Hackensack Meridian
Hackensack University
Medical Center

Dear Patient,

Congratulations, and thank you for making the decision to deliver your baby at Hackensack University Medical Center. For your convenience, we would like to register you in advance of your admission. Having the pre-registration forms on file will greatly facilitate the admission process upon your arrival to Labor and Delivery.

In order to help us better serve you, please complete the accompanying Maternity Pre-Admission Forms in their entirety. Maternity Pre-Admission Forms should be submitted *within 4 months of your expected delivery date*.

In the event you are scheduled for a Cesarean delivery (C-section), your pre-admission testing appointment will be scheduled by your Doctor, with the Hackensack University Medical Center schedulers to call you to confirm your appointment.

***Instructions to submit by email or mail*:**
Once the pre-admission forms are completed, please send the writable PDF as an attachment to:
HMHASCMaternity@HMHN.org

Mailed hard copies of the pre-admission forms, should be sent to:

Hackensack Meridian *Health* - Hackensack University Medical Center
Admission Services Department
30 Prospect Avenue
W&C Pavilion, Room G016
Hackensack, NJ 07601

Don't Forget to Include:
In addition to the Pre-Admission Forms, please be sure to include copies of your insurance card(s) (front and back of card) and a separate form of photo identification, not insurance related, such as your driver license or passport.

For any questions, please reach out to the Admission Services Center at HMHASCMaternity@HMHN.orgor call 551-996-3122 and 551-996-2099

What's included in your Maternity Pre-Admission Forms?

- Maternity Services Registration Form
- Joint Notice of Privacy Practices and Acknowledgment
- Your Rights as a Patient
- Consent for Appeal Form
- Two Consent Forms; one for you and one for the baby

Additional Information:
PARKING - Parking is available at the Medical Center for your convenience. We have general parking facilities and valet parking available, both for a fee.

PARENT EDUCATION - All virtual tour and educational webinar classes are available for free. To register, visit events.hackensackmeridianhealth.org or call (551) 996-2189 for further information.

We look forward to supporting your delivery journey.

Warm Regards,

The Maternity Admission Services Center

Hackensack Meridian
Hackensack University
Medical Center

MATERNITY SERVICES REGISTRATION FORM

PATIENT

EXPECTED DELIVERY DATE	OB/GYN NAME	PHONE #	PREVIOUSLY ADMITTED TO HUMC YES - DATE NO

PATIENT NAME	DATE OF BIRTH

ADDRESS	CITY	STATE	COUNTY	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS
PREFERRED LANGUAGE TO SPEAK	**INTERPRETER NEEDED** YES NO	**MARITAL STATUS**	**RELIGION**
ETHNICITY	**RACE**	**PHARMACY**	**PHONE #**

ANY SPECIAL NEEDS IN REFERENCE TO SEEING, HEARING OR MOBILITY?	ANY MORAL OR RELIGIOUS REASON WHY YOU WOULD NOT EXCEPT A BLOOD TRANSFUSION YES NO
DISABLED VETERAN *YES NO*	**SPOUSE OR DEPENDENT (UNDER 21) OF A DISABLED VETERAN YES NO** NAME

PRIMARY CARE PHYSICIAN	PRIMARY CARE PHONE NUMBER

NEXT OF KIN	RELATIONSHIP TO PATIENT

HOME PHONE NUMBER	WORK PHONE NUMBER Ext.	CELL #

ADDRESS	CITY	STATE	COUNTY	ZIP CODE

EMERGENCY CONTACT OTHER THAN NEXT OF KIN	RELATIONSHIP	HOME PHONE NUMBER	WORK PHONE NUMBER Ext.

INSURANCE

GUARANTOR NAME - A GUARANTOR IS THE PERSON WHO IS FINANCIALLY RESPONSIBLE	DATE OF BIRTH

ADDRESS	CITY	STATE	COUNTY	ZIP CODE

PHONE NUMBER	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE PLAN NAME	POLICY NO.	GROUP NO.

NAME OF SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP

EMPLOYER OF PRIMARY INSURER	IF RETIRED, FROM WHERE?

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

SECONDARY INSURANCE PLAN NAME	POLICY NO.	GROUP NO.

NAME OF SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP

EMPLOYER OF SECONDARY INSURER	IF RETIRED, FROM WHERE?

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

Hackensack Meridian
Hackensack University
Medical Center

Joint Notice of Privacy Practices

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. (an "OCHA") 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 about who can look at and 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 staffs 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 HIPAA 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 participating 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 OCHA 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, diagnoses, 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 document 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 who, 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 applicable 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 care information for **Payment**.

For example: A bill will be sent to you and/or a 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) 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 allows patient 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.

- Are 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
- Are separate from, and do not replace, the legal record of any health care provider
- Are 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 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 HMH 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/APPOITMENT 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 heath 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.

OCCUPATIONAL 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 (1) for 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 848-888-4419 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 877-696-6775 or visiting hhs.gov/ocr/privacy/hipaa/complaints/

There will be no retaliation for filing a complaint.

Hackensack Meridian
Hackensack University
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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 Perth 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* Nursing & Rehab Hartwyck 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

Health Innovations Unlimited, Inc.

Hackensack Meridian *Health* Shore Rehabilitation Institute

JFK Johnson Rehabilitation Institute

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

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***** Joint Notice of Privacy Practices Acknowledgement *****

Patient Name: ____

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 website, www.HackensackMeridianHealth.org or upon request.

