Patient Information Sheet

Service: _____ *Date:* _____ *Time:* _____

Mode of Arrival: _____

Demographics:

Patient Name: _____

Address: _____

Phone #: _____ _____ _____

DOB: _____ Gender: _____ MS: _____ SS#_____-_____-_____

Race: _____ Ethnicity: _____ Language: _____

Religion: _____ Congregation: _____

Employer: _____ PCP: _____

Veteran: _____ e-mail: _____

Guarantor (*if not patient*):

Name: _____ Relation: _____

Address: _____

Phone: _____ _____ _____

DOB: _____ SS# _____-_____-_____ Employer: _____

Emergency Contact:

Name: _____ Name: _____ Name: _____

_____ _____ _____

Reltn: _____ Reltn: _____ Relt: _____

Ph #: _____ Ph #: _____ Ph #: _____

Insurance *(Primary)*:

Company: _____ Subscriber: _____

ID/Member/Certificate #: _____ Group: _____

MMIS #: _____ Claim #: _____

Address: _____

Insurance *(Secondary)*:

Company: _____ Subscriber: _____

ID/Member/Certificate #: _____ Group: _____

MMIS #: _____ Claim #: _____

Address: _____

_____

Visit Info:

(Outpatient Only) Test: _____

(Outpatient Only) Diagnosis: _____

(Emergency Only) Symptoms: _____

Occurrence (*check*): Illness: ___ Date of Onset: _____

Accident: ___ Date of Accident: _____

Work ___ *Home* ___ *Auto* ___ *Other* _____

Ordering Physician: _____

Referring Physician: _____

Attending Physician: _____

Admitting Physician: _____

Downtime ID: _____

HAR #: _____

Registrar: _____

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CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I. Consent to Medical Care & Treatment

This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

1. I am seeking medical care and treatment at Mercy Health. I consent to the rendering of such medical care and treatment as is deemed necessary by my physician/practitioner and other members of the medical staff and by Mercy Health and its employees. I also understand that there are risks of injury from medical care and treatment and I acknowledge that no guarantees have been made to me about the outcome of my care and treatment.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, immunization administration, taking photographs/video and making audio recordings that may be used for my care and/or by Mercy Health for quality assurance purposes and clinical documentation, as well as health care operations purposes.
3. I understand that medical, nursing and allied health students train at this facility and may be involved in my care. I also understand resident physicians may also be involved in my care. All students and resident physicians are supervised by licensed and trained physicians, and I consent to care provided by them.
4. I authorize Mercy Health to allow physicians/practitioners and other healthcare facilities who are involved in my direct care and medical services coordination to receive access to my medical record contents including my test results and reports. Access to my medical record information may be exchanged in written, electronic formats or portals.

II. Notice of Legal Relationship between Hospital & Independent Medical Practitioners

1. I understand and acknowledge that Mercy Health hospitals and facilities allows physicians/practitioners who are not employed by Mercy Health to practice at Mercy Health facilities and that these providers may render professional services to me while I am in a Mercy Health hospital or facility. I understand that these care providers may include, but are not limited to emergency department physicians, anesthesiologists, certified registered nurse anesthetists, nurse practitioners, physician assistants, radiologists, pathologist, residents, students, hospitalists and may include any attending or on-call physician or other practitioner participating or consulting in the care provided. I understand that the actions of such treating physicians/practitioners, who are not agents or employees of Mercy Health, are not directed or controlled by Mercy Health and that Mercy Health relies upon these independent contractors to use appropriate professional judgment in providing care to me. Mercy Health is not responsible for the acts or omissions of any independent contractor.
2. I understand that the hospital's charges may not include the fees of my treating physicians/practitioners, if applicable. I understand that I may receive a separate bill for these services and such bills may come directly from the physician(s), such as emergency department physicians, radiologists, pathologists, anesthesiologists, hospitalists and other specialists. I understand that the level of insurance benefits payable for treatment by my treating specialist(s) may be different from the level of insurance benefits payable for treatment provided by the hospital.

