REGISTRATION AND ASSIGNMENT OF BENEFITS

Patient Name_____ Date_____
Last Name First Name M.I (MM/DD/YY)

Home Phone_____ Cell Phone_____ Email_____

Mailing Address_____

City_____ State_____ Zip_____

Sex ❒ M ❒ F Age_____ Birth date_____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Social Security #_____ Driver's License # _____

Insured Name_____ How did you learn about this hospital? _____
Last Name First Name M.I

Relationship to Insured ❒ Self ❒ Spouse ❒ Child ❒ Other_____

Condition / Illness related to ❒ Illness ❒ Employment Illness/Accident
❒ Auto Accident ❒ Other Accident ❒ Other_____

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ❒Full-time ❒Part-time City _____ State _____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ DOB:_____ SSN:_____ Last Name First Name M.I Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City _____ State _____ Zip_____ ❒Full-time ❒Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Policy Holder: _____ Date of Birth:_____ SSN #:_____ Guarantor:_____

SPOUSE (COINSURANCE) INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Policy Holder: _____ Date of Birth:_____ SSN #:_____ Guarantor:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ❒ Yes ❒ No** Your Initials:_____ If you answered yes, please fill out the accident specific form, available at the front desk. Pregnant ❒ Yes ❒ No Pacemaker ❒ Yes ❒ No Family Physician_____ Person to contact in emergency (Name & Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT & AUTHORIZATION FOR THE RELEASE OF MEDICAL AND HEALTH PLAN DOCUMENTS FOR CLAIMS PROCESSING & REIMBURSEMENT AS REQUIRED BY FEDERAL AND STATE LAWS	**Legal Assignment of Benefits and Designation of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

Meaningful Use Checklist

Please check all that apply:

Race:

- ❒ American Indian or Alaskan Native
- ❒ Asian
- ❒ Native Hawaiian or Other Pacific Islander
- ❒ Black or African American
- ❒ White
- ❒ Other race, Please Specify:_____

Ethnicity:

- ❒ Hispanic or Latino
- ❒ Not Hispanic or Latino

Preferred Language:

- ❒ English
- ❒ Indian (Includes Hindi and Tamil)
- ❒ Spanish
- ❒ Russian
- ❒ Other:_____

Pharmacy Name: _____

Pharmacy Phone: _____

Signature: _____ Date: _____

Disclosure and Authorization Form for

Patient Referral to Other Non-Participating Physician(s) or Facility

Advocacy for Patient Freedom of Choice for Provider(s)

Patient Name:_____ Physician Name: _____

Diagnosis: _____ Other Physician: _____

For Treatment:_____ Other Entity: _____

Location:_____

Dear Patient:

In order to better serve you with the highest care quality and safety at the most affordable costs, sometimes it is necessary and important to have other or more provider(s) or entities join our team to complete or continue your medical procedures or treatment in order to ensure a speedy recovery for you. We would like to keep you informed of your choice of these other provider(s) or entities and obtain your informed authorization before our referral and scheduling for your next treatment procedure(s).

The physicians below are affiliated with one or more of the healthcare providers/suppliers identified below and will receive, directly or indirectly, remuneration from such affiliated entity or entities for soliciting, securing, or referring patients to the entity or entities. Affiliations may include, but are not limited to, ownership, employment, consulting arrangements, or participation on advisory boards. If you have any questions about any of these relationships between your physician and these entities, please inquire with your physician. Your physician will be able to specifically address your unique medical situation and the impact of any potential outside relationships.

