Place Patient Identification Label Here

MEMORIAL HERMANN
Surgical Hospital
First Colony

REGISTRATIONINFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND IDENTIFICATION CARD TO THE RECEPTION DESK

REASON FOR VISIT:____ Time of Arrival:___________

PATIENT LAST NAME _____________________ FIRST NAME _________________________ MI _______

DOB_______________________SS#_____________________________________SEX ____M _____F

ADDRESS__________________________________CITY __________________ STATE_______ ZIP____________

HM#___________________ WK#_________________CELL#________________EMAIL_______________________

MARITALSTATUS: oSINGLE oMARRIED oDIVORCED oWIDOWED RETIRED oYES o NO DISABLED oYES oNO

Preferred Language: ____________________________ Religious Preference:_______________________

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN______________________________________ PHONE NUMBER_______________

INSURANCE INFORMATION

(DO NOT complete this section if insurance card on file or available for registration clerk)

PRIMARY INSURANCE:______________________SUBSCRIBER: o SELF o SPOUSE o MOTHER o FATHER o W/C

NAMEOFINSURED_________________________DOB _______________SSN ________________

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IS THIS VISIT DUE TO A WORK RELATED INJURY? YES NO

IF YES, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

EMPLOYER AND INSURANCE NAME______________________ PHONE # ____________________________

EMPLOYER Address ________________________________

CITY/STATE/ZIP ____________________________________

DATE OF INJURY [ ] CLAIM#_____________________ AREA INJURED _________________________

W/C INSURANCE ADDRESS___________________________ CITY/STATE/ZIP _________________________

ADJUSTER NAME___________________________________ PHONE#_______________________________

Ethnicity Question:

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds. The data obtained through this process will be used to assist researchers in determining whether or not all citizens of adequate healthcare.

NationalityorEthnicBackground (select one)

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I (patient or legal guardian) refuse to answer the question.

Race (select one)

- ☐ American Indian/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Other
- ☐ I (patient or legal guardian) refuse to answer the question

Patient/Patient Representative signature:________________________________ Date:_________________________
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Patient's Communication PreferencesRegarding their PHI

TelephoneCommunicationPreferences

Primary # _____

Work # _____

Mobile# _____

Other_____

Place Patient Identification Label Here

E-Mail Communication Preferences Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above, I agree that Memorial Hermann First Colony (MHFC) or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice messagethrough the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, MHFC or one of its legal agents may contact me with an email regarding my care, our services, or my financial obligation.

MailCommunicationPreferences

May we send mail to your home address? ☐ **YES** ☐ **NO**

Other than you, your insurance company, and healthcare providers involved in your care, whom can we talk with about your healthcare information?

Name: **Telephone** **Relationship to you**

1_____

2_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient Portal

The patient portal is a secure way to access your medical records. Examples: Educational Documents, Medications, Procedures, and Visit Summaries. We are offering the patient portal as a convenience to you at no cost. We will not sell or give away any private information, including email addresses.
The portal is for non-emergency uses only. By using this online patient portal, you agree to protect your password from any unauthorized individuals.
We will register you and send you an invite via email. Please provide the email address you wish to use as well as the answer to the challenge question; which is the last four digits of your social security number

You will be prompted to change your password the first time logging in.

Patient's Email Address
_____
Security Question: Last four digits of your Social Security Number?

_____ _____

Patient or Personal Representative Date

_____ _____

MEMORIAL HERMANN
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CONSENT TO MEDICAL PROCEDURES- The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis including emergency treatment or services, and which may include but not limited to laboratory procedures, x-ray examinations, medical treatment or procedures, or hospital services renderedthe patient under the general and special instructions of the patient's physician.

FINANCIAL AGREEMENT- The undersigned agrees, whether he signs as agent or a patient, that in consideration of theservices to be rendered to the patient, he hereby is responsible for paying facility copayments, deductibles, estimated facility coinsurance amounts; and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashiers check, credit card, or personal check. Self-pay and cosmetic surgery procedures must be paid in full to prior to surgery.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION- In consideration for services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance. I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to Memorial Hermann Surgical Hospital First Colony (**MHFC**), my attending physician, consulting physician, anesthesiologist, radiologists, ER physicians, professional laboratory and pathology services.I recognize the above physician/services are independent contractors who will generate separate bills for their respective services and I am financially responsible for all. MHFC provides cost estimates and generates bills for the facilityportion only. MHFC files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorizeMHFC and/or physicians/services indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

I acknowledge that one or more of the physicians providing my treatment at MHFC may have an ownership interestin the hospital. I also acknowledge that I have the right to choose the provider of my healthcare services and have chosen MHFC.

MEDICARE PAYMENTS- (Patient's certification, Authorization to Release Information, and 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, medical or other information about me to release to the Social Security Administration, itsintermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made onmy behalf.

PERSONAL VALUABLE AUTHORIZATION- I have been informed and understand that the hospital WILL NOT ASSUME RESPONSIBILITY for any personal property I may bring and/or keep in the hospital during my stay at MHFC.

ADVANCED MEDICAL DIRECTIVE/PATIENTS RIGHTS AND RESPONSIBILTIES- I have been given written materials about my right to accept or refuse medical treatments and informed of my rights to formulate Advanced Directives. **YES / NO**
I have an Advanced Directive YES / NO
I have provided a copy of my Advanced Directive to MHFC YES / NO

I acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, explains how to register any complaints I may have.

PRIVACY NOTICE ACKNOWLEDGEMENT- I have received a copy of the 05/2015 Privacy notice for MHFC.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER- I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the hospital may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to,Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERM.

_____ _____
Date Patient, Patient's Agent or Representative

_____ _____
Witness Relationship to Patient

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle):	Date of Birth:

Information that will be Disclosed; Purpose of the Consent for Disclosure

I hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE).

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. HOWEVER, IF YOU DO NOT SIGN [AND INITIAL) THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Person Representive's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT IF YOU WISH.

Include this consent in the individual's records.