Patient Registration Form

Patient Name DOB:

Street Address

City State Zip Code

State

Zip Code

Current Gender: (circle one) Female Male Undifferentiated

SS#

Phone Number-Home:

Phone Number-Cell:

E-mail Address:

Referring Physician/Primary Care Physician:

Name of person picking me up:

Cell phone number of person picking me up:

I certify that the information provided above is true and correct. I also certify that any insurance cards and identification cards provided to the Center are accurate and correct.

Signature of Patient or Responsible Party Print Name

Relationship to Patient Date Signed

revised 2/13/2019

STATE REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION

Texas law requires the Texas Health Care Information Collection Subunit to Collect information on the race/ethnic backgrounds of healthcare facility patients. Healthcare facilities 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 access to adequate health care.

If patients fail to identify their own race and ethnic backgrounds, healthcare Facility staff will use its best judgment in making the identification.

QUESTIONS

Question #1: Ethnic Background

(mark the box that the patient believes most accurately identifies his/her ethnic background)

Is the patient...?

- ☐ **(1)Hispanic/Latino**
- ☐ **(2)Not Hispanic/Latino**

Question #2: Race

(mark the box that the patient believes most accurately identifies his/her race)(1)

Is the patient...?

- ☐ **(1)American Indian/Eskimo/Aleut**
- ☐ **(2)Asian or Pacific Islander**
- ☐ **(3)Black**
- ☐ **(4)White**
- ☐ **(5)Other** *Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category*

Endoscopy El Paso

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I understand that I may receive separate bills from the Center, the physician's office, the anesthesia billing office and pathology when services are rendered. I also acknowledge that in the event there is an overpayment, the center will issue payment to the anesthesia services if there is an outstanding balance and then any remaining portion will be refunded to me.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to El Paso Endoscopy Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct. I authorize the Center to transfer any credit balance to the Anesthesia Services to satisfy any outstanding balance owed to the physician for services rendered to me for my procedure. Any remaining credit balance will be refunded to me.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at El Paso Endoscopy Center may have an ownership interest in the Surgical Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at El Paso Endoscopy Surgical Center.

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize El Paso Endoscopy Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature _____ Date Signed _____ Printed Name _____

Parent/Guardian Signature (if patient is a minor) _____ Date Signed _____ Printed Name _____

Contact Information:
Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from El Paso Endoscopy Center, you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

Signature of Patient or Responsible Party _____ Print Name _____

Relationship to Patient _____ Date Signed _____

Our Commitment to Each Other:
Patient & Provider's Mutual Responsibilities During COVID

In the setting of the current COVID-19 pandemic, it is critical to our patients' health and successful surgical/procedural outcomes to avoid COVID-19 infection after surgery/procedure.

In times of restrictive social isolation "Stay Home, Stay Safe" programs, the very act of leaving home and coming to any public place carries some inherent risk of SARS-CoV-2 exposure, and then COVID-19 disease. Therefore, it is incumbent on physicians, their teams, and their facilities to provide as safe and sanitary a patient surgical/procedural experience as possible to achieve currently.

Patient, caregiver, and family/"dwelling partner" actions and behavior are even more critical to prevention of COVID-19 during the postoperative recovery phase of care, as it lasts much longer than just the day of surgery/procedure.

An infection of COVID-19 in a patient recovering from surgery/procedure not only threatens their life and health, but can lead to postoperative complications, and have permanent damaging effect on the outcome of their surgery/procedure. Therefore, a COVID-19 infection is critical to prevent.

The, simplest, most scientifically-proven prevention methods to date include:

- Social distancing of *at least* 6 feet between people at all times if possible.
- Minimizing interaction with other people except as necessary (e.g. medical follow-up and physical therapy visits).
- Avoid any close contact with people who are sick with COVID-19 symptoms (e.g. cough, fever, body aches, and general fatigue).
- Frequent hand washing or sanitizing for at least 20 seconds each time, especially before and after eating or touching the face or nose, putting on and taking off face masks or coverings, and necessary touching of others (e.g., patient medical care, changing surgical dressings, etc.).
- [Ophthalmology] Wash hands before and after any time eye drops are administered.
- Regular and frequent cleansing of high-use surfaces (e.g. counters, doorknobs, drawer, cupboard, and refrigerator handles) with soap, bleach, or germicidal/virucidal cleansers.
- Wearing a face mask or cloth covering nose and mouth when outside your home <u>at all times</u>.

<u>Patient Acknowledgment:</u>

I hereby acknowledge reviewing this document fully, and understanding its contents. I hereby agree to abide by the COVID-19 prevention measures listed above for at least the first 2 weeks after my surgery/procedure. I agree to ask my caregivers, "dwelling partners," and those who come in near contact with me to do the same.

Patient Signature_____Date_____Time _____

PATIENT LABEL HERE

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Center Director:
Sandra E. Salas, R.N.
1300 Murchison Dr., Ste. 180
El Paso, TX 79902
(915) 544-5000

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement
_____Date:_____

MEDICATION RECONCILIATION FORM

Medication allergies *(alergia a medicinas)*	**Reaction (what happens?)** *Reaccion (que pasa?)*

MEDICATION *(Medicinas)*	**Dose** *(Dosis)*	**Route** *(Ruta)*	**Frequency** *(Frequencia)*	**Last Dose** *(cuando la tomo)*
Other Medications, Herbals, Vit., etc.				
(otras medicinas, hierbas, vitaminas)				

Admitting Nurse				
Date	**Signature**			**Initials**
Information received from	**Patient/Fam recall**	**Brought medicines**	**Nrg. Home MAR**	**Patient own list**

Discharging Nurse

Signature:

Patient/person receiving reconciled medication list:

Signature: **Date:**

IF YOU HAVE QUESTIONS REGARDING THIS MEDICATION LIST, CONTACT YOUR PRIMARY CARE PHYSICIAN.

Medication Discharge Instructions			
☐ **New Prescription**	**Dose**	**Route**	**Frequency**

Attending Physician

Medication list reviewed pre and post procedure

☐ **Resume medication as previously ordered**

MD Signature

White= Chart Copy **Yellow=Patient**

☐ **Check here if multiple pages are needed: Page ___ of ___**