LONG BEACH MEMORIAL
Miller Children's & Women's Hospital Long Beach
MEMORIALCARE HEALTH SYSTEM

2801 Atlantic Avenue • Long Beach, CA 90806 • (562) 933-1335 • FAX (562) 933-1532

PATIENT FINANCIAL POLICIES AND PRE-ADMISSION FORM

Dear Patient:

WELCOME! Your physician has referred you to Long Beach Memorial Medical Center for care. It is our goal to provide a warm, friendly place where your needs for comfort and caring will be met. **You will need to visit the hospital to preadmit one to 10 days before your admission / surgery date in order to complete any necessary tests ordered by your physician, sign all operative consents and receive educational instruction from nursing staff.**

Preadmission Process . . . To save you some time prior to your interview with Admitting, please complete the attached preadmission form and mail it to us as soon as possible. Please make sure you check the appropriate patient type on the envelope after completing the preadmission form; this will expedite your preadmission.

If time does not permit you to mail the form, please contact the Preadmission Department (562) 933-1360 or FAX form to: Surgery (562) 933-1532 or Labor and Delivery (562) 933-1352. Your cooperation is appreciated.

Surgical: This process is conducted in the PREP area located in Long Beach Memorial's Surgery Department. All surgical patients should contact a PREP scheduler at 562-933-1042 at least a week prior to your surgery date to schedule a PREP appointment with a nurse. PREP appointments are available Monday-Friday 8am to 5:30pm and Saturday from 8am to 12pm. On the day of your PREP appointment, please arrive 45 minutes prior to your appointment and stop by the Admitting Department to check in and sign Admitting paperwork.

Non-Surgical/OB Admissions: Please complete this form and return to Admitting prior to your scheduled Admit date.

Financial Responsibility . . . As a courtesy, we will be verifying and obtaining authorization for your admission. It is important that you notify your healthplan prior to admission. Failure to do so could increase your out-of-pocket expense. Please mail a copy of your insurance card(s) and have it available at the time of your interview.

If you are a cash paying patient, please contact our Admission Department at (562) 933-1360 for an estimate of costs which you will be expected to pay prior to Admission.

Arrival Time . . . Make sure you check with your physician's office regarding your hospital arrival time.

What to Bring . . . Bring as little as possible . . . Your checkbook, Mastercard or Visa if you have prepayment requirements and only a few personal items.

What Not To Bring . . . Please leave all valuables at home. The hospital cannot be responsible for valuables unless they are deposited in the cashier's safe. No electrical appliances (hair blowers, radios, curling iron, heating pad, electric blanket) are allowed to be brought into the hospital.

Choice of Rooms . . . Limited Private Rooms available upon request.

We are a Non-smoking Hospital.

Check Out Time . . . Is 10:00 a.m. or earlier.

Parking . . . The main parking entrance is located off Atlantic Avenue. See map on reverse side.

