EXCEPTIONAL EMERGENCY CENTER

Patient Label

PATIENT REGISTRATION FORM

Date:

PATIENT INFORMATION

Patient's Last Name, First Name, Middle Initial:	□ Mr. □ Miss. □ Mrs. □ Ms.	Marital Status (circle one): Single / Married / Divorced / Sep / Wid	
Social Security Number: - -	Phone Number: ( ) -	Birth Date: / /	Gender: □ Male □ Female
Street Address:	City/State/Zip:	E-mail Address:	
Employer:	Employer Phone: ( ) -	Occupation:	
Primary Care Physician (PCP):	Phone Number: ( ) -	Preferred method of contact: □ Phone □ Work □ Email □ Other:	

Please tell us how you learned of our service or whom we may thank:
□ Doctor's Office □ Magazine □ Hospital □ Drive By □ Internet □ Billboard □ Mailer □ Newspaper □ Pharmacy □ Radio
□ Friend/Family Member

INSURANCE INFORMATION

We accept all commercial insurance plans

Is this visit due to a work or auto accident? □ Yes □ No If, yes complete WC / MVA Accident Form

Please indicate Primary Insurance: □ Aetna □ Blue Cross Blue Shield □ Cigna □ Great West □ Humana □ Tricare □ United Health Care □ Other:

Subscriber's Last Name, First Name, Middle Initial:	Subscriber's Social Security: - -	Birth Date: / /	
Member ID Number:	Group Number:	Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other:	

If applicable, indicate Secondary Insurance □ Aetna □ Blue Cross Blue Shield □ Cigna □ Great West □ Humana □ Tricare □ United Health Care □ Other:

Subscriber's Last Name, First Name, Middle Initial:	Subscriber's Social Security: - -	Birth Date: / /	
Member ID Number:	Group Number:	Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other:	

GUARANTOR INFORMATION

Guarantor Last Name, First Name, Middle Initial:	Birth Date: / /	Gender: □ Male □ Female	
Social Security Number: - -	Phone Number: ( ) -	Email Address:	
Street Address / City / State / Zip:			
Relationship to Patient:	Preferred method of contact: □ Phone □ Work □ Email □ Other:		

IN CASE OF EMERGENCY

Name of Local Relative/Friend: (not living at the same address)	Relationship to Patient:	Home Number: ( ) - Leave Message: □ Yes □ No

ER Acknowledgment

Patient or Responsible Party to initial the following:

_____ I understand that I am checking into a free-standing emergency room, and this is not an urgent care.

OFFICE USE ONLY

_____

Administrative Assistant Signature

Date:_____

Patient Label

CONSENTS, TERMS, AND POLICIES

CONSENT TO TREATMENT

I consent to the procedures that may be performed during this visit including emergency treatment and/or services which may include, but are not limited to, laboratory services, x-ray examinations, diagnostic procedures, physician, nursing, or services rendered to me as ordered by my physician or other health care professional. I voluntarily request and consent for independently contracted physicians (via Exceptional Emergency Center) to order all necessary tests and treatments while I am a patient at Exceptional Emergency Center. I understand that medical care is not an exact science and that no guarantee or warrantee is being made as to my examination, treatment, result, or outcome. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. However, I understand that doing so may hinder my treatment and/or medical outcome.

CONSENT TO PHOTOGRAPH

I consent to photographs, videotapes, digital or audio recording, and/or images of me being recorded for security purpose and/or Exceptional Emergency Center healthcare treatment and/or operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recording when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representatives unless otherwise required by law.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received Exceptional Emergency Center Notice of Privacy Practices, which describes the way in which emergency room may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact Exceptional Emergency Center if I have questions or complaints.

ACCIDENTAL BODILY FLUID EXPOSURE TO HEALTHCARE WORKER

This consent includes testing for communicable blood-borne diseases, including, without limitation of, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Virus (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Emergency Room to test a patient that has exposed healthcare worker to HIV without obtaining the person's consent. I understand the potential side effects and complications of this testing are generally minor and are comparable to the routine collections of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding, or soreness at the puncture site. The results of this test will become part of my confidential medical record.

