Hackensack Meridian *Health*

Today's Date: _____

Covid-19 Vaccination Request Form

Full Legal Name (As shown on legal Identification)	**Last Name, First Name, Middle Initial**	
Date of Birth & Gender	**Month, Date, Year of Birth**	**Gender (please circle one)** **Male or Female**
Full Address	**Street Address, City, State, Zip Code**	
Phone Number(s)	**Home:**	**Cell:**
Email Address	**Personal Email Address**	
Primary Insurance Name and Member ID #	**Insurance Name**	**Member ID Number**
Primary Insurance Subscriber Information	**Subscriber Name**	**Subscriber Date of Birth**
Secondary Insurance Name and Member ID #	**Insurance Name**	**Member ID Number**
Secondary Insurance Subscriber Information	**Subscriber Name**	**Subscriber Date of Birth**

If you are enrolled with a Medicare Advantage Plan

Please provide your Traditional Medicare information instead

(Red, White & Blue Medicare Card)

****Please print and complete the form legibly****

Hackensack
Meridian *Health*
Palisades Medical Center

Patient Label

Consent For Treatment

1. CONSENT TO CARE: I wish to be treated by and/or admitted to HMH Palisades 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 HMH Palisades Medical Center is a teaching hospital and that under the appropriate supervision, medical students, fellows, and medical residents of HMH Palisades Medical Center may participate in my care and treatment but I may decline such participation. HMH Palisades Medical Center medical students, fellow, and medical residents are students and/or employees of HMH Palisades Medical Center. I understand that no guarantees have been or can be made to me about the outcome of the care I receive. I hereby authorize HMH Palisades 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.

2. INDEPENDENT PHYSICIANS: I understand and agree that: (i) the physicians who participate in my care and treatment at HMH Palisades 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 HMH Palisades Medical Center and (iii) HMH Palisades Medical Center is not in any way responsible for the judgement or conduct of any physicians providing medical services at the Medical Center. While physicians who practice at HMH Palisades Medical Center must be admitted to the staff and continue to meet certain educational and experience requirements, I agree that HMH Palisades Medical Center is not responsible for the care provided to me by them.

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

4. PERSONAL VALUABLES: I understand that HMH Palisades 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.

5. RELEASE OF INFORMATION: HMH Palisades 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 of 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 www.palisadesmedical.org

6. 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.

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

8. FINANCIAL AGREEMENT: When billed, I agree to make prompt payment to HMH Palisades 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 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

MEDICAL RECORD

Hackensack
Meridian *Health*
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Patient Label

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 I should call my insurance company or benefits program if I have questions about insurance coverage.

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

10. NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM: I understand that I may access Charity Care, Medicaid, and NJ Family Care. Information is available at www.palisadesmedical.org on the "For Patients" tab or I can call the HMH Palisades Medical Center Financial Assistance Office at 201-854-5092.

11. 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.

12. 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 hospital services to HMH Palisades Medical Center 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.

13. PATIENT PHOTO: I agree to be photographed as part of the admission/registration process so that I may be effectively identified for care and treatment. My photograph may be placed on my wristband and in my patient record.

14. I authorize HMH Palisades Medical Center, its providers, and agents, including debt collectors, to contact me at any wireless or residential phone number that I provide or which I 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 HMH Palisades Medical Center written notice directed to "Patient Accounts". For Questions and or concerns please contact Customer Service at 201-854-5092.

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 HMH Palisades Medical Center 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's / Representative's Signature **Date** **Time**

☐ Patient is medically unable to sign. ☐ Incommunicative ☐ Unresponsive

_____

Witness Signature

Witness Type: ☐ Next of Kin/Power of Attorney (if applicable) ☐ Witness ☐ Hackensack UMC Employee