Dear Patient,

For your convenience, we would like to register you in advance of your admission. Pre-registration will enable you to go directly to Labor & Delivery without going through the admission process.

Approximately in the 20th week of pregnancy, at the beginning of the fifth month, you should receive a packet from your OB/GYN doctor.

Included in your packet are one (1) pre-registration form, Patient Privacy Notice, Consent for Appeal form and two (2) consent forms, one for you and one for the newborn. It is a document that requires your signature. You are authorizing Hackensack University Medical Center to provide care to you and the newborn. If necessary, to release medical information in order to facilitate treatment of services, acknowledging a receipt of a copy of the New Jersey Patient Bill of Rights, and an Advance Directive brochure and other information that may be available to you and your financial obligation if any to the institution.

At the bottom of the consent there will be an X on the line where you need to sign your name. On the baby consent there will be an X on the line designated guarantor and also write your relationship on line designated and date. The yellow copy is your copy to keep for your records. The other 2 copies are to be mailed back with your completed packet to the Admissions office. Also please mail back the Privacy consent form and include your expected date of delivery.

To register you properly and to ensure accurate follow up with your insurance company (ies), please provide copies of your insurance card(s) and a separate form of identification, not insurance related, such as your driver license.

In the event you are scheduled for a Cesarean section your pre-admission testing appointment will be scheduled by your OB and the HUMC schedulers will call you to confirm your appointment.

**PARKING – Parking is available at the Medical Center for your convenience. We have general parking facilities and Valet Parking, both for a fee.**

The following classes are offered at our facility:

1. Infant Care and Safety Classes - $50 per couple
2. Breastfeeding Classes - $50 per couple
3. Tour of the Mother-Baby unit – No fee
   (Call (551) 996-2189 for appointment)
4. Childbirth/Lamaze classes - $175 per couple (Weeknights classes), $200 per couple (Weekend classes)
5. Sibling classes (Big Brother/Big Sister) - $40 per child.

Please call (551) 996-2189 for further information and registration for all classes above and other new classes being offered in the future.
### OB Registration Form

**HAR #**

**CSN #:**

**MR#:**

**Expected Delivery Date**

**OB/GYN Name**

**Previously Admitted to HUMC**

**Yes** / **No**

**Patient Name**

**Date of Birth**

**Address**

**City**

**State**

**County**

**Zip Code**

**Home Phone No.**

**Work Phone No.**

**Ext.**

**Mobile No.**

**Email Address**

**Preferred Language to Speak**

**Interpreter Needed**

**Marital Status**

**Religion**

**Ethnicity**

**Race**

**Pharmacy**

**Any Special Needs in Reference to Seeing, Hearing or Mobility**

**Any Moral or Religious Reason Why You Would Not Accept a Blood Transfusion**

**Yes** / **No**

**Disabled Veteran**

**Yes** / **No**

**Spouse or Dependent (Under 21) of a Disabled Veteran**

**Yes** / **No**

**Primary Care Physician**

**PCP Phone No.**

**Next of Kin**

**Relationship to Patient**

**Home Phone No.**

**Work Phone No.**

**Cell Phone No.**

**Address**

**City**

**State**

**County**

**Zip Code**

**Emergency Contact**

**Relationship**

**Home Phone No.**

**Work Phone No.**

**Ext.**

**Employer Name**

**Employment Status**

**Occupation**

**Employer Address**

**City**

**State**

**County**

**Zip Code**

**Guarantor Name**

**HIC (Health Insurance Card) #**

**Address**

**City**

**State**

**County**

**Zip Code**

**Phone No.**

**Relationship to Patient**

**Primary Insurance Plan Name**

**Policy No.**

**Group No.**

**Name of Subscriber**

**HIC # (Health Insurance #)**

**Date of Birth**

**Relationship**

**Employer of Primary Insurer**

**If Retired, From Where?**

**Address**

**City**

**State**

**County**

**Zip Code**

**Secondary Insurance Plan Name**

**Policy No.**

**Group No.**

**Name of Subscriber**

**HIC # (Health Insurance #)**

**Date of Birth**

**Relationship**

**Employer of Secondary Insurer**

**If Retired, From Where?**

**Address**

**City**

**State**

**County**

**Zip Code**
Information Regarding Your Admission

- Remember your camera, so you can take pictures of your baby in your room.
- Video and photo taking through the nursery viewing windows is not allowed.
- **Room temperatures are variable**
- Bring layers of clothing to accommodate the fluctuating temperatures
- **Items to Pack:**
  - Panties, chapstick, slippers, lounge wear, robes. Significant others must bring their own personal medication i.e. Motrin/Tylenol etc. We cannot dispense these medications.
  - Unmarried couples need to bring photo ID for completion of birth certificate paperwork. Any questions regarding birth certificates please call 551-996-3096
  - If your baby is born less than 37 weeks gestation, your baby's car seat is needed to conduct a car seat test prior to discharge.

**Visiting:**
Family members must wait in the Atrium area until "Mom" is transported to her postpartum room. The nurse may ask your family to step out while completing your postpartum assessment.

All patients who deliver may be placed on the 2nd, 4th or 5th floor depending on bed availability.

Only those who are wearing ID bracelets will be able to come into the nursery to pick up or drop off their baby. You **MUST keep** your bracelets on for the entire duration of the baby's hospitalization. This is to protect you and your baby.

**The nursery blinds will be open for family viewing at your request**

Babies in the Neonatal Intensive Care Unit (NICU) can only be visited when accompanied by someone wearing the baby ID bracelet.

Only adults, 18 years or older may stay with the "new mom". No children are permitted to sleep over. All visiting children must be accompanied by an adult in the room other than the "new mother".