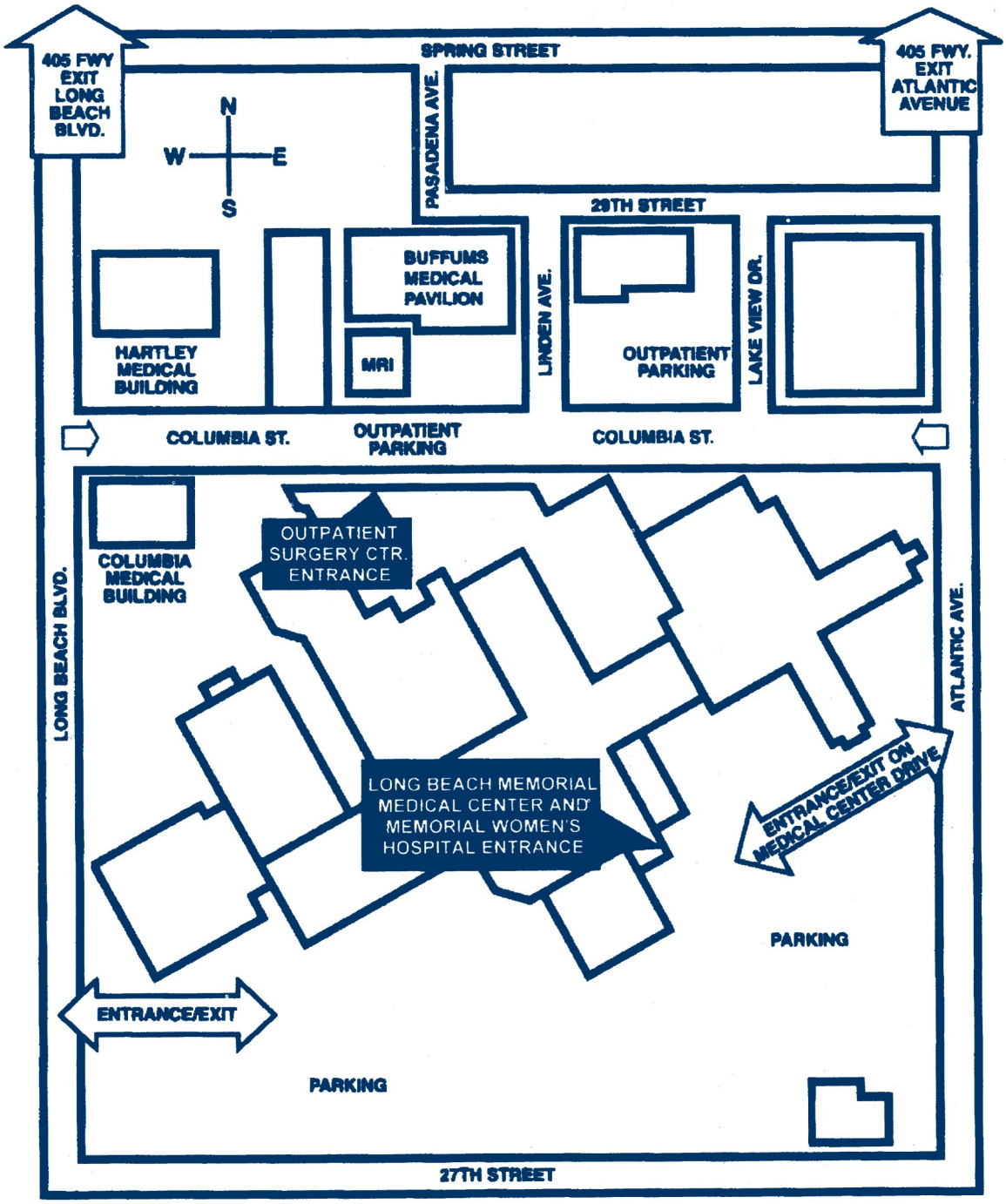
Visiting Hours . . . Throughout the hospital, visiting hours are from 10:00 a.m. to 9:00 p.m., with the following exceptions:

Children's hospital is open 24 hours a day, every day for parents only. All other visitors, please coordinate with the Child's nurse.

If you have any questions concerning your admission, please call our pre-admission office at (562) 933-1360 between the hours of 8:00 a.m. and 4:00 p.m. Monday-Friday.

Thank you for your cooperation

Admitting Office



DIRECTIONS:

From the 405 Freeway, take the Atlantic Avenue south exit.

PARKING INFORMATION:

- For outpatients, there is limited parking directly in front of the Outpatient Surgery Unit. Additional parking is located at the corner of Linden Avenue and Columbia Street.
- If you are staying in the hospital after your procedure, enter the Medical Center off Atlantic Avenue on Medical Center Drive and park in any of the patient/visitor parking areas.
- Valet Parking is available at Main Entrance and Outpatient Surgery Entrance.