HEALTHCARE PROVIDERS/SUPPLIERS:

The Woodlands Specialty Hospital	Ravi Moparty, M.D.
North Houston Family Medicine:	Rajgopal Pakanati, M.D.
Humble: 8901 FM 1960 Bypass Rd, Suite 202, Humble, TX 77338	Param Maewal, M.D.
Conroe: 2400 FM 1488, Suite 400, Conroe, TX 77384	Richard Francis, M.D.
Oaks: 25312 I-45, Suite A, Spring, TX 77386	Robert Case, M.D.
Porter: 25540 FM 1314 Rd., Porter, TX 77365	

Woodlands Specialty Hospital Surgery Department, TMC

While no provider or entity could be participating in every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. <u>This Form is used to inform you of our verification that the above-named provider(s) or entities are non-participating provider(s) or entities with your health plan.</u>

We have verified your insurance coverage for non-participating provider(s) or entities and the recommended treatment / procedure(s) and obtain pre-certification if applicable for all services as a courtesy to you.

Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan.

If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or hospital (The Woodlands Specialty Hospital) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility to which the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

I am aware that my physician may have financial interest in the facility; I have been made aware of this, and I acknowledge that I have the right to choose my healthcare providers and where my procedure is performed.

I certify that the Advocacy for Patient Freedom of Choice for Provider(s) with the above specific disclosure from my provider(s) is in full compliance with the Section 102.006 of Texas Occupations Code, in a manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (print)	Signature of Patient	Date

GENERAL CONSENT

CONDITIONS OF ADMISSION AND TREATMENT FORM

CONSENT TO MEDICAL CARE:	
INITIALS	I request admission to The Woodlands Specialty Hospital. I consent to the procedures which may be performed during this admission and/or outpatient visit, including emergency treatment or services and which may include, but are not limited to, laboratory services, x-ray examination, diagnostic procedures, medical nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by The Woodlands Specialty Hospital regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. However, doing so may hinder my treatment and/or medical outcome. I acknowledge that the medical care receive while in The Woodlands Specialty Hospital is under the direction of my attending physician(s) and that The Woodlands Specialty Hospital is not responsible for acts of omission of my attending physician(s). I further authorize The Woodlands Specialty Hospital to retain or dispose of any specimen or tissue taken.
TEACHING PROGRAMS:	
INITIALS	From time to time, WSH will allow healthcare students to observe patient care for educational purposes. You have the right to refuse their participation.
MEDICAL RECORD INTERPRETATION:	
INITIALS	I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold The Woodlands Specialty Hospital liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
DISCLOSURE OF INFORMATION:	
INITIALS	The undersigned agrees that all records concerning this patient's admission shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payors, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing.
SPECIAL CONSENT FOR HIV AND HEPATITIS:	
INITIALS	I acknowledge that under certain circumstances, Texas Law authorizes The Woodlands Specialty Hospital to test me for HIV, without my express consent (for example, in the event of an accidental exposure to blood or other bodily fluid). ***By initialing this box, I specifically consent to the testing of my blood for human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by my attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending***

