



Cass Regional Medical Center

2800 Rock Haven Road • Harrisonville, MO 64701
(816) 380-3474 • Fax: (816) 380-6526

OUTPATIENT REGISTRATION

Last Name	First Name	Middle Name	DOB	
Referring/Ordering Physician		Primary Care Physician		
Home Address	SSN	Home Phone	Sex	Marital Status
Employer	Address		Phone Number	
Guarantor (Name, Address, Phone)		Employer (Name, Address, Phone Number)		
Next of Kin	Relationship	Address	Phone Number	
Primary Insurance	Address		Phone Number	
Subscriber	Policy/Group #		Subscriber's Relationship	
Secondary Insurance	Address		Phone Number	
Subscriber	Policy/Group #		Subscriber's Relationship	
Comments:				
Accident:				
<input type="checkbox"/> Yes	Date: _____	Where: _____		
<input type="checkbox"/> No	Time: _____	How: _____		

CONDITIONS OF ADMISSION AND CONSENT FOR MEDICAL TREATMENT FORM

CONSENT FOR TREATMENT: I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instruction of my physician.

PATIENT SELF-DETERMINATION ACT: I have been offered information regarding Advanced Directives (such as durable powers of attorney for healthcare and living wills), and have been informed that I may receive a copy of this information at any time during my hospital stay. I have been informed that a Patient Handbook containing patient rights and responsibilities and other information relating to my stay is available to me in the Registration/Admitting area or at my request during my hospital stay.

Please initial the following applicable statements:

- I have executed an Advanced Directive and have been requested to supply a copy to the Hospital. ()
- I have not executed an Advanced Directive. ()
- I wish to execute an Advanced Directive at this time. ()
- I do not wish to execute an Advanced Directive at this time. ()

ASSIGNMENT OF BENEFITS: In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage to pay the Hospital directly for the services the Hospital provides me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital, I hereby irrevocably assign and transfer to the Hospital all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital to pursue any such right to recovery. In no event will the Hospital retain benefits in the excess of the amount owed to the Hospital for the care and treatment rendered during the admission. I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital.

FINANCIAL AGREEMENT: In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates established by the Hospital for the services provided. In the event that the Hospital has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by the Hospital. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. The Hospital will provide a medical screening examination to all patients who are seeking emergency medical services to determine if there is an emergency medical condition, the Hospital will provide stabilizing treatment. However, patients are not relieved of their obligation to pay for these services if they have the ability to pay.

PATIENT RIGHTS: I acknowledge that I have been given information and instruction regarding my Patient Rights, which include, but are not limited to, the right to make medical decisions, including the right to accept or refuse medical treatment, to participate in my plan of care and to receive care in a safe setting, free from verbal or physical abuse or harassment. I acknowledge that I have also received information about the Hospital's grievance process.

PRIVATE ROOM: I understand and agree that the patient or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and use of a private room.

COMMUNICATIONS ABOUT MY HEALTHCARE: I authorize the disclosure of my personal health information for purposes of communicating results, findings, and care decisions to those individuals with a pass-code consisting of the last four (4) digits of my patient account number for their use in obtaining information when I am not present or I am incapacitated.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Hospital's Notice of Privacy Practices, which describes the ways in which the Hospital will use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Hospital Privacy Officer designated on the Notice if I have a complaint.

Acknowledged: _____ (Initial)

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: I certify that the information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the Hospital by the Medicare or Medicaid Program.

PHOTOGRAPH CONSENT: Consent to have my photograph posted to the Electronic medical Record for identification purposes only. I understand that this photograph will not be posted or published for public viewing. ____ Yes, I consent to the use of my photograph for identification purposes. ____ No, I refuse to be photographed. _____ (Initial)

OTHER ACKNOWLEDGMENTS:

- A. Legal Relationship Between Hospital and Physicians: I acknowledge and agree that neither this Hospital or any outpatient department, clinic, or other healthcare entity operated as part of this Hospital to which I may be transferred or in which I may be treated is responsible for the judgment or conduct of any physician who treats or provides a professional service to me. I understand that other physicians may be called upon to provide care, either directly (as consultants) or indirectly through professional services (i.e., radiology, pathology, EKG interpretation, and anesthesiology). I acknowledge and understand that for emergency or unscheduled services, the Hospital may aid my selection of physicians by an established "on-call" roster provided through each department of the Hospital. I further agree that the Hospital is not responsible for the judgment or conduct of any of the physicians identified above.
- B. No Guarantees: I am aware that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been given to me as to the results of treatments, examinations, emergency services, or hospital care.
- C. Professional Services: I understand that there will be a separate charge for professional services, such as physician services. I understand that the Hospital bills for some but not all professional fees; professional fees not billed by the Hospital will be billed separately.
- D. Private Duty Nursing: The Hospital provides general nursing care on units other than intensive care or intermediate care units. If you or your family need or desire a private duty nurse, you must make arrangements for this service. You will be responsible for paying a private duty nurse directly.
- E. Personal Valuables: I understand 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, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.
- F. Weapons/Explosives/Drugs: I understand and agree that if the Hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

I hereby certify and state that I have read, and that I fully and completely understand this Conditions of Admission and Consent for Medical Treatment, and that I have signed this Conditions of Admission and Consent for medical Treatment form knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

Patient's Signature

Signature of Patient's Legal Representative, if applicable

Date

Printed Name of Legal Representative (if any)

Representative's Authority to Act for Patient: Witness

Date

The patient is unable to sign for the following reason: