INSTRUCTIONS FOR HOSPITAL REGISTRATION FORMS

IF YOU CHOOSE TO FAX:
UPON COMPLETION OF FORMS A,B,C, LENOX HILL HOSPITAL FINANCIAL STATEMENT, AND CONSENT TO SURGICAL PROCEDURE, PLEASE FAX TO 1-866-231-1027

IF YOU CHOOSE TO MAIL:
SEND COMPLETED FORMS A, B, AND LENOX HILL HOSPITAL FINANCIAL STATEMENT FORMS TO:
FINANCIAL CLEARANCE CENTER
LENOX HILL HOSPITAL
210 EAST 64TH STREET
NEW YORK, NY  10131-0041

PLEASE BRING FORM C (PATIENT QUESTIONNAIRE) AND CONSENT TO SURGICAL PROCEDURE ON THE DAY OF SURGERY.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT ME AT THE OFFICE.

SARAH
### Lenox Hill Hospital

**FORM A REGISTRATION**

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
</tr>
</thead>
</table>

**Address:** Street  
**City**  
**State**  
**Zip**

**County Of Residence:**  
**Phone:**

**S.S. #:**

**RACE:**  
- [ ] Asian  
- [ ] Black  
- [ ] White  
- [ ] Hispanic  
- [ ] American Indian

**SEX:**  
- [ ] Male  
- [ ] Female

**MARITAL STATUS:**  
- [ ] Married  
- [ ] Widowed  
- [ ] Single  
- [ ] Divorced  
- [ ] Separated

**DATE OF BIRTH**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Mother's Maiden Name:**

**Patient's Maiden Name:**

**Place of Birth:**

**Are you an Employee of LHH / MEETH?**  
- [ ] Yes  
- [ ] No

**Religion:**

**Advance Directives:**  
- [ ] Yes (Provide Copy)  
- [ ] No  
- [ ] Healthcare Proxy  
- [ ] Living Will  
- [ ] Do Not Resuscitate  
- [ ] Other:

**Do You Carry An Organ Donors Card?**  
- [ ] Yes  
- [ ] No

**Occupation:**

**Employer:**

**Employer Address:**

**Employer's Phone:**

**EMPLOYMENT STATUS:**  
- [ ] Employed  
- [ ] Disabled  
- [ ] Unemployed  
- [ ] Retired

**Length of Service With Current Employer:**

**CI:**

**State:**

**Zip**

**Accident Information**

**IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL**

**Type of Accident:**  
- [ ] Work Related  
- [ ] Auto  
- [ ] Home  
- [ ] School  
- [ ] Other

**Date of Accident:**

**Time of Accident:**  
- [ ] AM  
- [ ] PM

**Location of Accident:**

**PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS**

**Name of Person on Insurance Card:**

**Name:**

**Address:** Street  
**City**  
**State**  
**Zip**

**County of Residence:**  
**Phone:**

**Social Security #:**

**Employment Status:**  
- [ ] Employed  
- [ ] Unemployed  
- [ ] Disabled  
- [ ] Retired  
- [ ] Male  
- [ ] Female  
**Birth Date**

**Occupation:**

**Employer:**

**Employer Address:**

**Employer's Phone:**

**EXT:**

**PERSON TO CONTACT IN AN EMERGENCY**

**Relationship to Patient:**

**Name:**

**Address:** Street  
**City**  
**State**  
**Zip**

**Home Phone:**

**Work Phone:**

**LEGAL NEXT OF KIN**

**Relationship to Patient:**

**Name:**

**Address:** Street  
**City**  
**State**  
**Zip**

**Home Phone:**

**Work Phone:**

**MISCELLANEOUS**

**Have you ever been an inpatient at Lenox Hill Hospital / MEETH?**  
- [ ] Yes  
- [ ] No

**If yes, under what name?**

**Dates:**

**Have you been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days?**  
- [ ] Yes  
- [ ] No

**If yes, under what name?**

**Dates:**

**Name of institution:**
**FORM B REGISTRATION**

**Date of Surgery:**

**Physician's Name:**

**INSURANCE INFORMATION**

PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.

