



FLOYD
REGISTRATION CONSENT



TO: FLOYD HEALTHCARE MANAGEMENT, INC., OWNER AND OPERATOR OF FLOYD MEDICAL CENTER, HEREINAFTER CALLED THE "HOSPITAL," AND THE EMERGENCY DEPARTMENT PHYSICIANS, HEREINAFTER CALLED "EDP," AND ALL OTHER PHYSICIANS.

I, THE PATIENT, HEREBY REQUEST THAT I RECEIVE TREATMENT/CARE DURING THIS HOSPITAL ADMISSION, EMERGENCY DEPT OR OUTPATIENT VISIT. I UNDERSTAND THAT IF I AM TO BE PROVIDED A SERIES OF ONGOING SERVICES BASED ON MY PHYSICIAN'S ORDERS, THAT MY CONSENT AND AUTHORIZATION WILL BE ACQUIRED ONLY ONCE FOR ALL SERVICES PROVIDED IN THE SERIES. I VOLUNTARILY MAKE AND EXECUTE THE FOLLOWING AUTHORIZATIONS, CONSENTS, ASSIGNMENT, CERTIFICATION AND REQUESTS.

PATIENT'S AUTHORIZATION AND CONSENT FOR MEDICAL AND SURGICAL TREATMENT, ANESTHESIA, X-RAY EXAMINATION, CONSENT TO SEARCH, PHYSICAL RESTRAINTS, DISPOSAL OF TISSUES, AND OTHER RELATED MATTERS

I hereby authorize and consent to such tests, examinations, care and treatments, including, but not limited to surgical operations, anesthesia (either local or general), x-ray examination or treatment, and physiotherapy as may be requested by attending physician or any other physicians involved in my care. I hereby authorize any physician on duty in the Emergency Department of the hospital and any other member of the Medical Staff and any Physician Resident in training, to administer such medical and surgical treatment to me as he or they deem necessary. I consent to the search of my person and to reasonable physical restraints should any physician deem advisable in view of my condition. I also consent to the disposal of tissues or parts removed by or in the course of any surgical operation, which maybe performed. Consent is also given that such other physicians, physicians' employees, medical device manufacturer representatives, and Hospital personnel as may be reasonably required or desirable, and student nurses and other personnel in regular training at the Hospital, may assist in and/or observe such operations or procedures. I consent to being photographed, video- or audio taped should such images be necessary for the purpose(s) of identification, medical record documentation, or for performance improvement activities within the organization.

I understand and acknowledge that some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions, and the hospital shall not be liable for the acts or omissions of any such independent contractors.

PATIENT'S ASSIGNMENT OF INSURANCE BENEFITS FOR HOSPITAL/PHYSICIAN SERVICES, GUARANTEE OF ACCOUNT, AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby irrevocably transfer and assign to the Hospital, EDP and all other physicians all insurance benefits otherwise payable to me but not to exceed the Hospital's or EDP's or all other physicians regular charges rendered to me for this period of hospitalization. I authorize my insurance carrier, third party payor or managed care organization to pay such benefits directly to the Hospital, EDP and all other physicians in my behalf. I understand that I am financially responsible to the Hospital, EDP and all other physicians for charges not paid under the assignment. In the event that in addition to hospital, EDP and all other physicians' benefits, I am entitled to any insurance or other benefits covering other physician services, I hereby assign said benefits to the physicians rendering care or treatment to me during this stay or outpatient visits, to be applied to my bill from such physician. For and in consideration of services rendered by the Hospital, EDP, or other physicians to the below named patient, the undersigned jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. I understand that I am financially responsible to the Hospital for charges not paid under the assignment. I further authorize any holder of medical information or records concerning me to release such information or records to my insurance carrier, third party payor, managed care organization or to any other insurance carrier, including worker's compensation carriers, against which I have made, or shall hereafter make, a claim. I further understand that it may be necessary to contact my past or present employer(s) in regards to this claim. I permit a copy of this authorization to be used in place of the original.

PATIENT'S MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

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 information about me or any other information needed for this or related Medicare claims to be released to the Health Care Financing Administration or its intermediaries or carriers, and its agents. I request that payment of authorized Medicare benefits be made on my behalf. I assign the benefits payable for EDP, other physician services, or hospital services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

MEDIGAP AND MEDICAL ASSISTANCE

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the Hospital, EDP, or other physicians for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, managed care organization or to any other insurance carrier, including worker's compensation carriers. My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

IF THIS IS A PSYCHIATRIC, ALCOHOL OR DRUG ABUSE VISIT/ADMISSION WE WILL BE VERIFYING YOUR INSURANCE WITH YOUR THIRD PARTY CARRIER.

SIGNATURE OF PATIENT _____

SIGNATURE OF PERSON ACTING FOR PATIENT _____

RELATIONSHIP TO PATIENT _____ DATE _____

- It is impractical for the patient to execute the document because patient's mental or physical condition is such that patient should not be asked to transact business.
The patient is a minor.
I hereby acknowledge that I have received smoking cessation information from this hospital.

