



LONG BEACH MEMORIAL MEDICAL CENTER

2801 Atlantic Avenue • P.O. Box 1428 • Long Beach, CA 90801-1428 • (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 (562) 933-1532 to give the information. Your cooperation is appreciated.

Surgical: This process is conducted in the A.M. Nursing Unit for Surgical patients who are spending at least one night in the hospital. The outpatient surgeries are processed in the Memorial Outpatient Surgery Nursing Unit. Both units are open for preadmission Monday through Friday from 8 a.m. to 6 p.m. and Saturday (limited availability) from 8 a.m. to 1:30 p.m. For more information, please review your surgery Boarding Pass (if applicable).

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 Clinical Admission Coordinator at (562) 933-1346 for an estimate of costs which you will be expected to pay prior to Admission.

If you are a maternity patient with no insurance coverage, please call the Birthcare Admitting Representative at (562) 933-1340 to discuss our cash/discount programs.

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 for an additional charge of \$125.00 per night

We are a Non-smoking Hospital.

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

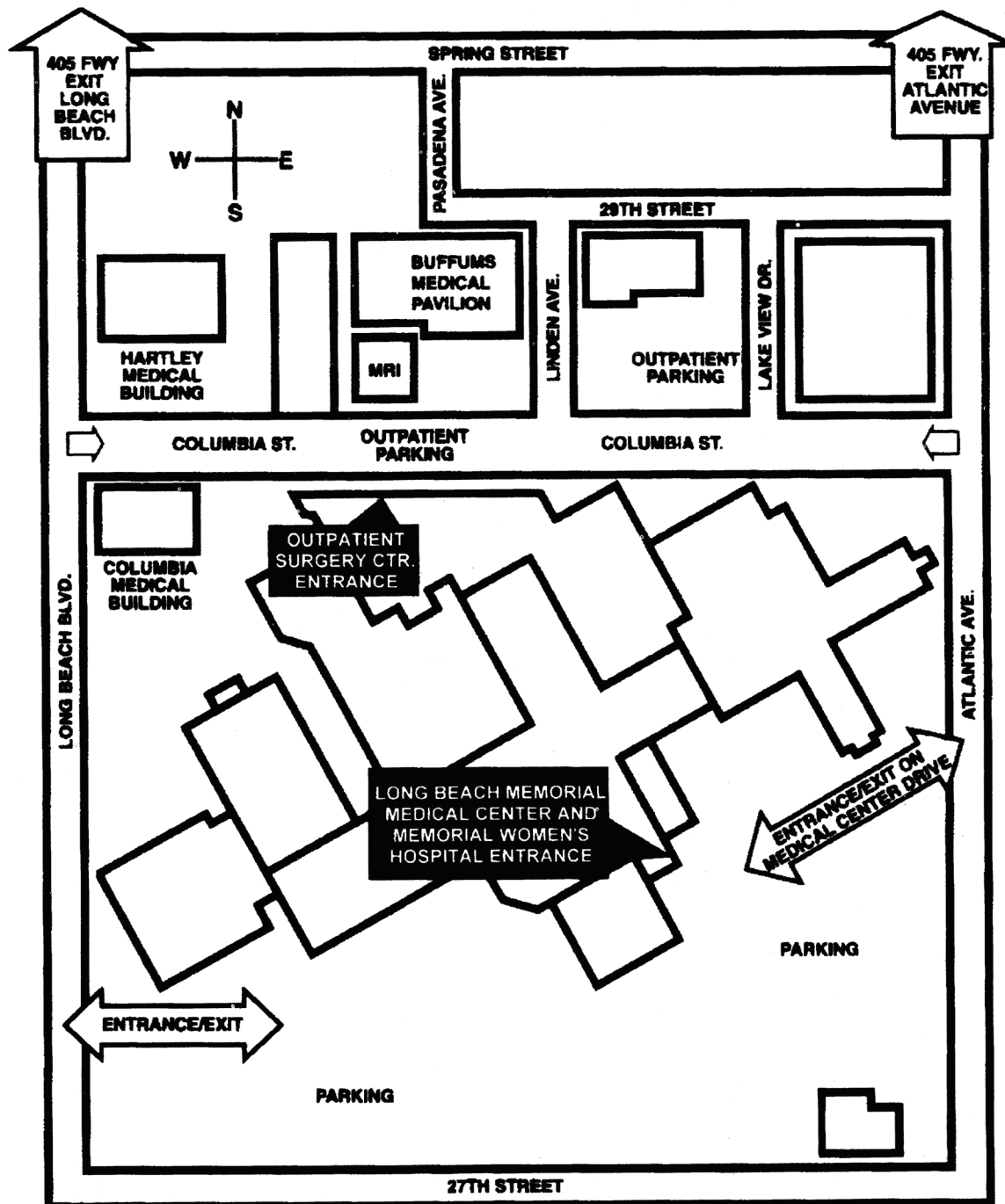
Parking . . . The main parking entrance is located off Atlantic Avenue. See map on reverse side.