SMOKING POLICY

To maintain the health and safety of patients, visitors, and staff, Exceptional Emergency Center is a strictly enforced smoke-free environment. Exceptional Emergency Center is not responsible for any claim or harm arising from smoking, or from my leaving the facility for the purpose of smoking or consuming tobacco products.

PERSONAL VALUABLES

Although the facility will make all reasonable efforts in safeguarding my valuables, I understand that Exceptional Emergency Center is not responsible for the loss or damage of personal valuables.

ASSIGNMENT OF INSURANCE BENEFITS

I assign Exceptional Emergency Center all rights, title, and interest in any and all health insurance and/or health plan proceeds/benefits from any plan(s) arising from the provision of any goods and services provided by Exceptional Emergency Center and/or physicians/healthcare providers thereof. This assignment is made in accordance with §1204.054, Texas Insurance Code.

I also assign and transfer to Exceptional Emergency Center all rights, title, and interest in any claims against any health insurers, sponsors and/or plan administrators of any of my health benefit plan(s) arising from or pertaining to any wrongful acts and/or omission pertaining to any of said health/benefit plan(s) or health insurance policy(ies) including, but not limited to, claims for a non-payment or underpayment of health provider invoices and claims. I further expressly and knowingly assign all rights under my insurer and/or benefit plan. I understand that any payment received from these policies and/or plans will be applied to the payments I have agreed to pay for services rendered during this emergency room visits.

Exceptional Emergency Center file primary and secondary insurance claims for insured patients. I authorize the facility and/or physicians 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 or health plan.

I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement.

Acknowledge:_____(Initial)

Patient Label

CONSENT TO USE AND DISCLOSE INFORMATION

I agree and consent to the use and disclosure of my health information for the purpose of treatment, payment from third party payers, and other healthcare operations, such as the maintenance of medical records, communication of health information with other health professional who contribute to my care, and quality peer reviews and assessments.

FINANCIAL AGREEMENT AND PATIENT GUARANTEE

I agree, whether signing as agent or a patient, that in consideration of the services to be rendered, I hereby am responsible for paying facility copayments, deductibles, estimated facility coinsurance amounts, and any balances deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payments are cash, money order, cashier's check, credit card, or personal checks.

Self-pay balances must be paid in full prior to discharge unless otherwise arrangements have been made with Exceptional Emergency Center. If the balance due is referred to a collection agency or attorney, I understand that there may be additional fees, interest, and expenses that I will be responsible for.

Exceptional Emergency Center will provide a medical screening as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to patient's ability to pay. If there is an emergency medical condition, the facility will provide stabilizing treatment and/or transfer to another facility within its capacity.

NON-COVERED SERVICES

If any of the provided services are not covered by my insurance company, or if Exceptional Emergency Center is not able to verify eligibility, I am responsible for all charges incurred for services rendered.

PATIENTS RIGHTS AND RESPONSIBILITIES

Patient has received a copy of patient's right and responsibilities.

Acknowledge:_____(Initial)

COMPLAINTS AGAINST EXCEPTIONAL EMERGENCY CENTER

For any questions or concerns regarding Exceptional Emergency Center please contact our facility and ask for our Administrator, corporate office (469) 341 – 7800, or the Department of State Health Services at (888) 973 – 0222.

The physicians, nurses, and the entire staff at Exceptional Emergency Center are committed to assure your safe and reasonable care at all times. To file or voice a complaint, grievance about the organization, the care provided, or patient rights, and to receive a timely response without reprisal or prejudicial treatment contact: Belinda Boswell (469) 436 – 3110. Presentation of a complaint will not compromise your care under any circumstances. If your complaint or grievance is not resolved to your satisfaction, you may contact:

Department of State Health Services

Health Facility Compliance Group (MC 1979)
Department of State Health Services
P.O. Box 149347 Austin, TX.
78714-9347

Complaint Hotline

(888) 973-0022 Texas

ACKNOWLEDGEMENT AND SIGNATURE

I have read, understand, and accept the consents, policies, and terms as set forth above. All information provided is true to the best of my knowledge.

