INSTRUCTIONS FOR COMPLETING PAPERWORK

PLEASE READ EACH FORM BEFORE SIGNING AND DATING

Treatment Authorization, Financial Assignment and Acknowledgements – This form authorizes the doctor to evaluate and examine you, authorizes us to bill your insurance, authorizes us to submit records to the insurance company if they request for payment. This form also acknowledges that you assume financial responsibility for charges which, for any reason, are not paid by your payer or insurance company. Please read and sign and date where applicable.

Patient Rights and Responsibilities – This form is to inform you of your rights and responsibilities as a patient. You may keep this form for your records.

Pennington Cancer Center Acknowledgment of Patient Rights – This form is acknowledges you have received a copy of the Patient Rights and Responsibilities. Please sign and date where applicable.

Authorization for Use or Disclosure of Protected Health Information – This form allows the doctor to obtain any additional records from any other doctors or hospitals necessary for your treatment or care. Please sign and date where applicable.

Demographic Sheet – Please complete this form to the best of your ability. The insurance information will not need to be completed as long as we have a copy of your insurance card. If the insured is different from yourself, please complete the name, date of birth and social security number of the individual. In the Emergency Information, please provide AT LEAST one name and phone number of an individual that may be contacted in the event we are not able to reach you.

Nutritional Screen Form - Please enter your height and weight (if known) and answer questions 1 and 2 only.

Self-Assessment Tool for Function – Your functional ability is important to us. Over the last month, how many times have you had difficulty with any of the following statements 1-26. Please circle the number that applies to you.

Please be advised that there will be a few additional forms for completion when you check-in. If you have any questions or concerns, please let us know.

Baton Rouge General

Name :

Date of Service/Admit: ____/____/____

Account Number:

Treatment Authorization, Financial Assignment and Acknowledgements

Financial Responsibility

This is to certify that the information provided to the Baton Rouge General Medical Center ("Medical Center") is true and correct to the best of my knowledge and belief. In consideration of the services rendered to the patient named below, I/we assume responsibility for and guarantee the payment of all Medical Center charges in accordance with the Medical Center's then current rate. Total charges are payable when rendered. I/we also agree that, except as provided by law, I/we shall be responsible for the payment of any Medical Center charges which, for any reason, are not paid by any payer or insurance company. In the event this account is rendered delinquent and requires legal action to resolve payment, I/we agree to pay, in addition to the principal sum due, a fee of thirty three and one-third (33 1/3%) of the amount due on the account to cover collection agency and/or attorney fees and other fees and expenses incurred by this facility.

Consent for Treatment

I/we agree and consent to all procedures, medical treatments, and photographs, video tapes, digital, or other images deemed necessary by the patient's physician(s). I/we acknowledge that there is no guarantee, express or implied, as to the results of procedures and medical treatments performed. The Medical Center is a Teaching Hospital which through its programs, services and facilities provides clinical settings for the training of medical and allied health professionals. As a patient in the Medical Center, part or all of your care may be rendered by practitioners in training (physicians, nurses, technicians, etc.) under the supervision of the appropriate medical and/or allied staff.

Medical Release and Assignment of Insurance Benefits

I/we authorize the Baton Rouge General Medical Center to release any and all medical records, including diagnoses related to alcohol/drug abuse, mental disorders, HIV/AIDS status and related illnesses and billing information to the Social Security Administration, Medicare, Medicaid (or their various intermediaries), the patient's insurance companies, health maintenance organizations, workers compensation carriers, employers, alternate care facilities, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), including but not limited to ______________________, when such information is requested for payment, utilization, review or coverage determination purposes, I/we understand that I/we may revoke this consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including, but not limited to securing full payment of the account(s). This authorization shall remain in effect, for a period of not more than one year from the date shown below or until payment of this account is rendered in full, whichever is greater. I/we further authorize any such payer or insurance company to pay directly to the Medical Center and/or affiliated physicians all benefits due and payable as a result of services rendered by the Medical Center and/or affiliated physicians. I hereby appoint the hospital and/or affiliated physicians as my authorized representative to pursue any claims, and administrative and/or legal remedies on my behalf for collection against any responsible payer or third party liability carrier of any
and all benefits due me for the payment of charges associated with my treatment. A photocopy of this Treatment Authorization, Financial Assignment and Acknowledgements shall serve as an original.