Hospital room phones turn off at 10 pm for incoming calls only, outgoing calls are permitted. Cell phone use is allowed on the unit.

**Visiting hours are allowed 24 hours a day, 7 days a week.**

Parking is available at a daily fee. Visitors who wish to return on the same day pay $10.00 and need to have their tickets validated at the gate when leaving.

**Significant others can purchase a meal through our dietary department for a nominal fee that requires a credit card. There is a cafe located in the Children's lobby and a cafeteria in the main hospital.**
YOUR DISCHARGE PLAN

YOUR DISCHARGE
When your doctor decides you are ready to leave the hospital, a discharge order will be written. You may want to make arrangements with a family member or friend to help you when it is time to go home. Here are some important things to remember:

CHECK-OUT TIME
Check-out time is 10 am for patients on a medical surgical unit. We ask that you make every effort to leave by this time so we can prepare for the next patient. If you require an ambulance or if you are being discharged to another facility, a member of the social services team will assist you in making arrangements. If travel cannot be arranged before 10 am, you will be transported to our Patient Accommodation Lounge. In the Patient Accommodation Lounge, a registered nurse will continue to provide you care until you are discharged from the lounge.

PERSONAL BELONGINGS
Remember to collect all of your belongings, double checking the closet and drawers. If you have valuables stored in the hospital safe, your nurse will contact security to arrange retrieval.

DISCHARGE INSTRUCTIONS
Your doctor and nurse will give you instructions about your post-hospital care. If you have any questions, please be sure to ask them at this time.

MEDICATIONS
If your physician orders new medication, your prescription can be filled at the pharmacy located on campus. You may fill your prescriptions in your community pharmacy if you prefer.

ESCORT SERVICES
When you are ready to leave, a member of the hospital staff will escort you to the front door of the medical center. If you wish, you may walk out on your own accompanied by a family member.

SPECIAL NEEDS
If necessary, social services or a case manager will arrange for special services such as equipment, oxygen, nurses or therapists to begin when you arrive home.
Dear Parents:

New Jersey State law requires that all newborn infants have their hearing screened before they leave the birthing hospital or by one month of age. Approximately three newborns per one thousand have permanent hearing loss. Newborn hearing loss is one of the most frequently occurring disorders present at birth. Over 50% of babies born with hearing loss have no known risk factors for hearing loss. It is important to identify these babies as soon as possible. Because infants are unable to tell us they can’t hear, it is important for all newborns to be screened for hearing loss.

The first two years of your child’s life are the most critical for learning speech and language. It is important to diagnose hearing problems early because a hearing loss can prevent your baby from learning speech and language. By identifying hearing loss early in infancy, children can receive early intervention services and be given the opportunity to develop normal language skills.

Newborn Screening  How Does Newborn Hearing Screening Testing Work at HUMC?

Currently there are two tests that Hackensack Medical Center (HUMC) uses to screen babies for hearing loss. Both of these tests are safe and comfortable. They pose no risks for babies. Otocoustic Emissions
One of the tests is called otocoustic emissions or OAEs. For this test, a miniature earphone and microphone are placed in the ear, sounds are played and a response is measured. If a baby hears normally, an echo is reflected back into the ear canal and this is picked up by the microphone. When a baby has a hearing loss, no echo can be measured on the OAE test.

Auditory Brainstem Response
The second test is called auditory brainstem response or ABR. For this test, sounds are played to the baby’s ears. Band-aid like electrodes that are placed on the baby’s head detect brainwaves. This test actually measures the brain responding to sounds. This test also identifies babies who have a hearing loss.

The two test methods are used in combination at HUMC. Babies will be first screened using OAEs, babies who do not pass this test are given the ABR test. All babies in ICN will be given the ABR test.

You will be informed about your baby’s results after the two stage screening is completed. Normal screening results will be placed on top of your baby’s chart for your review.

If your baby has an abnormal screening result after the second stage screening, further testing will be necessary. An audiologist from HUMC will meet with you to go over the results, provide some education materials and resources, and answer your questions. Your baby’s medical home provider will be notified of the POSSIBLE problem and the need for further testing.

NJ state law mandates that all babies be screened for hearing loss prior to discharge from the nursery. Parent’s have the right to refuse based on a conflict with the parent’s bona fide religious tenets or practices.

Thank you,
This Joint Notice of Privacy Practices ("Notice") explains how Hackensack Meridian Health, Inc. and its' affiliated entities (collectively "HMH") uses information about you and when HMH can share that information with others. It also informs you about your rights as a valued customer.

This Notice is being provided to you on behalf of Hackensack Meridian Health, Inc. ("OMH") and its' affiliated entities. All of the HMH hospitals, employed physicians, doctor offices, entities, foundations, facilities, home care programs, other services, and affiliated facilities follow the terms of this Notice. HMH-affiliated entities are noted in Exhibit A of this Notice and a complete list of locations are listed on our website, HackensackMeridianHealth.org/HIPAA-Privacy-Practices.

Hackensack Meridian Health ("HMH") respects the privacy and confidentiality of your protected health information ("PHI"). The federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") sets rules that will determine how you receive your health information. This law, and applicable state law, gives you rights over your health information, including the right to get a copy of your health information, make sure it is correct, and know who has seen it.

Please review this Notice carefully.

HMH hospitals, doctors, entities, foundations, facilities, and services may share your health information with each other for reasons of treatment, payment, and health care operations as described below.

Please note that the independent members and independent health professional affiliates of the medical staff are neither employees nor agents of HMH but are joined under this Notice for the convenience of explaining to you your rights relating to the privacy of your protected health information.

