	yes no
diarrhea	yes no	HEMATOLOGIC/LYMPH.	
abdominal pain	yes no	anemia	yes no
excessive gas	yes no	easy bruising	yes no
jaundice	yes no	blood transfusion	yes no
hepatitis	yes no	vasculitis	yes no
liver disease	yes no	autoimmune disorder	yes no
gall bladder trouble	yes no	PSYCHIATRIC	
GENITOURINARY		anxiety	yes no
urinary difficulty	yes no	depression	yes no
dark urine	yes no	suicidal thoughts	yes no
bloody urine	yes no	suicide attempts	yes no
urinary infections	yes no	feelings of paranoia	yes no
kidney stones	yes no	hallucinations	yes no
loss of control of urine	yes no	delusions	yes no
sexually transmitted disease	yes no	mood swings	yes no
hernia	yes no	difficulty sleeping	yes no
MUSCULOSKELETAL		decreased sexual interest	yes no
muscle pain	yes no	NEUROLOGIC	
joint pain	yes no	loss of consciousness	yes no
stiffness	yes no	seizure	yes no
arthritis	yes no	weakness	yes no
gout	yes no	paralysis	yes no
neck pain	yes no	numbness	yes no
back pain	yes no	tingling	yes no
BREAST		tremor	yes no
breast lump	yes no	falling	yes no
breast pain	yes no	abnormal involuntary movements	yes no
nipple discharge	yes no	headache	yes no
ENDOCRINE		memory loss	yes no
thyroid trouble	yes no		

Patient Signature: ______________________ Patient Name: ______________________
Medical Record #- ______________________