Congratulations

The Katena Center for Mother and Child

Congratulations on the expected birth of your newest family member! Your decision to deliver your baby at Saint Clare's Hospital is a good one. All of us here will do whatever is necessary to make your stay as pleasant and memorable as possible.

To assist in a smooth and speedy admission when you arrive to have your baby, we ask that you fill in the enclosed forms and mail them to us at: **Admitting Department, Saint Clare's Hospital, 25 Pocono Road, Denville, NJ 07834**. These forms will be kept on file. When you come to deliver, please go directly to the 3rd floor, Katena Center, Denville.

You must register at Outpatient Registration if you come to Saint Clare's for prenatal tests, lab tests or any other procedure regarding your pregnancy.

If you have any questions or concerns, or would like a tour, feel free to call 1-866-STCLARE (1-866-782-5273).

Please read the instructions below before you fill out the forms. All forms must be printed in ink, signed and completed. Incomplete forms will be returned to you. Please include one copy of both sides of your health insurance cards, and a copy of your driver's license or other photo identification.

Again, congratulations. We wish you and your family much joy in the months and years ahead.

PREADMISSION FORM

1. **Personal Information:** Information about you: home address, expected due date, religion, doctor and whether you have an Advance Directive. If you have an Advance Directive please send a copy. If you would like information, please check where indicated.

2. **Employer Information:** This section requests information about your employer. If you are not employed, check the appropriate box.

3. **Next of Kin:** Who would we contact in an emergency? That information goes into this section.

4. **Primary Insurance:** Who is responsible for paying all hospital bills associated with your pregnancy, delivery and recovery? The Responsible Party is the person who carries the primary insurance and should sign as guarantor of account. This person is the subscriber.

5. **Secondary Insurance:** Please complete as applicable.

Remember to sign, date and include a copy of both sides of your insurance card(s). If your insurance changes prior to delivery, please make sure to provide the Hospital with the new information.

ADMISSION CONSENT FORMS

Please read carefully and check the appropriate box at the bottom and sign the forms.

If you have any questions about these forms or the process, please call 973-625-6524.

CATHOLIC HEALTH INITIATIVES®

Saint Clare's Hospital

25 Pocono Road • Denville, New Jersey 07834 • saintclares.org

6061-109(6/07)

SAINT CLARE'S HOSPITAL
PREADMISSION FORM

PATIENT LABEL

Please read the instructions contained in the cover letter before you complete the form. Print in ink and return as soon as possible prior to your delivery date.

PERSONAL INFORMATION

Name: Last_____ First_____

Social Security Number:_____ ❑ Married ❑ Single Date of Birth:_____

Doctor's Name:_____ Due Date:_____

Advance Directive: ❑ Yes ❑ No ❑ Please send me further information Smoker: ❑ Yes ❑ No

Street Address:_____

Town:_____ State:_____ Zip:_____

Phone:_____ Religion:_____ Church/Parish:_____

Race / Ethnicity: ❑ Black ❑ White ❑ Asian/Pacific Islander ❑ Hispanic ❑ Other_____

EMPLOYER INFORMATION

Employer Name:_____

Street Address:_____

Town:_____ State: _____ Zip:_____

Phone:_____ Occupation:_____

Employment Status: ❑ Full Time ❑ Part Time ❑ Not Employed

NEXT OF KIN INFORMATION

Name: Last_____ First_____

Relationship:_____

Street Address:_____

Town:_____ State: _____ Zip:_____

Phone:_____ Work Phone:_____

PRIMARY INSURANCE INFORMATION

Subscriber's Name if different from patient:_____ Date of Birth:_____

Employer:_____ Social Security Number:_____

Relationship to Patient:_____

Insurance Company Name:_____ Policy Number:_____

Insurance Company Address:_____ Group Number:_____

Insurance Company Phone Number (on insurance card):_____

SECONDARY INSURANCE INFORMATION

Subscriber's Name:_____ Date of Birth:_____

Employer:_____ Social Security Number:_____

Relationship to Patient:_____

Insurance Company Name:_____ Policy Number:_____

Insurance Company Address:_____ Group Number:_____

Insurance Company Phone Number (on insurance card):_____

I hereby certify that the above statements are correct.