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

5. I authorize Mercy Health to release my medical information (including medical information in my Mercy Health record relating to services provided to me by third parties) or other information, if required to obtain payment from my insurance or other payer and their agents to process payments.
6. I authorize Mercy Health to release my medical or other information to government agencies or their designees for review of the care provided to me.
7. Your treating physician/practitioner may order services or items that require upfront approval from your insurance company before you receive the services or items. I agree to cooperate, aid and assist Mercy Health in obtaining all possible insurance benefits for such services or items (for example: completing an application for insurance, providing timely information as requested).
8. I understand that Mercy Health offers Financial Assistance to those that meet certain eligibility criteria outlined in Mercy Health's Healthcare Financial Assistance (HFA) Policy. A copy of the Plain Language Summary of Mercy Health's HFA Policy is available upon request. I certify that I am aware of Mercy Health's HFA Policy and a copy of the Plain Language Summary has been offered to me.
9. If I make an application for Financial Assistance according to Mercy Health internal policies, Mercy Health is permitted to provide information as necessary to determine whether I am eligible for Financial Assistance.

V. Notice of Privacy Practices / Release of Information

1. I have been provided and/or offered a copy of the current Notice of Privacy Practices. I understand that the Notice of Privacy Practices outlines how my medical information may be used and disclosed, that Mercy Health will request my authorization where required, and that I have a right to request a restriction to its release.

VI. Communication to Patients

1. I consent to receive, on the cellular phone or other telephone number(s) that are listed on this form (or that are hereafter provided) text message, telephone calls or other communications for any purpose related to my current or prospective medical care, current or upcoming services offered by any authorized caller, or my account. I understand that these communications may be made using live, artificial or prerecorded voices, automatic telephone dialing systems, text message systems, e-mails or any other computer-aided technologies. I also understand that these communications may come from Mercy Health and its affiliates, clinical providers, affiliated physicians, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. This consent is not required to receive services from Mercy Health or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent at any time.

I consent [initials: _____] I do not consent [initials: _____]

VII. Responsibility for Patient Valuables

1. I agree while in the hospital to accept sole responsibility for the safety of my money and personal property (examples: electronics, dentures, eyeglasses, clothing, jewelry, etc.) and understand Mercy Heath is not liable for the safety, security or loss of money or valuables. If possible, these items should be sent home.

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CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Language Interpreters

Mercy Health provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

- ¿Habla español? Le proporcionaremos un intérprete sin costo alguno para usted. (Spanish)
- 您讲国语吗？我们将免费为您提供 翻译 (Mandarin)
- Sprechen Sie Deutsch? Wir stellen Ihnen unentgeltlich einen Dolmetscher zur Verfügung. (German)
- هل تتحدث اللغة العربية؟ سوف نوفر لك مترجمًا فوريًا بدون أي تكلفة عليك. (Arabic)
- Вы говорите по-русски? Мы абсолютно бесплатно предоставим вам переводчика. (Russian)
- Parlez-vous français ? Nous vous fournirons gratuitement un interprète. (French)
- Quý vị nói được tiếng Việt không? Chúng tôi sẽ cung cấp một thông dịch viên miễn phí cho quý vị. (Vietnamese)
- 한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다. (Korean)
- Parla italiano? Le forniremo gratuitamente un interprete. (Italian)
- 日本語を話しますか？ 個人的な負担なしで通訳を提供致します。 (Japanese)
- Ви розмовляєте українською? Ми абсолютно безкоштовно надамо вам перекладача. (Ukrainian)
- Vorbiţi româneşte? Vă vom asigura gratis un interpret. (Romanian)

Complaints and Grievances

If you believe Mercy Health has failed to provide these services or discriminated in another way on the basis listed above, you can file a grievance. Mercy Health can provide a copy upon request of its grievance filing procedures and contact information for individual(s) who can assist in filing and addressing the grievance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509 F, HHH Bldg, Washington DC 20201 1-800-368-1019 or 1-800-537-7697 (TDD)

PLAIN LANGUAGE SUMMARY OF HEALTHCARE FINANCIAL ASSISTANCE POLICY

Overview

In with the light of its mission to improve the health of its communities, with special emphasis on the poor and underserved, and in the spirit of the healing ministry of Jesus, Mercy Health is committed to providing financial assistance to its patients. This is a summary of the Mercy Health Healthcare Financial Assistance (HFA) Policy.