× _____

Patient Signature

Date:_____

× _____

Administrative Assistant Signature

Date:_____

Patient Label

EXCEPTIONAL EMERGENCY CENTER

****(Please sign the applicable section) ****

Medicare Patients

I,_____,(print name) hereby agree to give my consent to Exceptional Healthcare Emergency Center that they can file my Medicare claims to my insurance company and I am liable to provide my complete and correct insurance information. I understand that I am financially responsible for the charges not covered by my insurance due to missing or incorrect information. I agree and consent to pay my Medical claim's charges if the given information is incorrect or fail to provide in a timely manner (*within 60 days*).

Patient Signature:_____**Date:** _____

All Workers' Compensation Patients

Exceptional Healthcare Emergency Center is authorized to send all Medical Claims to my Worker's Compensation Adjuster and/or Managers with my information so they can get reimbursement from Worker's Compensation Insurance for the treatment provided and I shall provide the following correct information within a timely manner (*within 60 days*).

- Worker's Compensation carrier name
- Claim Number
- Injury Date
- Adjusters name
- Carrier Address along with Phone and Fax Number

Patient Signature:_____**Date:** _____

All Motor Vehicle Accident Patients

Exceptional Healthcare Emergency Center is authorized to send all Medical Claims to my MVA Adjuster and/or Managers with my information so they can get reimbursement from MVA Insurance and I shall provide the following correct information within a timely manner (*within 60 days*).

- MVA carrier name
- Claim Number
- Injury Date
- Adjusters name
- Carrier Address along with Phone and Fax Number

Patient Signature:_____**Date:** _____

All Commercial & Private Insurance Patients

Exceptional Healthcare Emergency Center is authorized to send all Medical Claims to my Commercial or Private insurance with my information so they can get reimbursement by commercial or private insurance and I shall provide the correct information or if my Coordination of Benefits needs to be updated I will update this information with the insurance and also provide to Exceptional Healthcare Emergency Center within a timely manner (*within 60 days*).

Patient Signature:_____**Date:** _____

HIPAA ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Exceptional Emergency Center

I understand, that under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I can contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

× _____ _____

Signature of Authorized Patient Date Signed by Patient

_____ _____

Print Patient Name Relationship to Patient (if patient is unable to sign)

FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):

_____

_____

Signature and Printed Name of Administrative Assistant

_____

Date Signed by Administrative Assistant

Patient Label

EXCEPTIONAL EMERGENCY CENTER

Coordination of Benefits

1. Do you or another family member have other health coverage that may cover your emergency room visit besides the one you are submitting today?
   □ **Yes** □ **No**

   If Yes, please indicate your secondary health plan coverage information below:
   a. Health Insurance Name: _____
   b. Subscriber Name: _____
   c. Subscriber's Date of Birth: _____
   d. Member ID: _____
   e. Group Number: _____
   f. Effective Date: _____

2. Do you or another family member under your current policy have Medicare?
   □ **Yes** □ **No**

   If Yes, please provide the following for each family member with Medicare:
   a. Name of Medicare Beneficiary: _____
      □ Medicare A □ Medicare B □ Both
   b. Medicare Member ID: _____
   c. Entitlement Reason:
      □ Age □ Disability □ End Stage Renal Disease
   d. Effective Date: _____

_____

Print Name of the person completing the form

X_____ _____

Patient Signature Administrative Assistant Signature

Date:_____ Date:_____

Patient Label

EXCEPTIONAL EMERGENCY CENTER

Accident Questionnaire (If not applicable fill in N/A and sign bottom of page)

1. Date of Accident: _____
2. Where did the injury occur? _____
3. Please provide a brief description of how this injury took place:

   _____

   _____

   _____

   _____

4. Will this Injury be claimed on an accident insurance policy?

   □ **Yes** □ **No**

   a. Accident Policy Name: _____
   b. Accident Policy Number: _____
   c. Phone Number: _____
   d. Claim Number: _____

5. Will someone other than you be responsible for the claim and/or bill?

   □ **Yes** □ **No**

   a. Individual's name and title that is authorizing the visit?

      _____

   b. Phone Number for the person authorizing the visit?

      _____

I understand that I am responsible for any charges that are not covered by a policy or individual

× _____ _____

Patient Signature Administrative Assistant Signature

Date: _____ Date: _____

Patient Label