Medication Assistance Program

In some cases, when a patient has no Insurance Coverage, the hospital is able to obtain reimbursement for some of your medications from companies that manufacture them. When this occurs, the cost of the medication is removed from your hospital charges. Most of these programs require your signature on the application forms. So that you do not have to sign an application for each medication, we are requesting that you sign this Limited Power of Attorney, which allows a Medical Center representative to sign these forms on your behalf.

Limited Power of Attorney: I appoint Baton Rouge General Medical Center, 3600 Florida Boulevard, Baton Rouge, Louisiana 70806 as my attorney for the sole and exclusive purpose of carrying out in my name, the application forms required for Baton Rouge General Medical Center to obtain replacement of my medications from pharmaceutical manufacturers. This Limited Power of Attorney will be in full force from the date signed.

Physician's Medical Release and Assignment of Insurance Benefits

I/we hereby assign to any physician providing anesthesia, radiology or other related services rendered in connection with my treatment all benefits due me for such services under any applicable policy of insurance. I/we accept the financial responsibility to said physicians for all charges and services not paid by any payer or my insurance company and hereby promise to pay within 30 days of the date rendered any remaining balance. The authorization to release medical information herein contained shall also apply to the physicians referred to in this paragraph, and any physician involved in patient's primary care.

Personal Property and Valuables / Quality Survey

I/we understand and agree that the Medical Center cannot and shall not be responsible for any item or valuable not placed in the Medical Center's safe. I/we understand and agree that General Health System or a contracted agency may contact me/us to discuss information relative to quality concerns.

Patient Rights and Responsibilities

I/we have received a copy of the Patient Rights and Responsibilities.

Joint Notice of Privacy Practices

I/we, individually or on behalf of the patient, authorize the Medical Center to use and disclose my health information as required for treatment, payment, and healthcare operations as described in the Medical Center's Joint Notice of Privacy Practices. I hereby acknowledge that I was given a copy of the Medical Center's Joint Notice of Privacy Practices on the date written below.

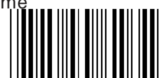
Smoking Cessation Information

I/we have been given information on smoking cessation and related resources. Smoking is prohibited within the hospital and is only allowed in designated areas.

Network Insurance Disclosure

I/we have been given information regarding the contracted status (network or non-network) of my insurance company with the Medical Center. The document provided to me also contains contact information for the ancillary providers that may be encountered during hospitalization.

Patient's Signature (if unable to sign, then by Legal Guardian or Next of Kin)	Relationship to Patient	Date	Time



Witness	Witness

Patient Rights & Responsibilities

You have the right to access healthcare which includes:

- Receiving treatment without discrimination as to age, race, color, religion, gender, national origin, disability, diagnosis, ability to pay, source of payment or sexual orientation.
- Receiving treatment for any emergency medical condition regardless of ability to pay.
- Being given a complete explanation if there is a need for you to be transferred to another facility, the alternatives to such a transfer, and the identity of the accepting physician at the accepting facility.
- Access to protective services, either for yourself, your child or any member of your family, who is a patient in our hospital. The Social Worker will assist you in making contact with such community resources.
- Information for Medicare admitted patients regarding beneficiary discharge rights, notice of non-coverage and the right to appeal premature discharge.
- Knowing about hospital resources that are available to you.
  Pastoral Care: (225) 387-7742
  Social Work: (225) 387-7738

You have the right to participate in your care which includes:

- Development, implementation and revision of your plan of care. This includes treatment plans, discharge plans and pain management plans. The hospital will assist in arranging for required follow-up care after discharge as needed.
- Having interpretive and translation services as needed. The hospital will communicate with you if you have vision, speech, hearing or cognitive impairments in a manner that meets your needs.
- Having a family member or representative of your choice and your physician notified promptly of your admission to the hospital.
- Being informed about and participating in decisions regarding your care; to include a surrogate decision maker in the decision making when you are unable to make decisions for your care, treatment or services. This information shall include the possible risks, burdens and benefits of the procedure or treatment. This information will be given to you in a language and words that you understand.
- The right to give or withhold informed consent as permitted by law. The effects of refusing treatment will be explained to you. Therefore, you will be able to make an informed decision regarding your care. This includes respecting the surrogate decision maker's right to refuse care, treatment and services on behalf of you when you are unable to make decisions for your care, treatment or services.
- Consent to or decline to participate in research, investigation and clinical trials.
- Requesting a second opinion regarding any treatment. If your insurance does not cover this cost, you will be responsible for payment.
- Discussing resuscitative measures with your physician and formulating or revising your Advance Medical Directive (living will or healthcare power of attorney). These documents express your choices about life prolonging procedures or name someone to make decisions if you are unable to speak for yourself. The hospital will follow your Advance Medical Directive.
- Requesting a consultation from the Ethics Committee for help with difficult medical decisions.
  Ethics Representative: (225) 387-7742
- Request family member, friend or other individual to be present with you for emotional support during the course of your stay unless medically contraindicated.
- Expressing concerns or asking questions about care or service.
  Mid City Administration: (225) 387-7767
  Bluebonnet Administration: (225) 763-4040

