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 Theda Oaks Surgery Center, 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, Theda Oaks Surgery Center, 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 Theda Oaks Surgery Center 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

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? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	______________________	______________________
☐ Caretaker	______________________	______________________
☐ Child	______________________	______________________
☐ Parent	______________________	______________________
☐ 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**

THEDA OAKS SURGERY CENTER

COMMUNICATION AUTHORIZATION

☐ I authorize the Doctor, Nurses, and/or Anesthesiologist providing my care to discuss the details of my procedure with the individuals listed below:

Name: ________________________ Relationship to Patient: _________________ Phone #: ________________

Name: ________________________ Relationship to Patient: _________________ Phone #: ________________

Name: ________________________ Relationship to Patient: _________________ Phone #: ________________

TRANSPORTATION AFTER PROCEDURE

Name: ________________________ Relationship to Patient: _________________ Phone #: ________________

Transportation Company: _________________ Transportation ID number: ____________________

PREFERRED PHARMACY INFORMATION

Name: __________________ Location (Cross-Street): ________________________ Phone #: ______________

POST-OPERATIVE CALL:

(PLEASE SELECT)

☐ May speak to me only

☐ May leave message on answering machine/voicemail

☐ May speak with one of the above mentioned individuals

____ ______________________

Signature of Patient/Guardian Date of signature

THEDA OAKS SURGERY CENTER

19226 STONE HUE, SUITE 103
SAN ANTONIO, TEXAS 78258

PHONE #: (210) 268-0100
FAX #: (210) 268-0150

In light of the recent outbreak of the Ebola Virus, we are asking you to answer the following questions. If you are concerned about any symptoms you might be having, please ask to speak with a nurse **IMMEDIATELY**.

Thank you.

1. In the past three (3) weeks, have you traveled to any of the following West African countries: Guinea, Liberia, Sierra Leone, Nigeria, or any other countries where Ebola is potentially present?

   Yes __________ No __________

2. Have you had close contact with someone who recently traveled to any region(s) where Ebola is potentially present?

   Yes __________ No __________

3. Have you traveled on an airline in the past three (3) weeks?

   Yes __________ (Destination: ____________________) No __________

4. Have you been in contact or are/were around anyone who has had **FLU-LIKE** symptoms, including diarrhea and fever, in the past three (3) weeks? **(Diarrhea which is not related to the colonoscopy prep)**

   Yes __________ No __________

5. Have you, in the past three weeks, or currently experiencing, **FLU-LIKE** symptoms or diarrhea and/or fever? **(Diarrhea which is not related to the colonoscopy prep)**

   Yes __________ No __________