Visiting Hours . . . Throughout the hospital, visiting hours are from 8:00 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.



**LONG BEACH
MEMORIAL**
MEDICAL CENTER

MEMORIAL HOSPITAL
WOMEN'S HOSPITAL
MILLER CHILDREN'S HOSPITAL
MEMORIAL REHAB HOSPITAL

2801 Atlantic Avenue
PO Box 1428
Long Beach, CA 90801-1428
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**SURGERY AND ADMISSION NOTICE
(FOR PHYSICIAN OFFICE USE ONLY)**

INSTRUCTIONS:

- 1. SURGICAL:** CALL SURGERY SCHEDULING DEPARTMENT AT (562) 933-1011 WITH APPLICABLE INFORMATION COMPLETED ON FORM BELOW. FAX COMPLETED FORM TO SURGERY SCHEDULING AT (562) 933-1062.
- 2. NON-SURGICAL:** COMPLETE APPLICABLE QUESTIONS IN ALL BOXES. FAX COMPLETED FORM TO ADMITTING / RESERVATION AT (562) 933-1532.
- 3. PLEASE FAX ATTACHED PRE-ADMISSION FORM (OR PHYSICIAN OFFICE PATIENT DEMOGRAPHICS WITH INSURANCE CARD COPIES) TO (562) 933-1532.**

ADMISSION DATE:		ADMIT TYPE	INPATIENT	<input type="checkbox"/> SURG	<input type="checkbox"/> SURG-GYN	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> OTHER
SURGERY DATE:			OUTPATIENT	<input type="checkbox"/> SURG	<input type="checkbox"/> SURG-GYN	<input type="checkbox"/> DAYCARE	<input type="checkbox"/> OBSERVATION
IF ADMITTING DATE IS DIFFERENT THAN SURGERY DATE PLEASE STATE REASON:						SPECIAL EQUIPMENT NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
KNOWN ALLERGIES:		<input type="checkbox"/> LATEX	ANESTHESIOLOGIST REQUEST? <input type="checkbox"/> YES <input type="checkbox"/> NO				
ADMITTING PHYSICIAN:		PHONE NUMBER:	ATTENDING PHYSICIAN:		PHONE NUMBER:		
SURGEON NAME:		PHONE NUMBER:	ASST. SURGEON:		PROCTOR Y N		
DIAGNOSIS:				CPT CODES			
PROCEDURE (IF SURGERY REQUIRED):				1. _____			
① _____				2. _____			
② _____				3. _____			
ORDERS WILL BE: <input type="checkbox"/> FAXED				4. _____			
<input type="checkbox"/> SENT WITH PATIENT				LOCATION: <input type="checkbox"/> OUTPATIENT SURGERY <input type="checkbox"/> AM UNIT <input type="checkbox"/> MAIN ADMITTING (NON-SURGICAL)			
PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)					SOCIAL SECURITY NUMBER:		
PATIENT'S DATE OF BIRTH:	AGE:	SEX:	PATIENT'S HOME PHONE:		PATIENT'S WORK PHONE:		
IF MINOR CHILD, PARENT OR GUARDIAN CONTACT NAME:					PARENT/GUARDIAN PHONE NUMBER:		
INSURANCE: <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> CHAMPUS <input type="checkbox"/> OTHER: _____							
PRIMARY CARE PHYSICIAN:				MEDICAL GROUP / IPA:			
INSURANCE NAME:							
INSURED'S SOCIAL SECURITY NUMBER:			INSURED'S MEDICARE NUMBER:			INSURED'S MEDI-CAL NUMBER:	
CERTIFICATE # / GROUP #:			AUTHORIZATION NUMBER:			DATE RECEIVED:	

