New Hanover Regional
Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)
DOB: _____ MR# _____
Acct: _____

CONDITIONS OF ADMISSION TO OR REGISTRATION AT NEW HANOVER REGIONAL MEDICAL CENTER

CONSENT FOR TREATMENT: The patient is under the care of his/her attending physician(s) and the undersigned consents to any routine x-ray examination, diagnostic and laboratory procedures, or other routine medical treatment or service rendered to the patient under the general and special instructions of the physician(s). The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities.

RELEASE OF INFORMATION: The undersigned hereby authorizes the Medical Center to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of the Medical Center's charges or having the responsibility for reviewing such charges, including but not limited to the medical center or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event the undersigned must be transferred to another care provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE/MEDICAID PATIENTS: The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by or in New Hanover Regional Medical Center, including physician services, and hereby assigns such benefits otherwise payable directly to the patient, to New Hanover Regional Medical Center or the physician(s) furnishing such services. The undersigned authorizes New Hanover Regional Medical Center or such physicians to submit a claim for such services to Medicare/Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agents, claims processors or utilization reviewers, any information needed to determine these benefits or benefits for related services. The undersigned acknowledges having received a copy of "An Important Message from Medicare" and "How to Request a Review" of the Notice of Norcoverage for Medicare, also that the information contained therein has been explained to me.

ASSIGNMENT OF INDIVIDUAL BENEFITS: In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes New Hanover Regional Medical Center or physicians to submit a claim for such services, and benefits are hereby assigned to the Medical Center for application on the patient(s) bill. It is agreed the New Hanover Regional Medical Center may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information contained on the front of this form that is given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT: The undersigned understands and agrees that the patient and guarantor are financially responsible to New Hanover Regional Medical Center for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient(s) hospitalization plan, insurance, or Medicaid/Medicare. A Financial Assistance application is available to any patient or responsible party anticipating difficulty financing all or part of the patient(s) Medical Center bill. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. The undersigned hereby agrees that upon discharge of the patient by New Hanover Regional Medical Center, the undersigned will be responsible for the patient and will make necessary arrangements to have the patient transferred from the Medical Center.

PERSONAL VALUABLES: New Hanover Regional Medical Center recommends that patients permit the Medical Center to place money and other items of personal property in the Medical Center safe. The undersigned acknowledges that the patient has been given an opportunity to place such belongings in the safe and therefore, agrees that the Medical Center shall not be liable for loss or damage to any such belongings unless it was deposited with New Hanover Regional Medical Center for placement in the safe.

SELF-ADMINISTERED DRUGS: The undersigned understands that Medicare will not cover drugs that are self-administered, and agrees to pay for self-administered drugs that are supplied by the Medical Center.

I ACKNOWLEDGE THAT, IN ADDITION TO THE HOSPITAL BILL, I WILL RECEIVE SEPARATE BILLS FROM PHYSICIANS THAT MAY INCLUDE THE RADIOLOGIST, THE ANESTHESIOLOGIST, AND THE PATHOLOGIST WHEN APPLICABLE.
INITIAL _____ DATE _____

I HAVE READ, OR I HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

SIGNED _____ DATE _____ TIME _____
(Patient or Patient's Guarantor) (Relationship to patient)

Conditions reviewed & signature witnessed by: _____ DATE _____ TIME _____

THIS FORM PART OF PERMANENT MEDICAL RECORD

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