You have the right to information regarding your care which includes:

- Knowing the name and the roles of the people treating you.
- Being informed of your health status, diagnosis and prognosis. This includes being informed about any continuing health care requirements after discharge.
- Knowing about hospital billing policies that affect your charges and payment options. You may request an explanation of your bill by calling Patient Financial Services at (225) 819-1000.
- Being informed about unanticipated outcomes of care (sentinel event).
- Lodging a concern or grievance about care or service.
  Mid City Administration: (225) 387-7767
  Bluebonnet Administration: (225) 763-4040
- Receiving a written response to your grievance within 7-10 days.
- Lodging a grievance with the licensing agency and/or accrediting agency for our facilities:
  The licensing agency for our facilities is:
  Louisiana Department of Health and Hospitals,
  Health Standards Section, PO Box 3767, Baton Rouge, LA. 70821
  (225) 342-0138, toll free (866) 280-7737
  The accrediting agency for our facilities is:
  The Joint Commission's Office of Quality Monitoring, toll free (800) 994-6610 or email: complaint@jointcommission.org

You have the right to maintain your dignity which includes:

- Receiving considerate and respectful care in a clean and safe environment.
- Privacy and confidentiality during consultation, examination, personal hygiene activities, treatments and discussions concerning your diagnosis and treatment. Your treatment records are confidential unless you have given permission to release information or reporting is required by law. You may review your medical record upon request.
- Being free from neglect, exploitation and abuse.
- Respect for your dignity and worth regardless of your diagnosis.
- Being free from restraints that are not medically necessary.

Your responsibilities as a patient are to:

- The best of your knowledge, provide accurate and complete information about present and past medical conditions.
- Ask questions when you do not understand information or instructions.
- Follow the treatment plan recommended by the physician or to inform your doctor if you believe you cannot follow through with your treatment.
- Notify the physician or nurse of any unexpected changes in your condition.
- Be considerate and respectful of the rights and needs of other patients and healthcare workers. This includes being sensitive to noise level, respectful of others property, limiting the number of visitors and abiding by the smoke-free environment.
- Provide the hospital with a copy of your most current Advance Medical Directive if you have one.
- Assure that financial obligations of your healthcare are fulfilled.
- Follow the hospital policies regarding patient care and conduct.
- Remain on the nursing unit unless the physician writes a specific order otherwise, or you are escorted/transported by a hospital staff member to another department to receive medical care.

Our Mission: Improving lives and strengthening our community by providing exceptional healthcare.

6-2014

Baton Rouge General
A Community of Caring

PENNINGTON CANCER CENTER
ACKNOWLEDGMENT OF PATIENT RIGHTS

Instructions: This form is to be completed during the admission or registration process for any person receiving diagnostic or patient care services at Baton Rouge General Medical Center. This includes the following departments:

CDU/BHU	Occupational Health
Clinical Nutritional Services	Outpatient Hem/Onc
Diabetes Center	Patient Intake (Admitting)
Emergency Department	Physical Medicine
Heart and Fitness Center	Radiation/Oncology Center
Industrial Rehabilitation	Radiology
Laboratory	Respiratory Care/Neuro Diagnostics

I acknowledge that I have read or have had explained to me the following information concerning my rights and responsibilities as a patient at Baton Rouge General (Check off those items covered)

- ☐ Patient Rights and Responsibilities
- ☐ Patient Charges and Insurance Requirements
- ☐ Billing and Payment Regulation
- ☐ Visiting Hours and Visitor Regulations
- ☐ Living Will and Advanced Directives
- ☐ Preoperative Instructions

I further acknowledge that if I need additional information I may contact:

Patient Concerns at Ext 6149 or 381-6149
Medical Social Work at Ext 7738 or 387-7738
Pastoral Care at Ext 7742 or 387-7742
Insurance at Ext 6297 or 381-6297