COMMENTS:

PLEASE FAX A COPY OF INSURANCE CARD IF AVAILABLE WITH THIS FORM: IF YOU HAVE ANY QUESTIONS, PLEASE CALL (562) 933-1360

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PLEASE PRINT

PRE-ADMISSION FORM

<input type="checkbox"/> INPATIENT MED/SURGERY <input type="checkbox"/> OB <input type="checkbox"/> OUTPATIENT SURGERY	EXPECTED ADMISSION / SERVICE DATE	IF MATERNITY EXPECTED DUE DATE: _____ LAST MENSTRUAL DATE: _____
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PATIENT'S NAME (LAST, FIRST, MIDDLE)	AKA, ALSO KNOWN AS (LAST, FIRST, MIDDLE)
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PATIENT'S ADDRESS	CITY	STATE	ZIP	AREA CODE	HOME PHONE
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SEX	BIRTHDATE	AGE	SOCIAL SECURITY NUMBER	MARITAL STATUS	RELIGION	RACE / ETHNICITY	ALLERGIES / DIABETIC? <input type="checkbox"/> YES <input type="checkbox"/> NO
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REFERRING PHYSICIAN NAME	REFERRING PHYSICIAN PHONE NUMBER	ADVANCE DIRECTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO
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IF YOU HAVE A PRIMARY CARE PHYSICIAN (PCP), PLEASE COMPLETE: PRIMARY CARE PHYSICIAN'S NAME:	MEDICAL GROUP/IPA:	AREA CODE	PCP'S PHONE
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RESPONSIBLE PARTY'S INFORMATION

GUARANTOR / RESPONSIBLE PARTY (LAST, FIRST, MIDDLE)	ADDRESS	CITY	STATE	ZIP	AREA CODE	HOME PHONE
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OCCUPATION	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	BIRTHDATE	SEX
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EMPLOYER OF PERSON RESPONSIBLE FOR BILL	ADDRESS	CITY	STATE	ZIP	AREA CODE	HOME PHONE
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PRIMARY INSURANCE INFORMATION

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

PRIMARY INSURANCE	AREA CODE	PHONE NUMBER
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1ST INSURANCE ADDRESS	CITY	STATE	ZIP
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1ST INSURED'S EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	AREA CODE	PHONE NUMBER
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INSURED'S NAME (PATIENT OR SPOUSE)	1ST INSURANCE GROUP/POLICY NUMBER	CERTIFICATE OR SOC. SEC. NUMBER	BIRTHDATE	RELATION TO PATIENT
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SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE	AREA CODE	PHONE NUMBER
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2ND INSURANCE ADDRESS	CITY	STATE	ZIP
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2ND INSURED'S EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	AREA CODE	PHONE NUMBER
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INSURED'S NAME (PATIENT OR SPOUSE)	2ND INSURANCE GROUP/POLICY NUMBER	CERTIFICATE OR SOC. SEC. NUMBER	BIRTHDATE	RELATION TO PATIENT
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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
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B EMPLOYER NAME AT TIME OF INJURY	ADDRESS	CITY	STATE	ZIP	AREA CODE	PHONE NUMBER
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C INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP	AREA CODE	PHONE NUMBER
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IN CASE OF EMERGENCY – GIVE NAME OF SPOUSE, PARENT, NEAREST RELATIVE OR FRIEND

FULL NAME	RELATION	HOME PHONE	AREA CODE	BUSINESS NUMBER
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ADDRESS	CITY	STATE	ZIP
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ALL INSURANCE IDENTIFICATION CARDS WILL BE REQUIRED UPON ADMISSION

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