ORGANIZED HEALTH CARE ARRANGEMENT ("OHCA")

An Organized Health Care Arrangement ("OHCA") is an arrangement or relationship that allows two or more HMH-covered entities to use and disclose PHI. A HIPAA-covered entity is any organization or corporation that directly handles Personal Health Information (PHI) or Personal Health Records (PHR). The most common examples of covered entities include hospitals, doctors' offices and health insurance providers. The entities involved in the HMH OHCA are covered entities under HIPAA and will share PHI with each other, as necessary to carry out treatment, payment, or health care operations relating to the OHCA.

The entities participating in the HMH OHCA agree to abide by the terms of this Notice with respect to PHI created or received by the entity as part of its participation in the OHCA. The entities, which comprise the HMH OHCA are in numerous locations throughout the greater New Jersey area. This Notice applies to all of these sites.

For a complete list of HMH-covered entities please refer to last page of this Notice or refer to HackensackMeridianHealth.org/HIPAA-Privacy-Practices.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit or interact with a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal documentation describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, however, HMH is not required to agree to such a request if the facts do not warrant it.
- Obtain a paper copy of the Notice of Privacy Practices upon request.
- Inspect and obtain a paper or electronic copy of your health record usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Request an amendment (correction) to your health record if you believe information is incorrect or incomplete.
- Obtain a list (an accounting of disclosures) of the times we have shared your health information for six years prior to the date you asked, who we shared it with, and why.

Exceptions: treatment, payment and health care operations.

- Request communications of your health information by alternative means or at alternative locations. For example, you may request that we send correspondence to a post office box rather than your home address.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken. If you pay for a service out-of-pocket in full, you can request that information not be shared for the purpose of payment or our operations with your health insurer.

You will be asked to sign an acknowledgment that you have received this Notice. We are required by law to make a good faith effort to provide you with the Notice and to obtain your acknowledgment. Your refusal to accept the Notice or to sign the acknowledgment will in no way affect your care or treatment in our facility.

HACKENSACK MERIDIAN HEALTH'S RESPONSIBILITIES

- Maintain the privacy and security of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location
- Notify you if a breach occurs that may have compromised the privacy or security of your information

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, revisions will be available at HackensackMeridianHealth.org and you may request a revised copy from the Office of Privacy, the Office of Patient Experience or any patient registration areas. The Hackensack Meridian Health Chief Compliance Officer is responsible for maintaining the Notice of Privacy Practices and for archiving previous versions of the Notice.

We will not use or disclose your health information without your authorization, except as described in this Notice and for treatment, payment, or health care operations.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records or other specially protected health information may have additional confidentiality protections under applicable State and Federal law. We will obtain your specific authorization before using or disclosing these types of information where we are required to do so by such State and Federal laws. However, we may be permitted to use and disclose such information to our physicians to provide you with treatment.

EXAMPLES OF PERMITTED DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We will use your health information for Treatment.

For example, Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment. Members of your health care team will record the actions they took, their observations, and their assessments. In that way, your health care team will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this facility.

We will use your health information for Payment.

For example: A bill will be sent to you and/or your third-party payer (insurance company). The information on the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may provide copies of the applicable portions of your medical record to your insurance company in order to validate your claim.

We will use your health care information for regular Health Care Operations.

For example, We will use or disclose your health information for our regular health operations. For example, members of the medical staff, the risk or quality improvement department, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

In addition, we will disclose your health information for certain health care operations of other entities. However, we will only disclose your information under the following conditions: (a) if the other entity must have, or have had in the past, a relationship with you; (b) the health information used or disclosed must relate to that other entity’s relationship with you; and (c) the disclosure must only be for one of the following purposes: (i) quality assessment and improvement activities; (ii) population-based activities relating to improving health or reducing health care costs; (iii) case management and care coordination; (iv) conducting training programs; (v) accreditation, licensing, or credentialing activities; or (vi) health care fraud and abuse detection or compliance.

The sharing of your PHI for treatment, payment, and health care operations may happen electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.
OTHER USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
Health Information Exchanges (HIE) and Personal health record (PHR) are emerging health information technologies that provide individuals and providers access to health care to improve the quality and efficiency of that care. In this rapidly developing market, there are several types of PHRs and HIEs available to individuals and providers with varying functionalities. PHRs and HIEs allow patients information to be shared electronically through a secured network that is accessible to the providers treating you.

HEALTH INFORMATION EXCHANGES
HMH participates in one or more electronic health information exchange organizations ("HIOs") designed to facilitate the availability of your health information electronically to health care providers who provide you with treatment.

PERSONAL HEALTH RECORD
A personal health record (PHR) is an electronic application used by patients to maintain and manage their health information in a private, secure, and confidential environment.
- Managed by patients
- Can include information from a variety of sources, including health care providers and patients themselves
- Can help patients securely and confidentially store and monitor health information, such as diet plans or data from home monitoring systems, as well as patient contact information, diagnosis lists, medication lists, allergy lists, immunization histories, and much more
- Separate from, and do not replace, the legal record of any health care provider
- Distinct from portals that simply allow patients to view provider information or communicate with provider

If you do not wish to allow authorized health care providers and other entities involved in your care to electronically share your Protected Health Information, including the HIEs as explained in this Notice, you can Opt-Out of participating in such and any Opt-Out selection that you make will be honored. If you choose to Opt-Out of this, it will prevent your information from being shared electronically however it will not impact how your information is otherwise traditionally and typically accessed and released in accordance with this HIPAA Notice and applicable law.

