EMORY
HEALTHCARE

EMORY UNIVERSITY HOSPITAL
THE EMORY CLINIC
EMORY UNIVERSITY HOSPITAL MIDTOWN
EMORY UNIVERSITY ORTHOPAEDICS & SPINE HOSPITAL
EMORY CHILDREN'S CENTER
WESLEY WOODS GERIATRIC HOSPITAL
BUDD TERRACE
EMORY DIALYSIS, LLC
EMORY SPECIALTY ASSOCIATES
WESLEY WOODS LONG TERM ACUTE CARE HOSPITAL
EMORY JOHNS CREEK HOSPITAL
EMORY SAINT JOSEPH'S HOSPITAL
EMORY UNIVERSITY HOSPITAL SMYRNA

# Admission/Registration Agreement

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

I. **CONSENT FOR TREATMENT:** I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my admission to an Emory Healthcare Hospital or my outpatient care at an Emory Healthcare facility. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I understand that Emory Healthcare's mission includes training physicians and other medical personnel and conducting medical research. I acknowledge that students may participate in my care. If I am asked to participate in a research study, I may refuse to participate and my refusal will not affect or compromise my access to medical services.

II. **INDEPENDENT CONTRACTORS:** I understand that some of the health care professionals providing care, treatment and services at the Emory Healthcare Hospitals or facilities are independent contractors, and are not agents or employees of the Hospitals or Emory Healthcare. Independent contractors are responsible for their own actions and neither the Hospitals nor Emory Healthcare shall be liable for the acts or omissions of any such independent contractors.

III. **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE:** If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for admission to and for services provided to me by an Emory Healthcare facility, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered during my admission to the Emory Healthcare facilities that provide services to me. I authorize payment of benefits directly to such Emory Healthcare facilities,with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not precertified or not preauthorized by my insurance plan.**

If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act - (ERISA), in order to assist me in obtaining my benefits: I authorize and appoint Emory Healthcare to act as my representative, when Emory Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.

IV. **PERSONAL VALUABLES:** I understand that Emory Healthcare Hospitals and Budd Terrace maintain a safe for patient money and valuables and that neither the Hospitals *nor* Budd Terrace nor any Emory Healthcare facility shall be legally responsible for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of value, unless deposited with Emory Healthcare staff for safekeeping.

V. **CONSENT FOR DISCLOSURE OF INFORMATION:** I understand the Emory Healthcare facilities are permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by the Emory Healthcare facilities only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary for purposes related to filing a claim for payment, or, if I am being evaluated for a transplant, for purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my discharge or transfer from an Emory Healthcare facility.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

VI. **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory University, Inc. d/b/a Emory University Hospital, Emory University Orthopaedics & Spine Hospital and Emory University Hospital Midtown; The Emory Clinic, Inc. (and the Ambulatory Surgery Center); Emory Healthcare, Inc.; Emory Children's Center, Inc.; Wesley Woods Long Term Acute Care Hospital; Wesley Woods Center of Emory University, Inc. (Wesley Woods Geriatric Hospital and Budd Terrace); Emory Johns Creek Hospital, or their employees or agents ("Emory"), except as otherwise provided herein, shall be resolved by final and binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses any claims arising out of or relating to health care services which shall be provided to me upon this admission as well as all health care services provided to me by Emory in the future, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia in accordance with the Rules and Procedures of Henning Arbitration and Mediation Services, Inc., a copy of which is available to me upon request. I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

**NOTE:** If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Emory for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

DATE: _____ _____

PATIENT, PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

VII. **PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS:** I understand that the physicians or staff at certain of the Emory Healthcare facilities may request to take photographs, videotapes or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Emory Healthcare, including, but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VIII. **HOSPITAL PATIENT DIRECTORY:** If I am a hospital patient, I understand the following information will be included in the Hospital Directory – my Name, my Room Number/Location, my General Condition such as Fair, Stable or Critical, and my Religious Affiliation (if expressed). I understand that my location in the hospital and my general condition will be provided to persons who inquire about me by name, and that my religious affiliation along with the other directory information will be provided to members of the clergy who request information on patients based on their religious affiliation. Patients in an Emory Healthcare Mental Health Unit are not included in the Hospital Directory.

*If you are a hospital patient and do not want your information included in the Hospital Directory, please check Opt-Out of Hospital Directory below and initial.*

• I Opt Out of the Hospital Directory _____ *(please initial)*

IX. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received the Emory Healthcare Notice of Privacy Practices. _____ *(please initial)*

X. **MEDICATIONS ASSISTANCE PROGRAM:**

In some cases, the hospital is able to obtain reimbursement for some of your medications from companies that manufacture them. When this occurs, the cost of the medication is removed from the charges on your hospital stay. Most of these programs require your signature on the applications forms. So that you do not have to sign this application for each medication, we are requesting that you allow a Pharmacy Healthcare Solutions ("PHS") representative to sign these forms on your behalf.

I appoint PHS to carry out in my name, the application forms required for PHS to obtain replacement of my medications from pharmaceutical manufacturers. This document will be in full force from the date signed.

The date of this Admission Agreement is (insert today's date) _____ Time _____

_____ _____

Witness Signature of Patient or Patient's Representative

_____ _____

Relationship of Representative to Patient

_____ _____

Interpreter name/operator number Date