Place Patient Identification Label Here

MEMORIAL HERMANN Surgical Hospital First Colony

REGISTRATION INFORMATION

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

TIME OF ARRIVAL: _____

PATIENT LAST NAME:_____FIRST NAME: _____

DOB: _____ SS#: _____ SEX: M_____F_____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

HM#: _____ WK#: _____ CELL#:_____

EMERGENCY CONTACT| NAME:_____RELATION: _____

PH#: _____

MARITALSTATUS: o SINGLE o MARRIED o DIVORCED o WIDOWED

PREFERRED LANGUAGE:_____ **RELIGIOUS PREFERENCE**:_____

RETIRED: ☐ YES ☐ NO **RETIREMENT DATE**:_____ | **DISABLED**: ☐ YES ☐ NO **DISABILITY DATE**:_____

PRIMARY CARE PHYSICIAN_____PHONE NUMBER_____

INSURANCE INFORMATION | SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ W/C

NAME OF INSURED:_____ **DOB**: _____

IS THIS VISIT DUE TO A WORK RELATED INJURY? YES NO **| IF ANSWER IS "NO" PLEASE SKIP THIS SECTION**

EMPLOYER AND INSURANCE NAME_____ PHONE # _____

EMPLOYER Address _____CITY/STATE/ZIP _____

DATE OF INJURY _____ CLAIM#_____ AREA INJURED _____

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 Texas are receiving adequate healthcare.

Nationality or Ethnic Background (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:**_____

General Consent for Treatment

CONSENT FOR TREATMENT: I consent to and authorize testing, treatment and hospital care at Memorial Hermann Surgical Hospital First Colony (MHFC) as ordered by my physician, his/her consultants, associates, and assistants, or as directed pursuant to standing medical orders or protocols. I understand that it may be necessary for representatives of outside health care companies to assist in my care and my care team may include resident physicians or other trainees. I consent to the taking of photographs or films related to my care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no guarantees or warranties have been made to me with the respect to treatment or services to be provided at MHFC.

DISCLOSURE OF PHYSICIAN OWNERSHIP: Memorial Hermann Surgical Hospital First Colony (MHFC) is partly owned by physicians and meets the federal definition of a "physician-owned hospital" in 42 C.F.R. 489.3. A list of our physician owners is available upon request.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or a patient, that in consideration of the services 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. Self-pay procedures must be paid in full to prior to surgery.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION: I irrevocably assign to MHFC, and any practitioner providing care or treatment to me, all benefits, interest and rights (including causes of action and the right to enforce payment) under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from any other payer providing benefits on my behalf, for and to the extent of the services and goods provided to me during this admission. Additional practitioners providing care may include but are not limited to: attending, or consulting physicians, anesthesiologist, radiologists, and/or laboratory and pathology services. I recognize the above practitioners/services are independent contractors who will generate separate bills for their respective services for which I am responsible. MHFC provides cost estimates and generates bills for the facility portion only. MHFC files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorize MHFC 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.

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, its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

ELECTRONIC HEALTH RECORD: MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Along with our hospital, Exchange Members include hospitals, physicians and other healthcare providers. The exchange members share medical records electronically to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical record system, MHFC may have access to those records and they may have access to your MHFC medical record. If you do not want medical records shared with other providers please let the front registration staff know.

(Continues on back of form)

PATIENT LABEL

ELECTRONIC PRESCRIPTIONS (E-Prescribing): I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

CONSENT TO TREATMENT USING TELEMEDICINE: I consent to treatment involving the use of electronic communications ("Telemedicine") to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and I understand that existing confidentiality protections apply.

MHFC does not have a doctor of medicine or doctor of osteopathy on site 24 hours per day, seven days per week. During weekday operations, physicians are ordinarily on site from 6:00 AM to 6:00 PM. A Nurse Practitioner, with training and experience in handling medical emergencies, is on site from 7:00PM to 7:00AM every weekday night and full time on weekends. In addition, an Emergency Response Team consisting of a Doctor of Internal Medicine, who can be quickly accessed via telemedicine, and Anesthesiologist are on call 24 hours per day, seven days per week. If you develop an emergency condition when a doctor of medicine or osteopathy is not present, a Registered Nurse certified in Advanced Cardiac Life Support (ACLS) and, if available an ACLS Nurse Practitioner, will assess your condition and begin initial treatment until the Emergency Response Team arrives.

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). I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record.

PATIENT RIGHT'S AND RESPONSIBILITIES: I acknowledge receipt of a written documentation regarding my rights and responsibilities as a patient. This document also explains how to register any complaints I may have.

PRIVACY NOTICE ACKNOWLEDGEMENT: I have received a copy of the 10/2016 Notice of Privacy Practices for MHFC. The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. 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 TERMs.

Patient / Authorized Person Signature	Relationship/Printed Name	Date

Witness Signature	Date

Translator Used: ☐ Staff – Approved Translator ☐ Language Line ☐ Patient family or authorized rep (pt offered other options)

Name of Translator:_____ Translator Operator ID:_____

ADVANCE DIRECTIVE

All patients have the right to participate in their own health care decisions and to execute Advance Directives which may include a Medical Power of Attorney, Living Will and/or Do Not Resuscitate order. This hospital respects and upholds those rights.

Have you executed an Advance Health Care Directive, a living will, or a power of attorney that authorizes someone to make health care decisions for you? Please check the appropriate box.

☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.

If you checked "yes" to this question please provide us with a copy to place in your medical record.

☐ Copy given to be placed in medical record ☐ Copy not available for medical record

☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.

☐ I would like to have information on Advance Directives.

IF YES, PLEASE READ THE FOLLOWING:

Your physician will discuss with you the specific risks associated with having the procedure as well as the risks associated with not having the procedure. Any additional questions associated with the risk of your procedure should be discussed with your physician **prior** to your scheduled date of surgery.

Most procedures performed in our hospital are considered to be elective and minimal to moderate risk. **Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a health care proxy/medical power of attorney, if an adverse event occurs during your treatment at this hospital we will initiate all resuscitative and/or stabilizing measures.** You will then be transferred to a hospital with a higher level of care for further evaluation. A copy of your advance directive, living will and/or healthcare power of attorney will be sent with your medical records to the next provider of care.

Your agreement with suspending any wishes for withholding life sustaining treatment while in our facility for this surgery, as indicated by your signature below, does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we are pleased to contact your surgeon's office and have them reschedule your procedure at another hospital.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

Patient / Guardian Printed Name _____ **Relationship to Patient** _____

Patient / Guardian Signature _____ **Date/Time** _____

PATIENT LABEL

Communication Preferences- Protected Health Information

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 following information, I agree that Memorial Hermann Surgical Hospital First Colony (MHFC), its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a prerecorded/artificial voice message through 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.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The messages you receive may contain your personal information. If you consent to receiving text messages you also agree to promptly update Memorial Hermann First Colony when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

Please provide the following contact numbers and select which type of communication you authorize:

METHOD	NUMBER	Voice Message	Text
Home Phone	_____	☐	☐
Cell Phone	_____	☐	☐
Alternate Phone	_____	☐	☐
Preferred email	_____@_____._____		

Mail Communication Preferences | May we send mail to your home address? ☐ YES ☐ NO

If NO, provide alternate address:_____

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		

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 SSN?** _____

Patient/Patient Representative Signature:_____ **Date:** _____

PATIENT LABEL