KINDLY CHECK WITH YOUR HMR PROVIDER TO SEE IF THEY PARTICIPATE IN AN HIE OR IF A PHR OPTION IS AVAILABLE TO YOU

BUSINESS ASSOCIATES
We may disclose your health information to contractors, agents and other associates who need this information to assist us in carrying our business operations. Our contracts with them require that they protect the privacy of your health information in the same manner as we do.

FACILITY DIRECTORY
Unless you notify us that you object, HMH will release your name and location to the general visiting public while you are a patient in a HMH facility. In addition, your religious affiliation will be made available to the visiting clergy.

NOTIFICATION
We may use or disclose information about your location and general condition to notify or assist in notifying a family member, personal representative, or another person responsible for your care.

COMMUNICATION WITH FAMILY
As long as you do not object, your health care provider is permitted to share or discuss your health information with your family, friends, or others to the extent that they are involved in your care or payment for your care. Your provider may ask your permission or may use his or her professional judgment to determine the extent of that involvement. In all cases, your health care provider may discuss only the information that the person involved needs to know about your care or payment for your care.

RESEARCH
We may disclose information to researchers when their research has been approved by HMH.

INSTITUTIONAL REVIEW BOARD ("IRB")
The IRB reviews the research proposals and establishes protocols to ensure the privacy of your health information.

FUNERAL DIRECTORS OR CORONERS
We may disclose health information to funeral directors or coroners consistent with applicable law to carry out their duties.

ORGAN AND TISSUE DONATION
If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

TELEPHONE CONTACT/APPOINTMENT REMINDERS
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may call you after you have been a patient to ask about your clinical condition or to assess the quality of care that you received.

FUNDRAISING
The Hospitals of HMH affiliated Foundations may contact you as part of a fundraising effort. The information used for this purpose will not disclose any health condition, but may include your name, address, phone number, email address, etc. When contacted, you may ask that we stop any future fundraising requests if you so desire.

IMAGES
The hospitals of HMH may record digital or film images of you, in whole or in part, for identification, diagnosis or treatment purposes and for internal purposes such as performance improvement or education. Such images may be used for documenting or planning care, teaching, or research. The medical center will obtain your authorization for any other use your identifiable image that is unrelated to treatment, payment or health care operations.

FOOD AND DRUG ADMINISTRATION ("FDA")
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

WORKERS COMPENSATION
We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

OCCIDENTAL HEALTH
We may disclose your PHI to your employer in accordance with applicable law. If we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury, you will be notified of these disclosures by your employer or HMH as required by applicable law.

PUBLIC HEALTH & SAFETY
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

CORRECTIONAL INSTITUTION
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary for (1) the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

LAW ENFORCEMENT
We may release PHI if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; and
- To report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

CHANGES TO THIS NOTICE
HMH may change this Notice at any time. We will post a copy of the current Notice at each of our facilities and on HackensackMeridianHealth.org. The effective date will be indicated on the Notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM
If you believe that your privacy rights have been violated, you should immediately contact the HMH Office of Patient Experience with the entity from which you received services or the HMH Privacy Office directly at 845-988-4419 or Hackensack Meridian Health Office of Privacy 343 Thornall Street Edison, NJ 08837

You may also file a complaint with the Secretary of the Health and Human Services 877-966-7675 or visiting hhs.gov/ocr/privacy/hipaa/complaints/

There will be no retaliation for filing a complaint.
JOINT NOTICE OF HEALTH INFORMATION PRACTICES HACKENSACK MERIDIAN HEALTH, INC.
Hackensack Meridian Health, Inc. Covered Entities

HMH Hospitals Corporation
- Hackensack Meridian Health Bayshore Medical Center
- Hackensack Meridian Health Hackensack University Medical Center
- Hackensack Meridian Health Jersey Shore University Medical Center
- Hackensack Meridian Health Joseph M. Sanzari Children’s Hospital
- Hackensack Meridian Health K. Hovnanian Children’s Hospital
- Hackensack Meridian Health Ocean Medical Center
- Hackensack Meridian Health Palisades Medical Center
- Hackensack Meridian Health Riverview Medical Center
- Hackensack Meridian Health Southern Ocean Medical Center
- Hackensack Meridian Health Raritan Bay Medical Center Old Bridge
- Hackensack Meridian Health Raritan Bay Medical Center Pohr Amboy
- Hackensack Meridian Health John Theurer Cancer Center
- Hackensack Meridian Health JFK Johnson Rehabilitation Institute
- Hackensack Meridian Health Shore Rehabilitation Institute

JFK Health
- Hackensack Meridian Health JFK Medical Center
- Hackensack Meridian Health JFK Medical Center at Cedar Brook
- Hackensack Meridian Health Nursing & Rehab at Hartwyck at Edison Estates
- Hackensack Meridian Health Nursing & Rehab at Hartwyck at Oak Tree
- Hackensack Meridian Health Assisted Living at Whispering Knoll

HMH Residential Care, Inc.
- Hackensack Meridian Health Nursing & Rehab at Bayshore
- Hackensack Meridian Health Nursing & Rehab at Brick
- Hackensack Meridian Health Nursing & Rehab at Ocean Grove
- Hackensack Meridian Health Nursing & Rehab at Shrewsbury
- Hackensack Meridian Health Nursing & Rehab at Palisades Medical Center
- Hackensack Meridian Health Nursing & Rehab at Wall
- Hackensack Meridian Health Assisted Living at Willows

Home Care Divisions
- Hackensack Meridian Health At Home Monmouth County
- Hackensack Meridian Health At Home Ocean County
- Hackensack Meridian Health At Home Infusion
- Hackensack Meridian Health At Home Life Transitions
- Hackensack Meridian Health Hospice
- Hackensack Meridian Health At Home

