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: oSINGLE oMARRIED oDIVORCED oWIDOWED

PERFERRED LANGUAGE: _____ **RELIGIOUS PREFERENCE**: _____

RETIRED: oYES o NO **RETIREMENT DATE**:_____ | **DISABLED**: oYES ONO **DISABILITY DATE**:_____

PRIMARY CARE PHYSICIAN_____ PHONE NUMBER_____

INSURANCE INFORMATION | SUBSCRIBER: o SELF o SPOUSE o MOTHER o FATHER o 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:**_____

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Primary # _____

Work # _____

Mobile# _____

Other_____

Place Patient Identification Label Here

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 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 text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. 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.

X_____

Patient's Signature for consent to text message.

Mail Communication Preferences | 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		

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:** _____

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.

MEMORIAL HERMANN
Surgical Hospital
First Colony

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. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier's 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 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 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.

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.

DISCLOSURE OF PHYSICIAN OWNERSHIP:
Memorial Hermann Surgical Hospital First Colony 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 to you upon request. Your Physician **DOES/DOES NOT** have an Ownership interest this facility (circle as appropriate)

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 10/18/2016 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 Surgical Hospital First Colony (MHFC)
Patient Bill of Rights and Responsibilities

Patients and family are our number one concern. It is a priority at MHFC that patients and families are as comfortable as possible during their stay at MHFC.

Patient Rights:

1. To reasonable access to the medical resources at MHFC without regard race, religion, color, sex, national origin, age, marital status, mental or physical ability, sexual orientation or gender identity.
2. To receive considerate, respectful, and compassionate care.
3. To be informed about and to participate in decisions regarding your care including the refusal of treatment.
4. To be involved in all aspects of care, and to be allowed to participate in that care.
5. To information about advance directives that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
6. To be assured that our provision of care for you will not be conditioned on your advance directive.
7. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your actions.
8. To have clinical and educational information about your treatment in language and terms that you understand.
9. To voice complaints about your care, and to have those complaints reviewed and, when possible, resolved.
10. To have access to organizational leaders in an ethical, cultural or spiritual dilemma presents itself.
11. To information about any research activities that involve your treatment, including benefits and risks, procedures involved, and alternative treatments.
12. To security, privacy, and confidentiality in all patient care areas as you undergo tests or treatments.
13. To know who is responsible for providing your immediate, direct care.
14. To information about the financial aspects of services and alternative choices.
15. To be supported in accessing protective services when requested.
16. To unrestricted communication unless restrictions are a part of your treatment. Any restrictions will be explained to you and will be reviewed as your treatment changes.
17. The hospital provides for the safety and security of patients and their property.
18. Patients who desire private telephone conversations have access to space and telephones appropriate to their needs and the care, treatment, and services provided.
19. To request an itemized statement of billed services.

Patient Responsibilities:

1. To give your doctor and the MHFC staff complete and accurate information about your condition and care, including the reporting of unexpected changes in your condition to your physician and nurse
2. To follow orders and instructions given by your doctor and instructions given by the staff for your care, including keeping follow-up appointments after discharge.
3. To report unexpected changes in your condition to your physician and nurse.
4. To bring a current copy of your advance directives to be placed in your medical record prior to the time of your admission.
5. To accept responsibility for refusing treatment.
6. To show consideration for other patients by following all rules and regulations pertaining to smoking, visitors, noise and general conduct.
7. To accept all financial obligations associated with your care
8. To be considerate of staff members who are caring for you. A mutual spirit of respect and cooperation allows us to serve you best.
9. To advise your nurse, physician, caregiver, and/or the business office staff of any dissatisfaction you may have regarding your care.

Patient Satisfaction:

Assessment of patient/family satisfaction is most important to us. Every attempt is made by the nurse to contact each patient within 24-48 hours after discharge. Please let us know how we can improve our service to you.