Availability of Financial Assistance

Eligibility for financial assistance is determined by the ability of the patient or his/her guarantor to pay after all available resources have been utilized and all available assistance programs have been assessed. Financial assistance is available for emergency and other medically necessary care provided by Mercy Health hospitals (and certain other providers) to uninsured and underinsured patients who live in the community served by a Mercy Health hospital, and whose family income does not exceed four times the Federal Poverty Guidelines (FPG).

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on the FPG. Individuals eligible for financial assistance under our Policy with an income level at 200% FPG or below receive free care. Individuals with an income level from 201% to 300% FPG, and 301% to 400% FPG, respectively, receive discounted care based on a sliding scale, as set forth in the Policy. The specific percentage discounts for the 201%-300% FPG, and 301% to 400% FPG, income levels are updated annually for each market commensurate with changes in the charge master.

No person eligible for financial assistance under the HFA policy will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. For those uninsured patients who do not qualify for any of the financial assistance discounts described in the HFA policy, Mercy Health extends an automatic (self-pay) discount to their hospital bills. Please refer to the full HFA Policy for a complete explanation.

About the Application Process

The process for applying for financial assistance under our HFA Policy includes these steps:

- Complete the HFA Application Form and include required supporting documents.
  - We look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on FPG outlined above.
  - We require that you must first explore eligibility for some type of insurance benefits that would cover your care (i.e. worker's compensation, automobile insurance, etc.) We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for financial assistance under our HFA Policy.
- We can help you arrange a payment plan for any remaining charges or bills that are not covered under our HFA Policy.
  - A payment plan will consider your financial situation to set payments that you can manage.

Where to Obtain Information

You may obtain a copy of our HFA Policy and the HFA Application Form, as well as information about the financial assistance application process: (i) by visiting our website at http://www.mercy.com/financial-assistance, (ii) by contacting Mercy Health Patient Financial Services by telephone at 1-877-918-5400, (iii) by mailing a request to Mercy Health, 4605 Duke Dr. Suite 600, Mason, OH 45040, Attn: Financial Counseling, or (iv) by contacting our financial counselors in person at any of our hospital locations (see the full HFA Policy for a complete listing of facilities and addresses).

We accommodate all significant populations served by Mercy Health that have limited proficiency in English by translating copies of our HFA Policy, Application Form, and this Summary in the primary languages spoken by those populations. We may also elect to furnish translation aids, translation guides, or provide assistance through use of qualified bilingual interpreters.

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Bar Code/Related Information

COORDINATION OF BENEFITS

Patient Information

Account #: _____

Admit Date: _____

Patient Name: _____

Patient DOB: _____

Primary Insurance

Insurance Plan Name: _____

Subscriber Name: _____

Insurance Policy #: _____

Insurance Group #: _____

Your insurance policy may contain a Coordination of Benefits (COB) provision. This form confirms that you or any other member of this insurance policy does or does not have another medical or dental insurance policy. If you have any questions regarding this questionnaire or if the information below changes, please contact the number found on the back of your insurance identification card.

Is this condition related to:

☐ Personal Injury
☐ Personal Illness
☐ Work Related Injury (Third Party Insurance Company)
☐ Automobile Collision (Third Party Insurance Company)

☐ I am covered by one ONLY insurance as listed above. I am covered for this insurance by my:

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Third/Other Party ☐ Other

If other, please specify: _____

☐ In addition to the insurance listed above, I am also covered by the insurance policy below:

Secondary Insurance

Name of Other Health Insurance Company

Health Insurance Policy/ID Number

Name of Guardian/Policy Holder

Guarantor/Policy Holder Relationship to Patient

Guarantor/Policy Holder Date of Birth

Printed Name

Third Party Liability

Name of Third Party Insurance Company

Third Party Insurance Policy/ID Number

Name of Third Party Insurance Adjuster

Policy Holder Telephone Number

Date of Injury

Date

X-1-814-075-1216