Ennis Medical Group
Today's Date: ___/___/___

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle		☐ Mr. ☐ Mrs ☐ Miss ☐ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?	Birthdate / /	Age Sex ☐ M ☐ F ☐ T
Mailing Address City State Zip Code			Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address (To be used for appointment reminders)		Social Security - -
Occupation	Employer	Employer Phone Number	

Employment Status : ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ☐F – Full-Time Student ☐P –Part-Time Student ☐N – Not a Student

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐White ☐ Hispanic ☐Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _________

Pharmacy:	Do you have a living will? ☐ YES ☐ NO

☐ Referred By (Please check one box)
☐ Dr.______________ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐Facebook ☐Website ☐Newspaper ☐Radio ☐Billboard ☐Other___________

Other Family Members Seen Here

PCP Name: Phone Number:

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐Self ☐Check here if information is same as patient

Name		Address	Home Phone Number ( )
Birth Date / /		E-Mail Address	
Occupation	Employer	Employer Address	Employer Phone Number

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC) ☐OCCUPATIONAL MEDICINE (OM)
☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE_________________________

Does the patient have healthcare coverage? ☐ YES ☐ NO

Insurance Name:	Social Security Number: - -	Date of Birth / /	Effective Date	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured					

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT:

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

______________________________ ______________________

Patient/ Guardian Signature Date

Ennis Medical Group

ENNIS MEDICAL GROUP

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____ Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
    - The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at anytime. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic to participate in organizations with Other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. EMAIL AND TEXT COMMUNICATIONS: If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

______________________________ Printed Name of Patient or Representative

______________________________ Signature of Patient or Representative

____________________ Date

Relationship to Patient (if other than patient) ______________________________

CLINIC STAFF USE ONLY

□ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

______________________________ Witness (Staff) Signature

______________________________ Witness (Staff) Printed Name

Date: ____________________

ENNIS MEDICAL GROUP

PATIENT RIGHTS

The following is a list of your basic rights for independence of expression, decision and action, concern for personal dignity and human relationships during your stay at this facility.

NOTICE OF PATIENT RIGHTS
The hospital will inform each patient of his/her rights in advance of furnishing or discontinuing patient care, whenever possible.

ACCESS TO CARE

- Individuals shall be accorded impartial to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.
- Nursing Care: this hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby release from any and all liability arising from the fact that said patient is not provided with such additional care.

REPECT AND DIGNITY
The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his/her personal dignity. The patient and family have the right to have psychosocial and spiritual concerns acknowledged during care.

PRIVACY AND CONFIDENTIALITY
The patient has the right, within the law, to personal and informational privacy, as manifested by the following rights:

- To refuse or talk with or see anyone not officially connected with the hospital, including visitors, or persons officially connected with the hospital; but not directly involved in his/her care.
- To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedure or treatment.
- To be interviewed and examined in surroundings designed to assure reasonable visible and auditory privacy. This includes the right to have a person of one's sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex and right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
- To expect that any discussion or consultation involving his/her case will be conducted discreetly and that the individuals not directly involved in his/her care will not be present without his/her permission.
- To have his/her medical record read only by the individuals directly involved in his/her treatment or in the monitoring of its quality; other individuals can only read his/her medical record on his/her written authorization or that of his/her legally authorized representative.
- To expect al communications and other records pertaining to his/her care, including the source of payment for treatment, to be treated as confidential.
- Tobe free from all forms of abuse and harassment.
- Release of information: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charges, including but not limited to insurance companies, health care service plans, or Worker's Compensation carriers. Special permission is needed to release information where the patient is being treated for alcohol or drug abuse.

PERSONAL SAFETY
The patient has the right to receive care in a safe hospital environment.

PERSONAL VALUABLES
Cash, credit cards and jewelry, as well as other valuables must be left at home. If you forget and are admitted with such items, a hospital safe is available. Ask an ERMC staff member about safekeeping. If you do not place items in the safe, ERMC will not be responsible or the loss or damage of the valuables.

IDENTITY
The patient has the right to know the identity and professional status of individuals providing service to him/her and to know which physician or other practitioner is primarily responsible for his/her care. This includes the patient's right to know the existence of any professional relationship among individuals who are treating the patient, as well as the relationship to any other health care or educational institutions involved in his/her care. Participation by patients in clinical training programs or in the gathering of data for research should be voluntary.

INFORMATION
The patient has the right to obtain, from the practitioner responsible for coordinating the patient's care, complete and current information concerning his/her diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patients can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

- The patient has the right to access to people outside the hospital by means of visitors and by verbal and written communication.
- When the patient does not speak or understand the predominant language of the community, he/she should have access to an interpreter. This is particularly true where language barriers are a continuing problem.