____ ______/_____/________
Patient or Guardian Signature Date

____ ______/_____/________
Hospital Representative Date

07/02/2012

Baton Rouge General
A Community of Caring

Pennington Cancer Center
Ph# 225-387-7280 Fax# 225-237-1711

Authorization For Use or Disclosure of Protected Health Information

Name of Individual (print)	**Date of Birth**	**Phone#**	
Address	**City**	**State**	**Zip Code**

I hereby authorize Baton Rouge General Pennington Cancer to use and/or disclose the information checked and/or listed below:

☐ **Consultation Report** ☐ **Pathology Reports** ☐ **Other** ____
☐ **History and Physical** ☐ **Radiology Reports**
☐ **Operative Reports** ☐ **Lab Reports** ☐ **Other** ____
☐ **Other** ____

The Information checked and/or listed above is to be released to Dr. ______________________________________ at the Baton Rouge General Pennington Cancer.

☐ **Continuation of Treatment** ☐ **Processing of Insurance Claim** ☐ **Application of Insurance**
☐ **At the Individual's Request** ☐ **Attorney (Name)** ____
☐ **Other:** ____

- **If authorizing certain marketing activities, I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.**

- **Unless otherwise revoked by me, I understand that this authorization will expire in one year or upon the completion of the use or disclosure of the information for the purpose it was intended, whichever is earlier.**

- **I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.**

- **I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.**

- **I hereby release the facility, its employees, officers, and healthcare professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

- **I understand that I may revoke this request at any time by providing the facility with my written notice of such revocation as outlined in the facility's Joint Notice of Privacy Practices.**

- **I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization.**

- **I understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.**

____ ____
Signature of Individual **Signature of Witness**

____ ____
Printed Name of Individual **Printed Name of Witness**

___________/__________/____________ ___________/___________/____________
Date **Date**

A copy of this record must be provided to the person making the request and a copy must be filed in the Medical Record. If a representative is signing, the relationship to individual should be listed. If individual is under 18, the parent or guardian must sign.

Baton Rouge General
A Community of Caring

Pennington Cancer Center
P.O. Box 2511
Baton Rouge, LA 70806-2511
(225) 387-7280
Fax (225) 237-1711

PATIENT LABEL

Do you have a Pacemaker or Neurostimulator? __Yes __No

Please print clearly

Last name ______________________ **First name**______________________ **MI**________

Social Security# _________-________-__________ **DOB** ________/_______/________ **Age** _____ **Sex** ______

Race _______ Marital Status _______ **Primary Care Dr** ______________________________

Home Address ______________________________ **City** ______________________ **State** _______ **Zip** __________

Home Phone# ______________________ **Wk#** ______________________ **Cell#** ______________________

EMAIL ADDRESS: ____

Place of Employment ____________________________ Occupation ____________________________

Employer's address ____

Primary Insurance plan ____________________ **Policy#** __________________ **Group#**________________

Insured name ________________________________ **Insured DOB** _________/__________/___________

Insured's Social Security#________/_______/__________

Place of Employment ____________________________ Occupation ____________________________

Employers Address ____________________________ City ______________________ State _______

Phone #________________________

2nd Insurance Plan ____________________ **Policy #** ____________________ **Group#** __________________

Insured name ________________________________ **Insured DOB** _________/__________/__________

Insured's Social Security# ________/_______/__________

Place of Employment ____________________________ Occupation ____________________________

Employers Address ____________________________ City ______________________ State ________

Phone # ________________________

Emergency Information

Name ____ Relationship ____________________________

Address ______________________________ Phone# _______________ Cell# __________________

Name of person **who does not live with you** to be notified in case of emergency:

Name ____ Relationship ____________________________

Address ______________________________ Phone#____________________ Cell# _________________

Place Label Here

Nutritional Screen Form

Instructions: Please enter your height and weight (if known) and answer questions 1 & 2 only.

Weight: _______ **Height:** _______ feet _______ inches

1. **Have you lost weight without trying recently (in the past 6 months)?**
   - ☐ No 0
   - ☐ Unsure 2
   - Yes, how much?
     - ☐ 2 - 13 lbs. 1
     - ☐ 14 – 23 lbs. 2
     - ☐ 24 – 33 lbs. 3
     - ☐ 33 lb. or more 4
     - ☐ Unsure 2

2. **Have you been eating poorly because of a decreased appetite?** (e.g., eating less than 75% of usual intake due to swallowing problems)
   - ☐ No 0
   - ☐ Yes 1

Office Use Only. Please Do Not Complete Below.