### MEDICARE

**SOCIAL SECURITY ACT**

Name of Beneficiary

Claim Number

Sex

Is Entitled To

Effective Date

Hospital (Part A)

Hospital (Part B)

**MEDICARE PATIENTS OR SPOUSE**

ARE YOU RETIRED? □ YES □ NO

IS YOUR SPOUSE RETIRED? □ YES □ NO

DATE OF RETIREMENT

PATIENT SPOUSE

### OTHER BLUE CROSS

**BLUE CROSS/BLUE SHIELD OF STATE**

SUBSCRIBER'S NAME

IDENTIFICATION

### OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

Name on Card

Policy Number

Payor ID Number

Group Name

Employer Name

Address

Phone

Insurance Company Name

Address

Phone

### WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY

EMPLOYER

WCB #

Accident Date / / Accident Time □ AM □ PM

Claim Filed: □ Yes □ No

### NO FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY

CAR OWNER

INSURANCE AGENT OR ATTORNEY

ACCIDENT DATE / / Accident Time □ AM □ PM

POLICY NO. □ YES □ NO

### MEDICAID

NAME ON CARD

ID NUMBER

ISO #

ACCESS NUMBER

SEQ #

□ SELF PAY/UNINSURED
**Patient Questionnaire**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Surgeon:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned procedure:</td>
<td>Please check any symptoms you have recently experienced:</td>
</tr>
<tr>
<td></td>
<td>□ Fever / chills □ Weight loss</td>
</tr>
<tr>
<td></td>
<td>□ Weakness □ Fatigue</td>
</tr>
<tr>
<td></td>
<td>□ Pain (identify location):</td>
</tr>
</tbody>
</table>

**Please list ALL Past Surgeries:**

| ANESTHESIA problems: □ Yes □ No |
| If Yes, please list: |

**Please list ALL Medications, Including Dosage:**

| Please list ALL Medical Conditions: |
| □ Anxiety □ Kidney disease |
| □ Arthritis □ Liver disease |
| □ Asthma □ Pacemaker |
| □ Bleeding problems □ Palpitations/irregular heart |
| □ Bronchitis □ Pneumonia |
| □ Chest pain □ Reflux |
| □ COPD □ Seizure |
| □ Depression □ Shortness of breath |
| □ Diabetes □ Sickle cell |
| □ Excessive bruising □ Sleep apnea |
| □ Glaucoma □ Stroke |
| □ Heart Attack □ TB |
| □ Heat/Cold problems □ Thyroid disease |
| □ Hiatal hernia □ Ulcer |
| □ High blood pressure □ Urinary problems |

**List any Allergies (medications/food/inhalant):**

| Family History of Medical Conditions: |
| □ Asthma □ Heart |
| □ Cancer □ High blood pressure |
| □ Diabetes □ Stroke |
| □ Emphysema □ Other: |

**Do you smoke? □ Yes □ No**

**Did you previously smoke? □ Yes □ No**

**Packs per day: ______ for ______ years Quit ______**

**Do you drink alcohol? □ Yes □ No**

**Number of drinks per week ______**

**Do you use recreational drugs? □ Yes □ No**

**Please list ______ How often ______**

**Please list any non-prescription medications: (e.g. cold tablets, vitamins):**

| Please list any HERBAL: (e.g. Cava-Cava, Ginkgo, Ginseng, St. John's wort, Echinacea): |
| Date: ____________________ | Patient Signature: ____________________ |
There are four separate statements on this form. If you have any insurance coverage such as Blue Cross, Commercial Insurance, Medicare, or if your hospital service will be for a condition as a result of a motor vehicle or employment related accident please complete sections 1, 2 and 4.

MEDICARE PATIENTS MUST ALSO SIGN # 3.

Your signature is required in each of the areas to:

1. Allow us to release information needed by your insurance carrier to pay the claim, either to you or to Lenox Hill Hospital.

2. Permit the insurance company to pay the bills we submit directly to Lenox Hill Hospital.

3. Serves the same purpose as #1 & #2 above and contains the special wording which Medicare requires in order for us to release information or receive payment from Medicare.

4. Acknowledge that you understand you are financially liable for any services we render which are not paid by insurance.

PLEASE READ THE STATEMENTS CAREFULLY AND SIGN IN EACH PLACE AS INDICATED. KEEP THE YELLOW COPY FOR YOUR RECORDS.
FINANCIAL AGREEMENTS

1. RELEASE OF INFORMATION

I hereby authorize and direct Lenox Hill Hospital and/or any physician or organization providing medical services to release to governmental agencies, insurance carriers, or others who are, or may be, financially responsible for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to my care and treatment.

DATE ____ / ____ / ____                  SIGNATURE ______________________________________________________

2. ASSIGNMENT OF BENEFITS

I hereby assign to Lenox Hill Hospital and/or any physician or organization providing medical services any and all benefits, including benefit of payment, to which I may be entitled from any governmental agency, insurance carrier, or others who are financially responsible for the hospitalization and medical care rendered to me or my dependant at said hospital.

DATE ____ / ____ / ____                  SIGNATURE ______________________________________________________

3. MEDICARE INSURANCE

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information regarding my treatment, to release to the Social Security Administration and/or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare in my behalf.

