THEDA OAKS SURGERY CENTER

			EMAIL:

PATIENT INFORMATION

PATIENT NAME (LAST NAME, FIRST NAME, M.I.)	**SEX**: F ( ) M ( ) **MARITAL STATUS** : M ( ), S ( ), D ( ), W ( )	**DATE OF BIRTH**:	**SOCIAL SECURITY NUMBER**:
ADDRESS:	**CITY**: **STATE**: **ZIP CODE**:	**MAIN PHONE NUMBER**:	**ALTERNATE PHONE NUMBER**:
EMPLOYER NAME & ADDRESS:		**EMERGENCY CONTACT INFO:** **NAME & RELATIONSHIP TO PATIENT**: **PHONE NUMBER**: ( ) -	
REFERRING PHYSICIAN:		**PRIMARY CARE PHYSICIAN (PCP)**:	

PRIMARY INSURANCE

INSURANCE COMPANY NAME:			**INSURED I.D. #**	**GROUP #**
INSURANCE COMPANY ADDRESS:			**CITY:**	**STATE:**
INSURED'S NAME:			**INSURED'S ADDRESS:**	
INSURED'S RELATION TO PATIENT:	**DOB:**	**SS#:**	**INSURED'S RELATION TO PATIENT:**	

SECONDARY INSURANCE

INSURANCE COMPANY NAME:			**INSURED I.D. #**	**GROUP #**
INSURANCE COMPANY ADDRESS:			**CITY:**	**STATE:**
INSURED'S NAME:			**INSURED'S ADDRESS:**	
INSURED'S RELATION TO PATIENT:	**DOB:**	**SS#:**	**INSURED'S EMPLOYER:**	

THEDA OAKS SURGERY CENTER

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times **financially responsible** to Theda Oaks Endoscopy/Surgery Center, (Theda Oaks), for any charges not covered by my health insurance benefit plan(s).

It is my responsibility to notify Theda Oaks of any changes in my health insurance benefit coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

I am responsible for the entire bill or balance of the bill as determined by Theda Oaks and/or my health insurance company. If the submitted claims or any part of them are denied for payment, then I am **responsible** for the balance due.

NOTICE ABOUT ELECTRONIC CHECK CONVERSION

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

I understand that by signing this form, I am accepting **financial responsibility** as explained above for all balances due for the **facility charges**.

Should I fail to promptly pay, I agree to be responsible for payment of any collection or statement rebilling fees that are incurred.

_____

Patient/Insured Signature Date of Signature

_____

Witness Signature Date of Signature

AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize the release of any medical and/or other information to the applicable carrier for the Centers for Medicare and Medicaid Services (CMS), my insurance carriers, or any other entity necessary to determine insurance benefits or the benefits payable for medical services and/or supplies provided to me by Theda Oaks Endoscopy Center, (Theda Oaks).

A copy of this authorization will be sent to the applicable carrier for the Centers for Medicare and Medicaid Services, (CMS), and/or my insurance carriers.

This will also authorize Theda Oaks to release information for adjudication of insurance benefits to any of my insurance carriers. A photocopy or facsimile of this Assignment of Benefits shall be deemed as valid as the original.

This authorization will remain in effect until revoked by me in writing.

_____

Patient/Insured Signature Date of Signature

_____

Witness Signature Date of Signature

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

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 _____