SCORE and MALNUTRITION RISK
0-1 No risk
2 Mild risk
3 – 4 Moderate risk
5 or > High risk

Diagnosis Score ________

Total Score ________

Adapted from Malnutrition Screening Tool (MST). Revised 5/2014.

Baton Rouge General
A Community of Caring

Self Assessment Tool for Function

PENNINGTON CANCER CENTER
RADIATION ONCOLOGY

NAME:____

DATE:______________________ AGE:______________DATE OF DIAGNOSIS:____________________________

WE ARE CONCERNED ABOUT YOUR WELFARE. PLEASE TAKE THE TIME TO ESTIMATE HOW THE FOLLOWING STATEMENTS APPLY TO YOU OVER THE COURSE OF THE LAST MONTH.

Please circle the number that applies:	NOT AT ALL	A LITTLE	A FAIR AMOUN,	MUCH	VERY MUCH
A.					
1. I HAVE DIFFICULTY WALKING ………………………………………………………………	0	1	2	3	4
2. I HAVE DIFFICULTY GETTING IN AND OUT OF BED ………………………………	0	1	2	3	4
3. I HAVE DIFFICULTY PARTICIPATING IN MY DAILY EXERCISE REGIMEN……	0	1	2	3	4
4. I HAVE RECENTLY FALLEN……………………………………………………….	0	1	2	3	4
5. I HAVE DIFFICULTY WITH BENDING OR LIFTING…………………………………….	0	1	2	3	4
6. I HAVE DIFFICULTY WALKING UP AND DOWN STAIRS…………………………	0	1	2	3	4
B.					
7. I HAVE DIFFICULTY PARTICIPATING IN LEISURE ACTIVITIES…………………	0	1	2	3	4
8. I HAVE DIFFICULTY BATHING, DRESSING, OR GROOMING…………………….	0	1	2	3	4
9. I HAVE DIFFICULTY DOING HOUSEHOLD CHORES……………………………….	0	1	2	3	4
10. I HAVE DIFFICULTY REACHING OVERHEAD………………………………………….	0	1	2	3	4
11. I HAVE DIFFICULTY GRASPING AND HOLDING OBJECTS………………………	0	1	2	3	4
12. I HAVE DIFFICULTY PARTICIPATING IN WORK ACTIVITIES…………………….	0	1	2	3	4
C.					
13. I HAVE DIFFICULTY WITH CONCENTRATING………………………………………….	0	1	2	3	4
14. I HAVE DIFFICULTY REMEMBERING THINGS………………………………………….	0	1	2	3	4
15. I HAVE DIFFICULTY WITH SPEAKING………………………………………………….	0	1	2	3	4
16. I HAVE DIFFICULTY WITH SWALLOWING, COUGHING OR CHEWING…….	0	1	2	3	4
D.					
17. I HAVE PAIN………	0	1	2	3	4
IF ANSWER IS 1-4 PLEASE STATE WHERE:______________________________________					
18. I HAVE SWELLING…………………………………………………………………………….	0	1	2	3	4
IF ANSWER 1-4 PLEASE STATE WHERE:____					
19. I HAVE NUMBNESS, TINGLING OR BURNING FEELINGS………………………	0	1	2	3	4
IF ANSWER 1-4 PLEASE STATE WHERE:____					
20.I DO NOT HAVE THE ENERGY I USED TO HAVE…………………………………….	0	1	2	3	4
21. I BECOME SHORT OF BREATH EASILY OR WITH LIGHT ACTIVITY…………..	0	1	2	3	4
E.					
22. I LEAK URINE WHEN I COUGH OR SNEEZE………………………………………….	0	1	2	3	4
IF ANSWER 1-4, ARE YOU SEEING A UROLOGIST: ________________________________					

23. I HAVE RECEIVED PHYSCIAL THERAPY BEFORE……………………………………. YES NO
24. I HAVE RECEIVED OCCUPATIONAL THERAPY BEFORE………………………… YES NO
25. I HAVE RECEIVED SPEECH THERAPY BEFORE…………………………………………. YES NO

26. I AM CURRENTLY RECEIVING HOME HEALTH SERVICES……………………… YES NO