HMH Physician Services, Inc.
- Meridian Medical Group-Primary Care, PC
- Meridian Medical Group-Faculty Practice, PC
- Meridian Medical Group-Specialty Care, PC
- Meridian Medical Group-Pediatric Urology, PC
- Meridian Medical Group-Retail Clinic, PC
- SOMC Medical Group, PC
- Meridian Trauma Associates, PC
- Meridian Pediatric Surgical Associates, PC
- Hackensack Meridian Urgent Care, PC
- Hackensack University Medical Group, PA
- Hackensack Occupational Medicine Associates, PC
- New Amsterdam Medical Associates, PC
- HUMC Medical Observation, PA
- Hackensack Specialty Care Associates, PC
- Primary Care Associates, PC
- Palisades Medical Associates LLC

Also available online at:
HackensackMeridianHealth.org/HIPAA-Privacy-Practices

Hackensack Meridian Health

Effective 05.18
*** Joint Notice of Privacy Practices Acknowledgement ***

HAR #: ___________________________          Reg. Date/Time: ______________
Patient Name: ________________________        Medical Record #: __________
Hospital Service: ________________________    Status: ______________________

I, ______________________________________, acknowledge receiving the HMH
Joint Notice of Privacy Practices.

I also acknowledge that any future revisions of this notice will be available on the HMH

Patient signature: ____________________________

Date signed: ___/___/

Hospital witness name (print): ____________________________

Hospital witness signature: ____________________________

Date signed: ___/___/

Revised: 08/28/2018
APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO’s contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

☐ representation by ☐ in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:25-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _______________________________ Ins. ID#: _______________________________ Date: _______________________________
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobihealthcarb 10/18

Page 1 of 1
Need a lift?

Just ask!

The mechanical lifting equipment in our hospital is here to help move our patients as safely as possible. Lifts also help reduce injuries among our caregivers. If you or your loved one needs help getting up or around, please let us assist you with care and comfort.

We Safely Move Patients, for your safety and ours.

Hackensack Meridian Health

OSHA
Occupational Safety and Health Administration
EQUAL VISITATION
AND NON-DISCRIMINATION

Respecting the needs of a culturally diverse clientele and recognizing the advantages of having families at the bedside, we acknowledge that visiting patients is a desirable component of patient-centered care.

Patients (or their representatives, where appropriate) may designate who may and may not visit the patient, including but not limited to a spouse, a domestic or civil union partner (including a same-sex partner), another family member or a friend. Patients have the right to withdraw or deny consent, in whole or in part, to visiting at any time.

Medical Center policy prohibits illegal discrimination against patients or their visitors because of their age, race, creed, color, nationality, national origin, ancestry, marital status, familial status, civil union status, domestic partnership status, pregnancy, sex, gender identity or expression, affectional or sexual orientation, disability, nationality, or religion. Hackensack University Medical Center complies with The New Jersey Law Against Discrimination (N.J.S.A. 10:5-1, et seq.) and all other applicable laws governing discrimination.

Visiting may be restricted based on the patient’s clinical condition and care needs. Staff will explain to patients and visitors any clinically necessary or reasonable restriction or limitation of visiting. The explanation will include the reasons for and expected length of restrictions or limitations.

All designated visitors must behave appropriately while on the hospital campus and follow the direction of hospital staff. Visitors that fail to do so may be required to leave the facility or be subject to other limitations.
Financial Assistance Policy and Financial Assistance Policy (Charity Care/Kid Care/Medicaid) – Plain Language Summary

The HackensackUMC Financial Assistance Policy and Financial Assistance Policy (Charity Care/Kid Care/Medicaid) (hereinafter, together, “FAP”) exists to provide eligible patients partially or fully-discounted emergency or other medically necessary healthcare services provided by HackensackUMC. Patients seeking Financial Assistance must apply for the program, which is summarized herein.

Eligible Services- Emergency or other medically necessary healthcare services provided by HackensackUMC and billed by HackensackUMC. The FAP only applies to services billed by HackensackUMC. Other services which are separately billed by other providers, such as physicians or laboratories, are not eligible under the FAP.

Eligible Patients- Patients receiving eligible services, who submit a complete Financial Assistance Application (including related documentation/information), and who are determined eligible for Financial Assistance by HackensackUMC.

How to Apply- FAP and related Application Form may be obtained/completed/submitted as follows:

View information on the Medical Center Website: An individual can view information about financial assistance online at the following website: http://www.hackensackumc.org/financialassistancepolicy

Application- An individual can apply for financial assistance by filling out a paper copy of the application. The paper application is available free of charge by any of the following methods:

By Mail: By writing to the following address and requesting a paper copy of the financial assistance application:
100 First Street - Suite 300
Hackensack, NJ 07601

In Person: By stopping by the Financial Assistance Department in person (Monday thru Friday, 8:00AM-4:00 PM), located at the following address:
100 First Street - Suite 300
Hackensack, NJ 07601

By Phone: The Financial Assistance Department can be reached at (551)-996-4343.

Available Languages- The Financial Assistance Policy, application, and plain language summary are available in the primary language of any populations with limited proficiency in English (“LEP”) that constitute the lesser of five (5%) percent or 1,000 individuals within the primary service area served by the Medical Center.

Completed applications can be sent to the Financial Assistance Department at 100 First Street, Suite 300, Hackensack, NJ 07601.

