MEMORIAL HERMANN Surgical Hospital First Colony

REGISTRATION INFORMATION

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

PATIENT LAST NAME: _____ **FIRST NAME:** _____ **DOB:** _____

SS#: _____ SEX: M_____ F _____ MARITAL STATUS: o SINGLE o MARRIED o DIVORCED o WIDOWED

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

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

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

RETIRED: YES___ NO___ RETIREMENT DATE:_____ | DISABLED: YES___ NO____ DISABILITY DATE:_____

PRIMARY CARE PHYSICIAN (PCP) _____ PCP Phone # _____

*Do we have permission to share your health information electronically, including admission, discharge and transfer status,with **your** healthcare providers such as your PCP?* Yes___No___ Would you like us to notify your PCP of your admission?Yes___No___

EMERGENCY CONTACT| NAME: _____RELATION:_____ PH#: _____

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 _____

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 or postal code. **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 or postal code?** _____

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 LABEL

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 or immediate family members of 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. This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than MHFC. You will not be treated differently by MHFC if you choose to use a different facility. If desired, your physician can provide information about alternate providers. If you have questions concerning this notice, please feel free to contact your physician or the Business Office Manager at MHFC.

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

(Continues on back of form)

PATIENT LABEL

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.

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

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

PATIENT LABEL

Memorial Hermann Surgical Hospital First Colony

Patient Rights and Responsibilities

To promote patient safety, we encourage you to speak openly with your health care team, be well informed, and take part in care decisions and treatment choices. Join us as active members of your health care team by reviewing the rights and responsibilities listed below for patients and patient representatives.

You or your designee have the right to:

Respectful and Safe Care

1. Be given considerate, respectful and compassionate care.
2. Have a family member/friend and your doctor notified when you are admitted to the hospital.
3. Be given care in a safe environment, free from abuse and neglect (verbal, mental, physical or sexual).
4. Have a medical screening exam and be provided stabilizing treatment for emergency medical conditions and labor.
5. Be free from restraints and seclusion unless needed for safety.
6. Know the names and jobs of the people who care for you.
7. Know when students, residents or other trainees are involved in your care.
8. Have your culture and personal values, beliefs and wishes respected.
9. Have access to spiritual services.
10. Have conversations with the members of our healthcare team about issues related to your care.
11. Be treated without discrimination based on race, color, national origin, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, ethnicity, language or ability to pay.
12. Be given a list of protective and advocacy services, when needed. These services help certain patients (e.g., children, elderly, disabled) exercise their rights and protect them from abuse and neglect.
13. Receive information about hospital and physician charges.
14. Ask for an estimate of hospital charges before care is provided.

Effective Communication and Participation in Your Care

15. Get information during your visit in a way you can understand. This includes communication assistance, such as sign language and foreign language interpreters, as well as vision, speech and hearing assistance provided free of charge.
16. Get information from your doctor/provider about:
    - your diagnosis * your test results
    - possible outcomes of care and unanticipated outcomes of care
17. Be involved in your plan of care and discharge plan or request a discharge plan evaluation at any time.
18. Involve your family in decisions about care.
19. Ask questions and get a timely response to your questions or requests.
20. Have your pain managed.
21. Refuse care.
22. Have someone with you for emotional support, unless that person interferes with your or others' rights, safety or health.
23. Ask for a chaperone to be with you during exams, tests or procedures.
24. Choose your support person and visitors and change your mind about who may visit.
25. Select someone to make health care decisions for you if at some point you are unable to make those decisions (and have all patient rights apply to that person).

End of Life Decisions

26. Create or change an advance directive (also known as a living will or durable power of attorney for health care).
27. Have your organ donation wishes known and honored, if possible.

Informed Consent

28. Give permission (informed consent) before any non- emergency care is provided, including:
    - risks and benefits of your treatment
    - alternatives to that treatment
    - risks and benefits of those alternatives
    - Risk of not having treatment
29. Agree or refuse to be part of a research study without affecting your care.
30. Agree or refuse to allow pictures for purposes other than your care.

Privacy and Confidentiality

31. Have privacy and confidential treatment and communication about your care.
32. Be given a copy of the HIPAA Notice of Privacy Practices, which includes information on how to access your medical record.

Memorial Hermann Surgical Hospital First Colony
Patient Rights and Responsibilities

Complaints and Grievances

33 Complain and have your complaint reviewed without affecting your care. If you have a problem or complaint, you may talk to your doctor, nurse manager or a department manager.

34 You may also contact Chief Executive Officer at 281-243-1007 or the Patient Experience Officer at 281-243-1060.

35 If your issue is not resolved to your satisfaction, other external groups you may contact include:

- **Hospital's Quality Improvement Organization (QIO) for coverage decisions or to appeal a premature discharge:** KEPRO Organization for Beneficiary Family Centered Care (BFCC-QIO)
  5201 West Kennedy Blvd., Suite 900
  Tampa, FL 33069
  1-888-315-0636; 855–843–4776 (TTY)
- **State Agency:**
  Texas Department of Health & Human Services
  Regulatory Services Division, Enforcement Unit
- P.O Box 149347
  Austin, Texas 78714
  Toll free: 1-888-973-0022
- **Accreditation Agency:**
  The Joint Commission Office of Quality and Patient Safety One Renaissance Blvd.
  Oakbrook Terrace, IL 60181
  Fax: 630-792-5635
  Using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website: www.jointcommission.org
- **To address discrimination concerns, you may also file a civil rights complaint with the U.S. Department of Health and Human Services:**
  Office for Civil Rights
  200 Independence Ave.,
  SW Room 509F, HHH Building Washington,
  DC20201
  1-800-368-1019, 1-800-537-7697 (TDD)
  OCRMail@hhs.gov
  Complaint forms are available at:
  http://www.hhs.gov/ocr/office/file/index.html

You have the responsibility to:

1. Provide accurate and complete information about your health, address, telephone number, date of birth, insurance carrier and employer.
2. Call if you cannot keep your appointments.
3. Be respectful of your hospital team, from the doctors, nurses and technicians to the people who deliver your meals and the cleaning crews.
4. Be considerate in language and conduct of other people and property, including being mindful of noise levels, privacy and number of visitors.
5. Be in control of your behavior if feeling angry.
6. Give us a copy of your advance directive.
7. Ask questions if there is anything you do not understand.
8. Report unexpected changes in your health.
9. Follow hospital rules.
10. Take responsibility for the consequences of refusing care or not following instructions.
11. Leave valuables at home.
12. Keep all information about hospital staff or other patients private.
13. Do not take pictures, videos or recordings without permission from hospital staff.
14. Pay your bills or work with us to find funding to meet your financial obligations.

Patient or Representative Signature

Date / Time