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PRE-ADMISSION FORM

FAX NUMBERS:
SURGICAL: (562) 933-1532
LABOR & DELIVERY: (562) 933-1352

PLEASE PRINT

❑ SURGERY
❑ OB ❑ OUTPATIENT

EXPECTED ADMISSION / SERVICE DATE

IF MATERNITY
EXPECTED DUE DATE: _____
LAST MENSTRUAL DATE: _____

PATIENT'S NAME (LAST, FIRST, MIDDLE) | AKA, ALSO KNOWN AS (LAST, FIRST, MIDDLE)

PATIENT'S ADDRESS | CITY | STATE | ZIP | AREA CODE | HOME PHONE

SEX | BIRTHDATE | AGE | SOCIAL SECURITY NUMBER | MARITAL STATUS | RELIGION | RACE / ETHNICITY | ALLERGIES / DIABETIC? ❑ YES ❑ NO

REFERRING PHYSICIAN NAME | REFERRING PHYSICIAN PHONE NUMBER | ADVANCE DIRECTIVE ❑ YES ❑ NO

IF YOU HAVE A PRIMARY CARE PHYSICIAN (PCP), PLEASE COMPLETE:
PRIMARY CARE PHYSICIAN'S NAME: | MEDICAL GROUP/IPA: | AREA CODE | PCP'S PHONE

RESPONSIBLE PARTY'S INFORMATION

GUARANTOR / RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) | ADDRESS | CITY | STATE | ZIP | AREA CODE | HOME PHONE

OCCUPATION | SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | BIRTHDATE | SEX

EMPLOYER OF PERSON RESPONSILBE FOR BILL | ADDRESS | CITY | STATE | ZIP | AREA CODE | HOME PHONE

PRIMARY INSURANCE INFORMATION

❑ MEDICARE ❑ MEDI-CAL ❑ PPO ❑ POS ❑ HMO ❑ WORKER'S COMP ❑ CHAMPUS ❑ OTHER _____

PRIMARY INSURANCE | AREA CODE | PHONE NUMBER

1ST INSURANCE ADDRESS | CITY | STATE | ZIP

1ST INSURED'S EMPLOYER NAME | ADDRESS | CITY | STATE | ZIP | AREA CODE | PHONE NUMBER

INSURED'S NAME (PATIENT OR SPOUSE) | 1ST INSURANCE SUBSCRIBER'S ID #/GROUP # | SOC. SEC. NUMBER | BIRTHDATE | RELATION TO PATIENT

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE | AREA CODE | PHONE NUMBER

2ND INSURANCE ADDRESS | CITY | STATE | ZIP

2ND INSURED'S EMPLOYER NAME | ADDRESS | CITY | STATE | ZIP | AREA CODE | PHONE NUMBER

INSURED'S NAME (PATIENT OR SPOUSE) | 2ND INSURANCE SUBSCRIBER'S ID #/GROUP # | SOC. SEC. NUMBER | BIRTHDATE | RELATION TO PATIENT

WORKER'S COMP / THIRD PARTY INFORMATION

IS THIS A WORK-RELATED INJURY? ❑ YES ❑ NO IF YES, PLEASE COMPLETE LINES A, B, C BELOW. IF NO, PLEASE DO NOT FILL OUT THIS SECTION

A DATE OF INJURY | WORKER'S COMP CLAIM # | SOCIAL SECURITY NUMBER | NAME OF WORKER'S COMP CLAIMS ADJUSTER

B EMPLOYER NAME AT TIME OF INJURY | ADDRESS | CITY | STATE | ZIP | AREA CODE | PHONE NUMBER

C INSURANCE COMPANY NAME | ADDRESS | CITY | STATE | ZIP | AREA CODE | PHONE NUMBER

IN CASE OF EMERGENCY – GIVE NAME OF SPOUSE, PARENT, NEAREST RELATIVE OR FRIEND

FULL NAME | RELATION | HOME PHONE | AREA CODE | BUSINESS NUMBER

ADDRESS | CITY | STATE | ZIP

ALL INSURANCE IDENTIFICATION CARDS WILL BE REQUIRED UPON ADMISSION

2801 Atlantic Avenue / P.O. Box 1428 / Long Beach, CA 90801-1428 / (562) 933-1335