

Place Patient Identification Label Here



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 \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HM#: \_\_\_\_\_ WK#: \_\_\_\_\_ CELL#: \_\_\_\_\_

EMERGENCY CONTACT | NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

PH#: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

PREFERRED LANGUAGE: \_\_\_\_\_ RELIGIOUS PREFERENCE: \_\_\_\_\_

RETIRED:  YES  NO RETIREMENT DATE: \_\_\_\_\_ DISABLED:  YES  NO DISABILITY DATE: \_\_\_\_\_

INSURANCE INFORMATION | SUBSCRIBE  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: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

# Surgical Questionnaire:

---

What procedure are you having today? \_\_\_\_\_

If applicable, on what area/side is the procedure being done (i.e. Left, Right, etc.?) \_\_\_\_\_

Have you had anything to eat or drink since midnight? No  Yes

**INTERNAL:** TOPS Registration Staff: Was site correct? Yes  No  If not, was PreOp RN Notified? Yes  No

Who will be taking you home?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Will Wait  Will Return  Need to Call – Phone No. \_\_\_\_\_

## PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Privacy Notice (HIPAA) for TOPS Surgical Specialty Hospital. Privacy Notice Revision Date: March 1, 2021, Version 1. I acknowledge that I have been given the opportunity to request restriction on use and/or disclosure of my protected health information and to request alternative means of communication of my protected health information.

\_\_\_\_\_

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE

\_\_\_\_\_

DATE

\_\_\_\_\_

RELATIONSHIP TO PATIENT

**INTERNAL: THIS AREA FOR USE BY TOPS Surgical Specialty Hospital Personnel Only.**

### DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided with a copy of the TOPS Surgical Specialty Hospital's Privacy Notice (HIPAA) on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice (HIPAA). However, acknowledgement has not been obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement.
- Patient was unable to sign because: \_\_\_\_\_
- There was a medical emergency. TOPS Surgical Specialty Hospital will attempt to obtain acknowledgement as soon as Possible.
- Other reason: \_\_\_\_\_

\_\_\_\_\_

EMPLOYEE SIGNATURE

\_\_\_\_\_

DATE



## Patient Consent and Admission Agreement

**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 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 for medical and/or surgical services under said policies to TOPS Surgical Specialty Hospital (**TOPS**), 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. I understand I am financially responsible for the above physician’s services. TOPS provides cost estimates and generates bills for the facility portion only. TOPS files primary and secondary insurance claims for patients who are not scheduled as self-pay. I authorize TOPS 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 TOPS.

**DISCLOSURE OF PHYSICIAN OWNERSHIP-**TOPS Surgical Specialty Hospital is partly owned by physicians and meets the federal definition of a “physician owned hospital” in 42 C.F.R. 489.3. TOPS Surgical Specialty Hospital maintains a list of all its physician owners and this list is available to you 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 TOPS Surgical Specialty Hospital. You will not be treated differently by TOPS Surgical Specialty Hospital if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

**PHYSICIAN COVERAGE-**TOPS Surgical Specialty Hospital does not provide 24/7 physician coverage in-house. There is a physician on call 24/7. In case of an emergency that exceeds the capability of this facility, you may be transferred to a local acute care hospital.

**ADVANCED MEDICAL DIRECTIVE/PATIENTS RIGHTS AND RESPONSIBILITIES-** I have been given the opportunity to request written materials about my right to accept or refuse medical treatments and informed of my rights to formulate Advanced Directives.

\_\_\_\_\_ Patient Rights: I have received a copy of the “Patient’s Rights and Responsibilities.”

\_\_\_\_\_ I  DO or  DO NOT want the hospital to notify a family member/representative and/or my physician in the event of my admission.

Contact Information:

Family/Representative Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I have an Advanced Directive and it is located \_\_\_\_\_.

I have provided a copy of my Advanced Directive to TOPS.

YES / NO

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 Version 1, 3/1/2021 Privacy notice for TOPS.**

**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 rendered the patient under the general and special instructions of the patient's physician. If the attending physician believes it is beneficial for you to undergo one or more of the following exams that produce ionizing radiation: diagnostic X-rays, Computed Tomography (CT), and the use of Fluoroscopy while undergoing an injection, Surgical or PAIN procedure. Although both short and long term risks is present with radiation exposure, this rarely results in significant short or long term injury. In complex cases, local tissue damage to the skin or even underlying layers may occur that may require additional follow up and treatment.

**REMOTE MONITORING AND USE OF ELECTRONIC DEVICES-**The undersigned understands that techniques of telemedicine may be employed to facilitate the Patient's care. Techniques include, but are not limited to, electronic transmission of radiographic images (X-rays), remote access to laboratory results, electronic transmission of vital signs and/or remote monitoring of life support equipment. Techniques of telemedicine also include bedside video imaging of patients. For example, the Patient may be monitored by camera while the Patient is undergoing care in the Emergency Treatment Area. All electronic transmission of data will be restricted to authorized Physicians or care provider's staff and will be performed in compliance with confidentiality guidelines of the Federal Health and Portability and Accountability Act (HIPAA) and applicable state privacy laws. I also understand that I have the right, at any time, to refuse telemedicine monitoring of Patient by informing the treating Physician of my objection.

**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.

**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, TOPS may have access to those records and they may have access to your TOPS medical record. If you do not want medical records shared with other providers please let the front registration staff know.

**PHARMACY:** I consent to have my medication records accessed from my preferred pharmacy for use by the physician providing my care to ensure accuracy in obtaining my medication history. This information will only be used to help order the physician assess my medical condition and aid in ordering appropriate medications for the care provided while I am hospitalized.

Pharmacy Name \_\_\_\_\_ Phone number \_\_\_\_\_

**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.**

**FOR YOUR SAFETY-**I understand that I am not to drive a motor vehicle, operate machinery, sign legal documents, or take medication OTHER THAN THOSE PRESCRIBED by my surgeon or other physicians for twenty-four (24) hours following the administration of general anesthesia. I understand that I MUST have a responsible adult drive me home. I also understand that I must have someone with me for at least twenty-four (24) hours following surgery.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient, Patient's Agent or Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

# Patient's Communication Preferences Regarding their PHI

## Telephone Communication Preferences

Home # \_\_\_\_\_

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 TOPS Surgical Specialty Hospital its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/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, TOPS Surgical Specialty Hospital, its legal agents, or affiliates may contact me with an email notification 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 TOPS Surgical Specialty Hospital 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.

---

Patient's Signature for consent to text message.

## Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

**Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)**

<u>Name:</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse _____	_____
<input type="checkbox"/> Caretaker _____	_____
<input type="checkbox"/> Child _____	_____
<input type="checkbox"/> Parent _____	_____
<input type="checkbox"/> Other _____	_____

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 or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient



# Patient Portal Consent Form

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 you wish to use below.

<b>Patient's Email Address</b>  _____	
<b><u>Challenge Question Options:</u> (circle one)</b> <ul style="list-style-type: none"><li>• Last four digits of your SSN</li><li>• Year you got married</li><li>• Year you graduated high school</li><li>• Year your father was born</li><li>• Year your mother was born</li><li>• Postal code</li></ul>	<b><u>Answer:</u></b>  

\_\_\_\_\_  
Signature of Patient (or Legal Rep.)

\_\_\_\_\_  
Date

## Patient Portal

User Name Password

Note: We will send you a Portal invitation to the email account you provided. You will then be able to create an account with your own username and password.