	physician exposed to the bodily fluids of the patient in a manner which could transmit disease. I have been informed about the nature of the blood test, its expected benefit, and have been given the opportunity to ask questions about the blood test.
RELATIONSHIP BETWEEN PHYSICIANS AND HOSPITALS:	
INITIALS	**General Relationship:** The Physicians and Allied Health Professionals (AHPs) practicing at The Woodlands Specialty Hospital are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at The Woodlands Specialty Hospital, but they are not agents or employees of The Woodlands Specialty Hospital. I understand that physicians or other health care professionals may be called upon to provide care or services to me on my behalf, but I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that in most cases there will be a separate charge for professional services rendered by physicians to me or on my behalf and that I will receive a bill for these professional services this is separate from the bill for hospital services. **Ownership Relationship:** THE WOODLANDS SPECIALTY HOSPITAL BELIEVES THAT YOU ARE ENTITLED TO MAKE INFORMED DECISIONS REGARDING YOUR MEDICAL CARE. TO ASSIST YOU IN MAKING AN INFORMED DECISION, THE WOODLANDS SPECIALTY HOSPITAL HEREBY NOTIFIES YOU THAT IT MEETS THE FEDERAL DEFINITION OF A PHYSICIAN-OWNED HOSPITAL, PURSUANT TO 42 C.F.R. §489.3. PHYSICIAN OWNERS INCLUDE: Ravi Moparty, M.D.
FINANCIAL AGREEMENTS:	
INITIALS	For services hereto performed or to be performed for the Patient by The Woodlands Specialty Hospital, below signed, whether as patient, agent or guarantor, agrees to pay the charges for the care so provided to the Patient by The Woodlands Specialty Hospital in accordance with The Woodlands Specialty Hospital then current standard rates and all costs incurred in collecting same, together with attorney's fees, which The Woodlands Specialty Hospital deems necessary and reasonably required to enforce the rights of The Woodlands Specialty Hospital. A copy of the facility's Financial Policy is included in your admission packet. By signing below, you acknowledge receipt of a copy of this policy.
ASSIGNMENT OF INSURANCE BENEFITS TO THE WOODLANDS SPECIALTY HOSPITAL:	
INITIALS	As or on behalf of the Insured under the insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due there from termed "Contract Rights", the below signed irrevocably assigns and transfers to The Woodlands Specialty Hospital the Contract Rights, and orders and directs such insurer(s) to pay all monies due or to become due there under directly to The Woodlands Specialty Hospital or its assignee. To effect such payment, The Woodlands Specialty Hospital irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of Insured and to endorse in the name of the Insured any check or other instrument for the payment or monies thereunder. Further, I understand that **ANESTHESIOLOGY, PHYSICIAN SERVICES, PATHOLOGY, RADIOLOGY** and some **LABORATORY SERVICES** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

INITIALS	If Insured receives monies directly from the Insurer(s), same shall be held in trust and immediately transferred to The Woodlands Specialty Hospital for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by The Woodlands Specialty Hospital from Insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid if credit is approved.
UNBORN CHILD COVERAGE:	
INITIALS	If pregnant, the above consent for treatment, releases, assignments and guarantor agreement apply to my newborn child if born at this facility during this period of treatment.
INSURANCE PRECERTIFICATION:	
INITIALS	I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.
MEDICARE ASSIGNMENT, PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:	
INITIALS	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 of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims, I request that payment of authorized benefits be made on my behalf.
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:	
INITIALS	A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice. I understand that if I have questions or complaints, I may contact the Privacy Officer at: **The Woodlands Specialty Hospital (281) 602-8160**
ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES:	
INITIALS	A copy of the facilities Patients' Rights and responsibilities is included in your admissions packet. By signing below you acknowledge receipt of a copy of the facilities Patients' Rights and Responsibilities.
PATIENT SELF-DETERMINATION ACT:	
INITIALS	I have received information concerning my rights under state law to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive.

PLEASE INITIAL THE FOLLOWING APPLICABLE STATEMENTS:

_____ I have executed an Advance Directive/Living Will and have been requested to supply a copy to the Hospital.

_____ I have not executed an Advance Directive.

_____ I wish to execute an Advance Directive.

_____ I do not wish to execute an Advance Directive.

I, the undersigned, as the patient, parent, guardian, spouse, guarantor, or agent of the patient, hereby certify I have read, and fully and completely understand this Conditions of Admissions and Treatment Form knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

❒ Patient is medically unable to sign consent

Signature: _____

Name: _____ Date: _____

If other than Patient, indicate relationship: _____

Spouse (If Married/Available): _____ Date: _____

Witness Signature: _____ Date: _____

❒ Patient refused to sign ❒ Patient left Against Medical Advice

Witness Signature: _____ Date: _____

Commercial Insurance Participating Disclosure Notice

The Woodlands Specialty Hospital participates with Select Commercial Insurance Plans as an In-Network Provider.

The Woodlands Specialty Hospital will, on your behalf, file a claim to your commercial insurance plan whether in or out of network.

All patients should know that Texas and Federal law supports your choice of any Facility/Emergency room. You must not be held harmless for choosing the nearest Emergency Room.

Patient Signature: _____

Date: _____