Cleveland Clinic
Akron General

Dear Maternity Patient:

Your physician has made arrangements for your admission to Cleveland Clinic Akron General. In order to help us process your admission and to save you time, please complete both sides of the form and mail it to us as soon as possible.

It is very important that you bring your insurance cards with you at the time of admission. Should you have any questions concerning coverage or finances, please contact the Patient Accounts Department at 330-344-6082.

Please see the enclosed sheet on what to bring with you to the hospital. If you have not selected your baby's physician, please do so at this time and complete the form in your maternity packet.

If you have any questions, please contact the Admitting Department at 330-344-6770.

Sincerely,

Cleveland Clinic
Akron General

AGREEMENT TO RELEASE OF MEDICAL INFORMATION

Your treatment at Cleveland Clinic Akron General may necessitate sharing your Medical Records and other related information with others who have a need to know so that your bills may be processed. The purpose of this agreement is to acquaint you with our procedures and obtain your consent to release that information.

As a patient you agree to the following:

1. Cleveland Clinic Akron General and Physicians providing services to you in connection with your treatment, including Physician employees of Cleveland Clinic Akron General and attending and consulting Physicians may disclose your medical record to any person which may be liable for all or part of Cleveland Clinic Akron General's or Physician's charges, including but not limited to hospital or medical service companies, insurance companies, utilization or professional standards review companies, worker compensation carriers, welfare funds or your employer.

2. This release of information is applicable to all medical information arising out of your admission to Cleveland Clinic Akron General (including alcohol, drug and psychiatric treatment except as otherwise restricted by law) whether such information is given prior to, during or after discharge from Cleveland Clinic Akron General and specifically includes but is not limited to all information released in the pre-authorization, pre-certification, concurrent and retrospective review process whether such information is in verbal or written, original or copied form and whether given personally, via telephone or otherwise.

3. You specifically authorize Cleveland Clinic Akron General and all Physicians to rely on the stated identity of persons requesting reimbursement and utilization related information over the telephone, by letter or in person.

PATIENT'S REPRESENTATIVE	RELATIONSHIP	DATE

Cleveland Clinic
Akron General

ADVANCED REGISTRATION

If maternity, due date _____ Admitting Physician_____ Primary Care Physician_____

Have you selected a pediatrician? ☐ Yes ☐ No Newborn's Physician_____

Name of Baby's Primary Insurance Carrier_____ (Please remember to add the baby to your plan)

PLEASE FILL IN ALL BLANKS COMPLETELY

PATIENT INFORMATION:

PATIENT NAME - FIRST	MIDDLE	LAST	MAIDEN	BIRTHDATE	MARITAL STATUS	SEX

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiin or other Pacific Islander ☐ White ☐ Decline to provide ☐ Unavailable

WHAT LANGUAGE WOULD YOU FEEL MOST COMFORTABLE USING TO DISCUSS YOUR HEALTH CARE?

ETHNIC GROUP THAT BEST DESCRIBES YOUR ANCESTRY
☐ Hispanic or Latino ☐ Jamaican ☐ African ☐ American ☐ Haitian ☐ Korean ☐ European ☐ Middle Eastern

ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	SOCIAL SECURITY NUMBER	RELIGION	CHURCH NAME

EMPLOYER	EMPLOYER ADDRESS	BUSINESS PHONE	OCCUPATION	STATUS
				☐ DISABLED ☐ FULL TIME ☐ PART TIME ☐ RETIRED

SPOUSE OR NEAREST RELATIVE:

NAME - FIRST	MIDDLE	LAST	BIRTHDATE	RELATIONSHIP TO PATIENT

ADDRESS, IF DIFFERENT FROM PATIENT

EMPLOYER	EMPLOYER ADDRESS

SOCIAL SECURITY NUMBER	BUSINESS PHONE	OCCUPATION	STATUS
			☐ DISABLED ☐ FULL TIME ☐ PART TIME ☐ RETIRED

GUARANTOR OR RESPONSIBLE PARTY

NAME - FIRST	MIDDLE	LAST	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	HOME PHONE

EMPLOYER	EMPLOYER ADDRESS	BUSINESS PHONE	OCCUPATION	STATUS
				☐ DISABLED ☐ FULL TIME ☐ PART TIME ☐ RETIRED

PRIMARY INSURANCE:

POLICY HOLDER NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT

EMPLOYER	EMPLOYER ADDRESS

POLICY / ID NUMBER	GROUP NUMBER	EFFECTIVE DATE	IS THIS AN ☐ HMO or ☐ PPO

NAME OF INSURANCE	ADDRESS TO SEND CLAIM	PHONE NUMBER

SECONDARY INSURANCE: Is there a second Insurance ☐ Yes ☐ No

POLICY HOLDER NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT

EMPLOYER	EMPLOYER ADDRESS

POLICY / ID NUMBER	GROUP NUMBER	EFFECTIVE DATE	IS THIS AN ☐ HMO or ☐ PPO

NAME OF INSURANCE	ADDRESS TO SEND CLAIM	PHONE NUMBER

Person to contact in case of emergency (other than spouse): (Name) _____
(Address) _____ (Phone No.)_____
Do you currently have an Advance Directive, Living Will or Power Of Attorney? ☐ Yes ☐ No
If yes, please bring a copy of Directive or Living Will on admission.
If no, do you want more information at time of admission? ☐ Yes ☐ No

All Patients including Maternity: Does your insurance company require pre-certification, ☐ Yes ☐ No.
Call your insurance company to pre-certify your hospital stay. Pre-certification #: _____