Determination of Financial Assistance Eligibility- Generally, Eligible Persons are eligible for Financial Assistance, using a sliding scale, when their Family Income is at or below 500% of the Federal Government’s Federal Poverty Guidelines (FPG). Eligibility for Financial Assistance
**New Jersey Hospital Care Assistance Program**

**APPLICATION FOR PARTICIPATION**

PROOFS OF IDENTIFICATION, INCOME AND ASSETS MUST ACCOMPANY THIS APPLICATION. SEND COPIES OF ALL REQUESTED DOCUMENTS TO: HackensackUMC, 100 First Street Suite 300, Hackensack, NJ 07601 Attn: Financial Assistance Department. DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.

### SECTION I – Personal Information

<table>
<thead>
<tr>
<th>1. PATIENT NAME</th>
<th>2. SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td></td>
</tr>
<tr>
<td>(First)</td>
<td></td>
</tr>
<tr>
<td>(M.I.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. DATE OF APPLICATION</th>
<th>4. INITIAL DATE OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Month</td>
</tr>
<tr>
<td>Day</td>
<td>Day</td>
</tr>
<tr>
<td>Year</td>
<td>Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. REQUESTED DATE OF SERVICE</th>
<th>6. STREET ADDRESS OF PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. CITY, STATE, ZIP CODE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9. FAMILY SIZE*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>10. U.S. CITIZENSHIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11. PROOF OF 6 MONTH RESIDENCY IN THE STATE OF NJ</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>12. NAME OF GUARANTOR (if other than patient)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>13. IS PATIENT COVERED BY INSURANCE?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>14. INDIVIDUAL ASSETS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>15. FAMILY ASSETS</th>
</tr>
</thead>
</table>

### Eligible Family Members, Including Applicant

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>SS Number</th>
<th>Occupation</th>
<th>Monthly Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Family size includes self, spouse and minor children. A pregnant woman is counted as two family members.

### SECTION II – Assets Criteria

14. Individual Assets

15. Family Assets

<table>
<thead>
<tr>
<th>A. Cash</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Savings Accounts</td>
</tr>
<tr>
<td>C. Checking Accounts</td>
</tr>
<tr>
<td>D. Certificate of Deposits/I.R.A</td>
</tr>
<tr>
<td>E. Equity in Real Estate (Other than primary residence)</td>
</tr>
<tr>
<td>F. Other Assets (Treasury Bills, negotiable paper, corporate stocks and bonds)</td>
</tr>
<tr>
<td>G. Total</td>
</tr>
</tbody>
</table>
New Jersey Hospital Care Assistance Program

DETERMINATION OF APPLICATION FOR PARTICIPATION

SECTION I – Applicant Information

<table>
<thead>
<tr>
<th>1. PATIENT NAME</th>
<th>2. FAMILY SIZE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. DATE OF SERVICE</th>
<th>4. DATE OF DETERMINATION</th>
<th>5. DATE OF EXPIRATION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. INCOME COMPENSATION</th>
<th>7. TOTAL INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>13 weeks x 4</td>
</tr>
<tr>
<td>3 months</td>
<td>1 month x 12</td>
</tr>
</tbody>
</table>

SECTION II – Medicaid Determination

☐ Yes ☐ No Explain: ____________________________

SECTION III - Determination

☐ Your request for New Jersey Hospital Care Assistance has been approved. Your financial responsibility is _____% of the hospital bill for services beginning on __________. The hospital may provide assistance of _____% of the hospital charges for any future hospital services for a period of ________ months from the initial date of service.

☐ Your request for New Jersey Hospital Care Assistance has been denied because you do not meet the eligibility requirements. Specific reasons for ineligibility are as follows:

- Documentation of income not provided. *
- Documentation of assets not provided. **
- Income exceeds eligibility criteria.
- Assets exceed eligibility criteria.
- Patient referred to Medicaid
- Failure to provide Medicaid denial
- Other ____________________________

* Applicants found ineligible on the fact that specific information was not provided should direct this information to the hospital:

HACKENSACK UNIVERSITY MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM
100 First Street Suite 300
Hackensack, New Jersey 07601
Financial Assistance Department
Tel: (551)996-4343
Fax: (551)996-4333

** Applicants with assets that exceed eligibility have the option to “spend down” the excess assets toward the hospital bill. If you pay _________________ toward your hospital bill, the remaining balance can be considered eligible for ___________% under the New Jersey Hospital Care Assistance Program.

NAME OF EVALUATOR

SIGNATURE

TITLE

DATE

Applicants who have questions about the program may contact the

New Jersey State Department of Health
HEALTH CARE FOR THE UNINSURED PROGRAM
CN 360, Trenton, New Jersey 08625-0360
Telephone Number 1-866-588-5696

REV. 12/21/2015
CONSENT FOR BABY

MOTHER'S NAME: __________________________

MOTHER'S MR#: __________________________

CONSENT TO CARE: I wish to be treated by and/or admitted to a Medical Center of the Hackensack Meridian Health Network at the Medical Center named above (Hackensack University Medical Center). While I am a patient, I give permission to my doctor(s), medical center employees, and all other caregivers to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that Hackensack Meridian Health includes teaching medical centers and that under the appropriate supervision, medical students, fellows and medical residents of Rutgers University, Hackensack Meridian Health, or other teaching affiliates may participate in my care and treatment but I may decline such participation. Rutgers University medical students, fellows and medical residents are students and/or employees of Rutgers, The State University of New Jersey, a body corporate and politic and an instrumentality of the State of New Jersey. I understand that no guarantees have been or can be made to me about the outcome of the care that I receive. I hereby authorize the medical center to preserve, use and/or transfer for scientific and/or teaching purposes, or dispose of any specimens or tissues taken from my body during my treatment or admission and hereby waive any claim or right I may have in such specimens or tissues.