DATE ____ / ____ / ____                  SIGNATURE ______________________________________________________

4. FINANCIAL AGREEMENT & GUARANTEE

For services rendered or to be rendered, the undersigned (jointly or severally) promise to pay to Lenox Hill Hospital, New York, New York and/or any physician or organization providing medical services the full and entire amount of any and all bills not paid by my hospitalization insurance plan, private or governmental, or combination of plans. I understand that all such bills are due and payable upon presentation; are in accordance with the posted charges of the hospital which are available upon request. Payment may be demanded at any time from either of the undersigned and failure to demand payment of the patient shall not be a prerequisite to the guarantors immediate responsibility for payment.

We agree that if all or part of the patient's hospital bill is rejected by Blue Cross, Medicare, Medicaid, Workman's Compensation, or other hospital insurance plan, payment of the balance shall be due immediately upon notice. While the patient is in the hospital, we agree to pay hospital bills rendered on a weekly basis for services not covered by the patient's insurance plan.

WE HAVE READ THIS AGREEMENT AND WE FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE. WE HAVE RETAINED A COPY OF THIS AGREEMENT.

DATE ____ / ____ / ____                  SIGNATURE ______________________________________________________

PATIENT OR RESPONSIBLE PARTY
(PARENT IF A MINOR)

ORIGINAL

LH # ADM-159A
CONSENT TO SURGICAL PROCEDURE,
INVASIVE TEST, PROCEDURE,
TREATMENT and/or ANESTHESIA

I hereby authorize Dr. ____________________________, and his/her associates or assistants to perform upon the named patient or me the following surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s):

____________________________________________________________________________________________________________________________________________________________

including such photographing, videotaping, televising or other observation of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) has/has been explained to me and I have also been informed of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) that unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) which the above-named physician or practitioner or his/her associates or assistants may consider necessary.

I consent to the release of my social security number to the manufacturer of any device that is surgically implanted in me during my admission. I understand release of my social security number is for the purpose of helping the manufacturer locate me if there is a need to contact me with regard to the implanted medical device.

I further consent to the administration of blood transfusion(s) during surgery and during the Recovery Room period as may be considered necessary. I recognize that there are always risks to life and health associated with blood transfusion(s) and such risks have been fully explained to me. The benefits of blood transfusion(s) and alternatives to their use have also been explained to me.

I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary will be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use will also be explained to me.

I understand any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s).

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above, which do not pertain to me.

Patient/Healthcare Agent/Guardian/Next-of-kin: ____________________________  Signature

Print Name  Date/Time

Relationship (if signed by other than patient): ____________________________

Witness: ______________________________________________________________________________________________  Signature

Print Name  Date/Time

Interpreter: ___________________________________________________________________________________________  Signature

Print Name  Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) and blood transfusion(s) have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: ____________________________  Signature/Title

Print Name  Date/Time

LH183 (11/27/03) 1.2
SEDATION ANALGESIA CONSENT

I hereby authorize Dr. ______________________________ and his/her associates or designees to administer sedation analgesia to me/the patient during the performance of: (Name of Procedure(s))

________________________________________________________________________

The risks, benefits and alternatives to sedation analgesia, including withholding sedation analgesia, have been explained to me. I acknowledge that I have been given an opportunity to ask any questions I have concerning the administration of sedation analgesia and my questions have been answered fully and to my satisfaction.

Patient/Healthcare Agent/Guardian/Next-of-kin: ______________________________
Signature
________________________________________________________________________
Print Name
Date/Time
Relationship (If signed by other than patient): ______________________________
________________________________________________________________________
Witness: ______________________________
Signature
Print Name
Date/Time
Interpreter: ______________________________
Signature
Print Name
Date/Time

Physician/Practitioner Certification
I hereby certify that the nature, purpose, benefits, risks of, and alternatives to sedation analgesia, including no sedation analgesia have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: ______________________________
Signature/Title
Print Name
Date/Time

UNAUTHORIZED DEPARTURE (AGAINST MEDICAL ADVICE) DOCUMENTATION

I acknowledge that ______________________________ (Name of Patient) is leaving the Hospital against the advice of Dr. ______________________________ and his/her associates or assistants. I have been advised of the potential risks of leaving against medical advice. I have been provided with an opportunity to ask questions about my/the patient's care and the potential consequences of my/the patient's actions. All of my questions have been answered. I agree not to hold the Hospital, its agents, servants and employees and Dr. ______________________________ responsible for any harm or injury that may result from my action.

Patient/Healthcare Agent/Guardian/Next-of-kin: ______________________________
Signature
________________________________________________________________________
Print Name
Date/Time
Relationship (If signed by other than patient): ______________________________
________________________________________________________________________
Witness: ______________________________
Signature
Print Name
Date/Time
Interpreter: ______________________________
Signature
Print Name
Date/Time

Physician/Practitioner Certification
I hereby certify that the nature, purpose, benefits, risks of, and alternatives to the patient leaving the Hospital against medical advice have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: ______________________________
Signature/Title
Print Name
Date/Time