Signature:_____

Date:_____

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PATIENT LABEL

SAINT CLARE'S HOSPITAL
ADMISSION CONSENT

I, the undersigned agree and give consent for admission to Saint Clare's

Hospital under the care of Dr. _____ or physician's associates and/or partners.

1. **GENERAL CONSENT AND AUTHORIZATION:** I further consent to any hospital care which encompasses routine diagnostic procedures or medical treatment which my physician, associates and/or partners may deem necessary or advisable during my hospitalization. It is understood that no guarantees have been made to me about the outcome of medical treatment.
   - I acknowledge the fact that the hospital has the authority to dispose of specimens taken for laboratory or pathology examination.
   - I understand if I am to receive a specific implanted medical device, the hospital will release my social security number to the manufacturer of the device for identification purposes. Federal Law requires that Medical Device Tracking be done for implantable pacemaker pulse generators, vascular grafts and certain prostheses in addition to other devices.
   - The hospital provides general duty nursing care. If the patient needs continuous or private duty nursing care, it is agreed that such must be arranged by the patient, patient's legal representative or physicians. The hospital staff is not responsible for failure to provide continuous or private duty nursing care, and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
2. **PHOTOGRAPH/VIDEO/AUDIO:** I understand that photographs and/or video recordings may be used in the performance of specific treatments or procedures or for internal staff education and performance improvement. My specific consent will be obtained for any release of photographs, video, audio or other electronic recordings to external parties.
3. **RELEASE OF MEDICAL INFORMATION:** I authorize the hospital and or physicians participating in my care to release (either in writing or verbally) any medical information which may be needed to assist in my continued care plan or may be needed to process claims for medical insurance benefits relative to this hospitalization (including pre-certification and verification, if necessary). I understand my treatment providers will also access my prior hospital medical records to aid in treatment.
4. **FINANCIAL ARRANGEMENTS: I understand that the hospital charges do not include the fees of my treating physicians, including radiologists, pathologists or anesthesiologists or other hospital based physician providers.**
   - I understand that I am financially responsible for the payment of medical fees to the physicians who render services through the Saint Clare's Health System. I authorize payments of medical insurance benefits (including managed care and Medicare when applicable) directly to the hospital and/or any physician participating in my care. I authorize any holder of medical or other information about me (the patient) to release to the Center for Medicare and Medicaid Services and its agencies, any information needed to determine these benefits or benefits for related services. **I understand if I qualify for hospital charity services, physician fees are not covered.**
   - I hereby agree to pay for charges not covered or approved by my medical insurance company or managed care organization. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries and it may be my responsibility to obtain appropriate pre-approval. Some medical insurance or managed care organizations require a co-pay that I may be asked to pay at the time of service.
   - I agree to allow the Hospital to appeal on my behalf, any utilization management decision rendered by or on my behalf, of my insurance carrier or responsible payor.
5. **PATIENT ACKNOWLEDGES:**
   - **VALUABLES:** I have been advised to remove all valuables and give them to my family member/friend for safekeeping. I understand that it is in my best interest to send all personal property home. I understand that the hospital maintains a safe for the retention of patient valuables. The hospital is not liable for loss or damage of personal property unless deposited for safekeeping. I assume all risk for the loss or damage of any valuables that I keep. **I understand the Saint Clare's Health System is not responsible for the security or loss of patient personal belongings.**
   - **Receipt of Notice of Privacy Practices/Patient Rights**
   - ***REQUIRED:*** **I require and have been offered a sign language interpreter or other assistive listening devices.**
     ❑ Yes ❑ No ***(If yes, use form 1220-001, Request for Services by Deaf & Hard of Hearing Persons)***

_____ _____
Patient or Legal Representative Signature | Printed name & relationship of person signing on behalf of patient

_____ _____ _____
Witness Signature | Date | Time

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SAINT CLARE'S HOSPITAL
NEWBORN ADMISSION CONSENT

PATIENT LABEL

Mother's Name:_____

Mother's Date of Birth:_____

Please read the instructions contained in the cover letter before you complete. Print in ink and return as soon as possible prior to your delivery date.