☐ elect to opt out of the teaching program.

1. INDEPENDENT PHYSICIANS: I understand and agree that: (i) the physicians who participate in my care and treatment at the medical center are independent contractors or private practitioners who have been granted the privilege of using medical center facilities for the care and treatment of their patients; (ii) these physicians are not the agent or employee of the medical center and (iii) the medical center is not in any way responsible for the judgement or conduct of any physicians providing medical services at the medical centers. While physicians who practice at the medical center must be admitted to the staff and continue to meet certain educational and experience requirements, I agree that the medical center is not responsible for the care provided to me by them.

2. PATIENT RIGHTS: Information regarding Advance Directives and the New Jersey Patient Bill of Rights is available on our website at www.hackensackmeridian.org and can be found under the "Patients and Visitors" tab.

3. PERSONAL VALUABLES: I understand that the medical center and its employees are not responsible for the loss of, or damage to, any money, articles or personal property. I acknowledge that these items should be sent home with family and friends. I accept full responsibility for any items that I keep in my possession and waive any claim that I may have if they are lost or damaged.

4. RELEASE OF INFORMATION: The medical center may use or disclose all or part of my financial and medical information, as permitted under applicable law. I agree that the medical center may verify my address through a database search of the Federal Credit Reporting System and may be required to release my information to federal and state agencies that monitor healthcare facilities, as well as to industries that produce and/or manufacture medical products. I consent to the release of my name, general condition and room telephone number when requested. The medical center may provide access to my medical information in order to facilitate the provision of post hospital care treatment or services, as well as in connection with the medical center's efforts to obtain payment. I can access additional information regarding the medical center's privacy policies at https://www.hackensackmeridianhealth.org/hipaa-privacy-practices/.

5. PRE-CERTIFICATION REQUIREMENTS: I understand that my health insurance policy or benefits program (i.e., Medicare) may include certain conditions concerning pre-certification and provision of care by in-network providers and if I do not comply with those conditions, I may be responsible for charges that otherwise might be covered by my insurance. I agree to pay such charges.

6. ASSIGNMENT OF BENEFITS: I authorize my health insurance benefits to be paid directly to the medical center. Under the terms of my policy this payment may not exceed the balance due for services performed during this period or treatment. I further authorize the medical center to appeal on my behalf any denial by my insurance carrier.

7. FINANCIAL AGREEMENT: When billed, I agree to make prompt payment to the medical center for all charges not paid by my insurance or benefits program, to the fullest extent permitted by law. I understand that in addition to my bill from the medical center, I will receive separate bills from physicians for professional services (i.e., anesthesia, emergency services, pathology, radiology, etc.).

First Copy: Finance Second Copy: Medical Records Third Copy: Patient Revised: 12/2018
CONSENT FOR BABY

MOTHER'S NAME:

MOTHER'S MR#:

authorize payment directly to my physicians for benefits otherwise payable to me for such services. I understand that (i) these separate physician charges may not be covered, in whole or in part, by my insurance or benefits program, and (ii) physicians providing treatment may not participate with my insurance or benefits program. Regardless, I agree that I am financially responsible for all medical center and physician charges not paid by my insurance or benefits program. I understand I that should call my insurance company or benefits program if I have questions about insurance coverage.

8. DEPOSIT REQUEST: A deposit may be requested of me because I will be paying for all and/or part of the medical center bill. The medical center's acceptance of partial payment does not relieve me of responsibility for the full amount.

9. NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM: I understand that I may access Charity Care, Medicaid, and NJ Family Care. Information is available at www.hackensackmeridian.org on the "Pay a Bill" FAQ page or I can call the Hackensack Meridian Financial Assistance Offices at the phone numbers indicated on the referenced website.

10. MEDICARE 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 or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign 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 for payment. THE SERVICE YOU RECEIVE MAY NOT BE COVERED BY YOUR MEDICARE INSURANCE. IN THIS EVENT YOU WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED. For Medicare Inpatients: I have received "AN IMPORTANT MESSAGE FROM MEDICARE" / "TRICARE" and I understand my rights as outlined in this document.

11. MEDICAID SERVICES: I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for medical center services to the medical center furnishing care and 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 Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

12. I authorize the medical center, its providers, and agents, including debt collectors, to contact me at any wireless or residential phone number that I provide or which is listed in my name. I agree that this contact may be by way of live operator, artificial or pre-recorded voice, or auto-dialer technologies for any permissible purpose, including communications about my account communications, which communications may contain protected health information. In order to revoke this authorization, I must provide Hackensack Meridian Health written notice directed to "Patient Accounts". For Questions and/or concerns please contact Customer Service for the above named medical center using the phone number provided on our website at www.hackensackmeridian.org under the "Patients and Visitors" tab, Billing & Insurance – Customer Service.

I have read the information contained above, any questions I had have been answered, and I understand its contents. I attest that my personal information provided to the hospital is correct. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

Patient

☐ Next of Kin/Power of Attorney (if applicable) ☐ Witness ☐ HMH Employee

Date and Time

First Copy: Finance Second Copy: Medical Records Third Copy: Patient

Revised: 12/2018
CONSENT FOR TREATMENT

CONSENT TO CARE: I wish to be treated by and/or admitted to a Medical Center of the Hackensack Meridian Health Network at the Medical Center named above (Hackensack University Medical Center). While I am a patient, I give permission to my doctor(s), medical center employees, and all other caregivers to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that Hackensack Meridian Health includes teaching medical centers and that under the appropriate supervision, medical students, fellows and medical residents of Rutgers University, Hackensack Meridian Health, or other teaching affiliates may participate in my care and treatment but I may decline such participation. Rutgers University medical students, fellows and medical residents are students and/or employees of Rutgers, The State University of New Jersey, a body corporate and politic and an instrumentality of the State of New Jersey. I understand that no guarantees have been or can be made to me about the outcome of the care that I receive. I hereby authorize the medical center to preserve, use and/or transfer for scientific and/or teaching purposes, or dispose of any specimens or tissues taken from my body during my treatment or admission and hereby waive any claim or right I may have in such specimens or tissues.