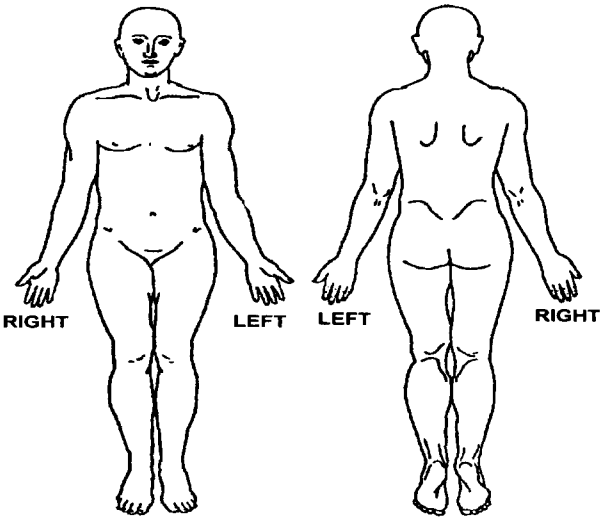
VOICING COMPLAINTS: Our staff strives to provide excellent care and service. If we fail to meet your expectations, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will not hinder the care and service we provide. Usually a word to your nurse or Director of Nursing is all that is needed, but if you prefer, you can contact the Administrator of MHFC at 281-243-1000. Your concern will be promptly addressed. You also have the right to register a complaint with the Texas Department of Health at 888-973-0022, Medicare & Medicaid Services at 800-633-4227, or Joint Commission Fax at 630-792-5636.

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ❒ Yes ❒ No Aneurysm clip(s)
- ❒ Yes ❒ No Cardiac pacemaker
- ❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
- ❒ Yes ❒ No Electronic implant or device
- ❒ Yes ❒ No Magnetically-activated implant or device
- ❒ Yes ❒ No Neurostimulation system
- ❒ Yes ❒ No Spinal cord stimulator
- ❒ Yes ❒ No Internal electrodes or wires
- ❒ Yes ❒ No Bone growth/bone fusion stimulator
- ❒ Yes ❒ No Cochlear, otologic, or other ear implant
- ❒ Yes ❒ No Insulin or other infusion pump
- ❒ Yes ❒ No Implanted drug infusion device
- ❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
- ❒ Yes ❒ No Heart valve prosthesis
- ❒ Yes ❒ No Eyelid spring or wire
- ❒ Yes ❒ No Artificial or prosthetic limb
- ❒ Yes ❒ No Metallic stent, filter, or coil
- ❒ Yes ❒ No Shunt (spinal or intraventricular)
- ❒ Yes ❒ No Vascular access port and/or catheter
- ❒ Yes ❒ No Radiation seeds or implants
- ❒ Yes ❒ No Swan-Ganz or thermodilution catheter
- ❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
- ❒ Yes ❒ No Any metallic fragment or foreign body
- ❒ Yes ❒ No Wire mesh implant
- ❒ Yes ❒ No Tissue expander (e.g., breast)
- ❒ Yes ❒ No Surgical staples, clips, or metallic sutures
- ❒ Yes ❒ No Joint replacement (hip, knee, etc.)
- ❒ Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❒ Yes ❒ No IUD, diaphragm, or pessary
- ❒ Yes ❒ No Dentures or partial plates
- ❒ Yes ❒ No Tattoo or permanent makeup
- ❒ Yes ❒ No Body piercing jewelry
- ❒ Yes ❒ No Hearing aid
  (Remove before entering MR system room)
- ❒ Yes ❒ No Other implant _____
- ❒ Yes ❒ No Breathing problem or motion disorder
- ❒ Yes ❒ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other _____

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❒ Female ❒ Body Part to be Examined _____
month day year

Address _____ Telephone (home) (_____) _____-_____

City _____ Telephone (work) (_____) _____-_____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (_____) _____-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒No ❒ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other_____	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❒ No ❒ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ❒ No ❒ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❒ No ❒ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? ❒ No ❒ Yes
   If yes, please describe: _____

For female patients:

10. Date of last menstrual period:_____/_____/_____ Post menopausal? ❒ No ❒ Yes
11. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❒ No ❒ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❒ No ❒ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ❒ No ❒ Yes

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____

Name of Patient | Signature of Patient

_____ / _____ / _____

Date Signed

_____ _____

Name Patient's Personal Representative | Signature of Patient's Personal Representative

_____ / _____ / _____

Date Signed

_____

FOR INTERNAL USE ONLY

_____ _____

Name of Employee | Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other _____

_____

____ - ____ (Version: As noted on NPP) ____/ ____/ ____ (Date: As noted on NPP)

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

PATIENT I