I, the undersigned agree and give consent for admission of my child to Saint Clare's Hospital under the care of

Dr. _____, or physician's associates and/or partners.

1. **GENERAL CONSENT AND AUTHORIZATION:** I further consent to any hospital care which encompasses routine diagnostic procedures or medical treatment which my physician, associates and/or partners may deem necessary or advisable during my child's hospitalization.
   - I acknowledge the fact that the hospital has the authority to dispose of specimens taken for laboratory or pathology examination.
   - I understand if my child is to receive a specific implanted medical device, the hospital will release my social security number to the manufacturer of the device for identification purposes. Federal Law requires that Medical Device Tracking be done for implantable pacemaker pulse generators, vascular grafts and certain prostheses in addition to other devices.
   - The hospital provides general duty nursing care. If the patient needs continuous or private duty nursing care, it is agreed that such must be arranged by the patient, legal representative, or physicians. The hospital staff is not responsible for failure to provide continuous or private duty nursing care, and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
2. **PHOTOGRAPH/VIDEO/AUDIO:** I understand that photographs and/or video recordings may be used in the performance of specific treatments or procedures or for internal staff education and performance improvement. My specific consent will be obtained for any release of photographs, video, audio or other electronic recordings to external parties.
   - I agree to allow the hospital or designated baby photo vendor to photograph my newborn for security purposes.
3. **RELEASE OF MEDICAL INFORMATION:** I authorize the hospital and or physicians participating in my child's care to release (either in writing or verbally) any medical information which may be needed to assist in my continued care plan or may be needed to process claims for medical insurance benefits relative to this hospitalization (including pre-certification and verification, if necessary).
4. **FINANCIAL ARRANGEMENTS: I understand that the hospital charges do not include the fees of my treating physicians, including radiologists, pathologists or anesthesiologists or other hospital based physician providers.**
   - I understand that I am financially responsible for the payment of medical fees to the physicians who render services through the Saint Clare's Health System. I authorize payments of medical insurance benefits (including managed care and Medicare when applicable) directly to the hospital and/or any physician participating in my child's care. I authorize any holder of medical or other information about me (the patient) to release to the Center for Medicare and Medicaid Services and its agencies, any information needed to determine these benefits or benefits for related services. **I understand if I qualify for hospital charity services, physician fees are not covered.**
   - I hereby agree to pay for charges not covered or approved by my medical insurance company or managed care organization. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries and it may be my responsibility to obtain appropriate pre-approval. Some medical insurance or managed care organizations require a co-pay that I may be asked to pay at the time of service.
   - I agree to allow the Hospital to appeal on my child's behalf, any utilization management decision rendered by or on my child's behalf, of my insurance carrier or responsible payor.
5. **PATIENT ACKNOWLEDGES:**
   - **VALUABLES:** I have been advised to remove all valuables and give them to my family member/friend for safekeeping. I understand that it is in my best interest to send all personal property home. I assume all risk for the loss or damage of any valuables that I keep. **I understand that Saint Clare's Health System is not responsible for the security or loss of patient personal belongings.**
   - **Receipt of Notice of Privacy Practices / Patient Rights**
   - ***REQUIRED*** **I require and have been offered a sign language interpreter or other assistive listening devices.** ☐ **Yes** ☐ **No** ***(If checked yes, use form 1220-001, Request for Services by Deaf & Hard of Hearing Persons)***

_____ _____

Patient or Legal Representative Signature | Printed name & relationship of person signing on behalf of patient

_____ _____ _____

Witness Signature | Date | Time

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