CONSENT

- The patient has the right to reasonable informed participation in decisions involving his/her healthcare. To the degree possible, this should be based on a clear concise explanation of the patient's condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subject to any procedure without his/her voluntary, component, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.
- The patient has the right to be involved in his/her care planning and treatment.
- The patient has the right to know who is responsible for authorizing and performing the procedures of treatment.
- The patient shall be informed if the hospital proposes to engage in or perform human experimentation or order research/educational projects affecting his/her care or treatment; the patient has the right to refuse to participate in any such activity.
- The patient or designated representative has the right to participate in the consideration of ethical issues that arise in the care being or to be given.
- Consent to medical and surgical procedures: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patients physician or surgeon.

MANAGEMENT OF PAIN
The patient has the right to appropriate assessment and management of pain.

CONSULTATION

The patient, at his/her own request and expense, has the right to consult with a specialist.

REQUEST OR REFUSAL OF TREATMENT

The patient has the right to makes decisions about the plan of care prior to and during the course of treatment and refuse a recommended treatment or plan of action to the extent permitted by law and hospital policy, and to be informed of the medical consequences of this action. When refusal of treatment by the patient or his/her legal authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice. When a conflict arises that is not reasonably resolved by termination of the patient/physician relationship, the patient may refer the matter to the Administrator and/or Medical Executive Committee. The patient or designated representative has the right to make decisions regarding the withholding of resuscitative services of the foregoing or withdrawing of life sustaining treatment if a doctor's order is written in the chart.

TRANSFER AND CONTINUITY OF CARE

A patient may not be transferred to another facility or organization unless he/she has received a complete explanation of the need for the transfer and of the alternatives to such a transfer, and unless the transfer is acceptable to the facility or organization. The patient has the right to be informed by the practitioner responsible for his/her care, of his/her delegate, or any continuing health care requirements following discharge from the hospital.

HOSPITAL CHARGES

Regardless of the source of payment for his/her care, the patient has the right to request and receive an itemized and detailed explanation of his/her total bill for services rendered in the hospital. The patient has the right to timely notice prior termination for his/her eligibility. The patient has the right to timely notice prior termination of his/ her eligibility for reimbursement by any third party payer for the cost of his/her care once the hospital has received confirmation.

HOSPITAL RULES AND REGULATIONS

The patient and/or parent/legal guardian should be informed of the hospital rules and regulations applicable to his/her conduct as a patient/parent/legal guardian. Patients/Parents/Guardians are entitled to information about the hospitals mechanism for initiation, review, and resolution of the patient complaints.

AGE SPECIFIC CARE

- A patient has the right to care that is appropriate for his/her age.
- When a course of treatment requires a child or adolescent hospitalization for a significant period of time, the patient has the right to continued education and activities appropriate to his/her age and condition.
- A parent or legal guardian has the right to remain in attendance with their minor child unless their presence may hinder the performance of necessary medical procedures or treatment, or as prohibited by hospital policy.

ADVANCE DIRECTIVES

The patient has the right to formulate advance directives and have hospital staff practitioners who provide care in the hospital comply with these directives.

NOTIFICATION OF ADMISSION

The parent has the right to have a family member or representative of his/her choice and his/her own physician notified promptly of his/her admission to the hospital.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN

All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesia provider and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility if the physician or surgeon to obtain the patients informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and special instructions of the physician.

RESTRAINTS

The patient has the right to be free from any form of restraints (physical restraint or drug being used as a restraint) that is not medically necessary or is used as a means of coercion.

- A restraint can only be used if necessary to improve the patient's well-being and less restrictive interventions have been determined to be ineffective.
- The use of a restraint must be in accordance with the order of a physician or other licensed independent practitioner permitted by the state and hospital to order a restraint.

SECLUSION AND RESTRAINT FOR BEHAVIOR MANAGEMENT

The patient has the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline, convenience or retaliation by staff.

- Seclusion or restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective.

GRIEVANCE/COMPLAINT PROCESS

The patient has the right to a prompt resolution of a patient grievance or complaint. You may voice or file a complaint by phoning the Administrative Offices at 469-256-2156, 8:00 a.m. to 5:00p.m Monday thru Friday. You may also voice or file a complaint by contracting the department Director, Nursing Supervisor, and/or any staff member.

- The grievance process allows for the timely referral of patient quality care or premature discharge issues, to a quality care/Compliance Committee.
- The grievance/complaint will be reviewed within a two-week period and logged in the Complaint Log. The Complaint Log will be reviewed on a monthly basis by the Compliance Committee for appropriate follow-up.
- The resolution will include a response from the hospital that includes the name of the contact person and steps taken to investigate the results of the process.

You may also file a grievance/complaint with our licensing agency, Texas Department of Health, directly by phone 1-888-973-0022, or in writing:

Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

Other Contact Information:

Texas Medical Foundation (TMF) — Phone: 1-800-725-9216
Barton Oaks Plaza Two, Suite 200
901 South MoPac Expressway, Suite 11200
Austin, Texas 78746

Centers for Medicare and Medicaid Services (CMS) — Phone: 1-877-267-2323
7500 Security Blvd.
Baltimore, MD 21244

Office of Quality Monitoring — Phone: 1-630-792-5636
Joint Commission Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrance, IL 60181