Patient Identification Sticker



FLOYD
ADULT PATIENT DEMOGRAPHIC INFORMATION



Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City / State / Zip Code: _____ County: _____

Phone No.: _____ Cell No.: _____ Sex: M or F DOB: _____

Social Security No.: _____ Marital Status: S M D W Race: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____ Retired?: Y or N If yes, date retired: _____

Emergency Contact Information

Name of Contact: _____ Relationship to Patient: _____

Phone No. of Contact: _____

Does the Patient have Insurance Coverage through a relative, spouse or parent/guardian? Y or N
If Yes, please complete the below information. If No, the form is completed.

Policy Holder's Information

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City / State / Zip Code: _____ County: _____

Phone No.: _____ Sex: M or F DOB: _____

Social Security No.: _____ Marital Status: S M D W Race: _____

Relationship to Patient: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____ Retired?: Y or N If yes, date retired: _____

Other Policy Holder's Information

(If there is another insurance)

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City / State / Zip Code: _____ County: _____

Phone No.: _____ Sex: M or F DOB: _____

Social Security No.: _____ Marital Status: S M D W Race: _____

Relationship to Patient: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____ Retired?: Y or N If yes, date retired: _____



FLOYD
ADULT MEDICAL HISTORY



Name: _____ Diagnosis: _____

Date of Birth: _____ Sex: M or F

If female, are you pregnant? Yes or No

Primary Language Spoken:

Referring Physician: _____

- ENGLISH
- SPANISH
- OTHER

Occupation: _____

** Do you have any religious or cultural concerns that will affect your care/treatment?

Please check any of the following that apply:

ANEMIA	HEAD INJURY	MENINGITIS	SKIN DISORDERS	ARTHRITIS
HEADACHES	NERVOUSNESS / BREAKDOWN	STROKE	BLEEDING DISORDER	HEART CONDITION
HIGH BLOOD PRESSURE	TUBERCULOSIS	CANCER	THYROID	PHLEBITIS
VASCULAR DISEASE	DEPRESSION	DIZZINESS/ FAINTING	KIDNEY PROBLEMS	DIABETES
POLIO	RHEUMATIC FEVER	GASTRO-INTESTINAL	LUNG/ BREATHING PROBLEMS	SEIZURES
INFECTION/ MRSA				

PAST SURGERIES AND/OR INJURIES

HISTORY OF PRESENT INJURY

DESCRIBE YOUR INJURY AND LIST DATE OF INJURY:

WHERE IS THE MOST PAIN?

WHAT INCREASES AND/OR DECREASES YOUR PAIN?

CURRENT MEDICATIONS: _____

SIGNATURE: _____ DATE: _____



FLOYD

RIGHTS OF PARTICIPANTS SERVED

In keeping with the philosophy of Floyd Medical Center Outpatient Rehabilitation that each human being is a unique individual deserving of respect and dignity, we recognize that there are certain basic rights belonging to you.

1. You have the right to considerate, respectful care at all times and under all circumstances, with recognition of your personal dignity.
2. You have the right and responsibility to be treated and treat others with respect, with dignity and safety with no instances of physical, verbal, emotional or sexual harassment; and without regard to race, color, creed, national origin, or the source of payment for your care.
3. You should not be subject to any procedure without your voluntary, competent and understanding consent or that of your legally authorized representative.
4. You have the right to expect that any discussion or consultation involving your case will be conducted discreetly and will not involve individuals not directly involved in your care.
5. You have the right to receive services from experienced, qualified personnel and to know the identity and professional status of any individuals providing services to you.
6. You have the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.
7. You have the right to refuse treatment and to be informed of the consequences of such action.
8. You have the right to receive a timely response to a request for services.
9. You have the right to discuss problems, suggest changes, and participate in the, development/review of your treatment plan including the discharge process without fear of discrimination.
10. You have the right to be discharged from the facility as soon as you no longer need care and treatment.
11. You have the right to file a report regarding an incident or grievance you deem appropriate.

Patient Identification Sticker



FLOYD



NO SHOW / CANCELLATION POLICY

Cancellation: Notify our department 24 hours prior to your appointment.

No Show: Miss an appointment, or fail to notify our department within 24 hours.

Discharge: If you cancel or no show 3 times in a two week period, it is at your therapist's discretion to reschedule or discharge you from therapy. Upon discharge, you will need to obtain another prescription from your doctor, reschedule with us and undergo another evaluation to continue treatment.

* * If you have a reason for being out for more than one appointment (for example, if you have the flu, death in the family, etc ...), please be sure to let us know. We can put your treatment temporarily on hold for up to two weeks. Be sure to let the person you speak with know you wish to do this.

Consistent attendance is vital to your recovery.

Your therapist is committed to being on time, providing you with expert and professional care and involve you in each step of your rehabilitation to make your time together productive and successful. **Your** commitment to attend your scheduled appointments, follow your home exercise program and inform your therapist of your follow up physician appointments in advance will greatly assist in your recovery.

ACKNOWLEDGEMENT OF RECEIPT OF RIGHTS OF PARTICIPANTS SERVED

My signature below indicates that I have received a copy of the Notice of Privacy Practices of Floyd Healthcare Management, Inc.

Registrar: If this patient did not receive the Notice of Privacy Practices, state reason: _____

By signing below, I am indicating my understanding of the **No Show/Cancellation policy** and acknowledgement of the **Privacy Practices and Rights of Participants**.

Signature

Date

Patient Name (Printed)