Patient signature:

____

Date signed: ____/____/____

Hospital witness name (print):

____

Hospital witness signature:

____

Date signed: ____/____/____

YOUR RIGHTS AS A PATIENT

Your Rights As A Patient

Each patient shall be entitled to the following rights, none of which shall be abridged or violated by the Medical Centers of Hackensack Meridian *Health* or any of its staff:

Medical Care

- Receive an understandable explanation from your physician of your complete medical condition including recommended treatment, expected results, risks and reasonable alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation must be given to your next of kin or guardian.
- Give informed written consent prior to the start of specified, nonemergency medicalprocedures or treatments only after your physician has explained – in terms you can understand-specific details about the recommended procedure or treatment, the risks, time to recover and reasonable medical alternatives.
- Be informed about the hospital's written policies and procedures regarding life saving methods and the use or withdrawal of life support.
- To refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of refusal.
- Be included in experimental research only when you have given informed consent to participate.
- Choose your own private professional nurse and to contract directly for this care during hospitalization. You can request from the hospital a list of local non-profit professional nurses' association registries that refer nurses.
- Receive appropriate assessment and treatment for pain.

Transfers

- Be transferred to another facility only if the current hospital is unable to provide the level of appropriate medical care or if the transfer is requested by you or your next of kin or guardian.
- Receive from a physician in advance an explanation of the reasons for transfer including alternatives, verification of acceptance from the receiving facility, and assurance that the move will not worsen your medical condition.

Communication and Information

- Be treated with courtesy, consideration and respect for your dignity and individuality.
- Know the names and functions of all physicians and other health care professionals and educational institutions that participate in your treatment. You have the right to refuse to allow their participation.
- Expeditiously receive the services of a translator or interpreter, if needed, to communicate with the hospital staff.
- Be advised in writing of the hospital's rules regarding the conduct of patients and visitors.
- Receive a summary of your rights as a patient, including the name(s) and phone number(s) of the hospital staff to whom to direct questions or complaints about possible violations of your rights. At Hackensack Meridian Health, the Office of Patient Experience serves as the Ombudsman and will advocate for your rights as a patient. If at least 10% of the hospital's service area speaks your native language, you can receive a copy of the summary in your native language.

Medical Records

- Have prompt access to your medical records. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your records.
- Obtain a copy of your medical records for a reasonable fee within 30 days after submitting a written request to the hospital.

Cost of Hospital Care

- Receive a copy of the hospital charges, an itemized bill, if requested, and an explanation.
- Appeal any charges and receive an explanation of the appeals process.
- Obtain the hospital's help in securing public assistance and private health care benefits to which you may be entitled.

Discharge Planning

- Be informed about any need for follow up care and receive assistance in obtaining this care required after your discharge from the hospital.
- Receive sufficient time before discharge to arrange for follow up care after hospitalization.
- Be informed by the hospital about the discharge appeals process.

Privacy and Confidentiality

- Be provided with physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
- Be assured confidentiality about your stay. Your medical and financial records shall not be released to anyone outside the hospital without your approval, unless you are transferred to another facility that requires the information, or release of the information is required and permitted by law.
- Have access to individual storage space for your private use and to safeguard your property if unable to assume that responsibility.

Freedom from Restraints and Abuse

- Be free from physical and mental abuse.
- Be free from restraints unless authorized by a physician for a limited period of time to protect your safety or the safety of others.

Civil Rights

- Receive treatment and medical services without discrimination based on sex/gender, race, age, religion, ethnicity, disability, diagnosis, creed, color, national origin, nationality, marital status, domestic partnership status, affectional or sexual orientation, gender identity and expression, military service, ability to pay or source of payment, in sum or substance, any other category protected by state or federal law.
- Exercise your constitutional, civil and legal rights.

Questions, Complaints and Appeals

- Ask questions or file grievances about patient rights with a designated hospital staff member and receive a response within a reasonable period. At Hackensack Meridian *Health*, the Office of Patient Experience serves as the Ombudsman and will serve as the point of contact to address your questions, concerns and special needs.
- Be provided, by the hospital, with contact information for the New Jersey Department of Health and Senior Services unit that handles questions and complaints.

Contact Information:

Hospital

Office of Patient Experiences

Direction

Phone

Email

New Jersey Department of Health and Senior Services
24-hour Complaint Hotline: 1-800-792-9770

New Jersey State Department of Health
Division of Health Facilities Evaluation and Licensing
P.O. Box 367, Trenton, New Jersey 08625 Telephone: (800) 792-9770

Medicare patients may file a complaint or "grievance" through Medicare. Visit **www.medicare.gov** for additional information.

You may also file quality of care complaints with the Joint Commission by emailing the name and address of the hospital and concerns to **complaint@jointcommission.org** or by submitting a your concerns online via their website at: **www.jointcommission.org**. You may also call **1-800-994-6610** and speak with joint commission representative.

Hackensack Meridian *Health*

HackensackMeridianHealth.org

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

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.[1] 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

I, ____ (PATIENT NAME), by marking √ (or x) and signing below, agree to:

☐ representation by HMHN in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-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 **below**)

Name: ______________________________

[1] 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.

CONSENT FOR BABY

CONSENT FOR TREATMENT

MOTHER'S NAME: ______________________________

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.). I

Hackensack Meridian
Hackensack University
Medical Center

CONSENT FOR BABY

CONSENT FOR TREATMENT

MOTHER'S NAME: ______________________________

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 *Date and Time*

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

Hackensack Meridian
Hackensack University
Medical Center

PATIENT NAME: ______________________________________

ATTENDING PHYSICIAN: ______________________________________

DOB: ____________________

CONSENT FOR TREATMENT

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Hackensack Meridian
Hackensack University
Medical Center

PATIENT NAME: ______________________________

ATTENDING PHYSICIAN: ______________________________

DOB: ____________________

CONSENT FOR TREATMENT

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_______________________________________ _____________________
Patient *Date and Time*

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