☐ I elect to opt out of the teaching program.

1. INDEPENDENT PHYSICIANS: I understand and agree that: (i) the physicians who participate in my care and treatment at the medical center are independent contractors or private practitioners who have been granted the privilege of using medical center facilities for the care and treatment of their patients; (ii) these physicians are not the agent or employee of the medical center and (iii) the medical center is not in any way responsible for the judgement or conduct of any physicians providing medical services at the medical centers. While physicians who practice at the medical center must be admitted to the staff and continue to meet certain educational and experience requirements, I agree that the medical center is not responsible for the care provided to me by them.

2. PATIENT RIGHTS: Information regarding Advance Directives and the New Jersey Patient Bill of Rights is available on our website at www.hackensackmeridian.org and can be found under the "Patients and Visitors" tab.

3. PERSONAL VALUABLES: I understand that the medical center and its employees are not responsible for the loss of, or damage to, any money, articles or personal property. I acknowledge that these items should be sent home with family and friends. I accept full responsibility for any items that I keep in my possession and waive any claim that I may have if they are lost or damaged.

4. RELEASE OF INFORMATION: The medical center may use or disclose all or part of my financial and medical information, as permitted under applicable law. I agree that the medical center may verify my address through a database search of the Federal Credit Reporting System and may be required to release my information to federal and state agencies that monitor healthcare facilities, as well as to industries that produce and/or manufacture medical products. I consent to the release of my name, general condition and room telephone number when requested. The medical center may provide access to my medical information in order to facilitate the provision of post hospital care treatment or services, as well as in connection with the medical center’s efforts to obtain payment. I can access additional information regarding the medical center's privacy policies at https://www.hackensackmeridianhealth.org/hipaa-privacy-practices/

5. PRE-CERTIFICATION REQUIREMENTS: I understand that my health insurance policy or benefits program (i.e., Medicare) may include certain conditions concerning pre-certification and provision of care by in-network providers and if I do not comply with those conditions, I may be responsible for charges that otherwise might be covered by my insurance. I agree to pay such charges.

6. ASSIGNMENT OF BENEFITS: I authorize my health insurance benefits to be paid directly to the medical center. Under the terms of my policy this payment may not exceed the balance due for services performed during this period or treatment. I further authorize the medical center to appeal on my behalf any denial by my insurance carrier.

7. FINANCIAL AGREEMENT: When billed, I agree to make prompt payment to the medical center for all charges not paid by my insurance or benefits program, to the fullest extent permitted by law. I understand that in addition to my bill from the medical center, I will receive separate bills from physicians for professional services (i.e., anesthesia, emergency services, pathology, radiology, etc.). I
CONSENT FOR TREATMENT

authorize payment directly to my physicians for benefits otherwise payable to me for such services. I understand that (i) these separate physician charges may not be covered, in whole or in part, by my insurance or benefits program, and (ii) physicians providing treatment may not participate with my insurance or benefits program. Regardless, I agree that I am financially responsible for all medical center and physician charges not paid by my insurance or benefits program. I understand that should call my insurance company or benefits program if I have questions about insurance coverage.

8. DEPOSIT REQUEST: A deposit may be requested of me because I will be paying for all and/or part of the medical center bill. The medical center’s acceptance of partial payment does not relieve me of responsibility for the full amount.

9. NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM: I understand that I may access Charity Care, Medicaid, and NJ Family Care. Information is available at www.hackensackmeridian.org on the "Pay a Bill" FAQ page or I can call the Hackensack Meridian Financial Assistance Offices at the phone numbers indicated on the referenced website.

10. MEDICARE 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 or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign 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 for payment. THE SERVICE YOU RECEIVE MAY NOT BE COVERED BY YOUR MEDICARE INSURANCE. IN THIS EVENT YOU WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED. For Medicare Inpatients: I have received "AN IMPORTANT MESSAGE FROM MEDICARE" / "TRICARE" and I understand my rights as outlined in this document.

11. MEDICAID SERVICES: I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for medical center services to the medical center furnishing care and 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 Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

12. I authorize the medical center, its providers, and agents, including debt collectors, to contact me at any wireless or residential phone number that I provide or which is listed in my name. I agree that this contact may be by way of live operator, artificial or pre-recorded voice, or auto-dialer technologies for any permissible purpose, including communications about my account communications, which communications may contain protected health information. In order to revoke this authorization, I must provide Hackensack Meridian Health written notice directed to "Patient Accounts". For Questions and/or concerns please contact Customer Service for the above named medical center using the phone number provided on our website at www.hackensackmeridian.org under the "Patients and Visitors" tab, Billing & Insurance – Customer Service.

I have read the information contained above, any questions I had have been answered, and I understand its contents. I attest that my personal information provided to the hospital is correct. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

__________________________   __________________________
Patient                                Date and Time

☐ Next of Kin/Power of Attorney (if applicable)   ☐ Witness   ☐ HMH Employee   ☐ Date and Time

First Copy: Finance   Second Copy: Medical Records   Third Copy: Patient   Revised: 12/2018