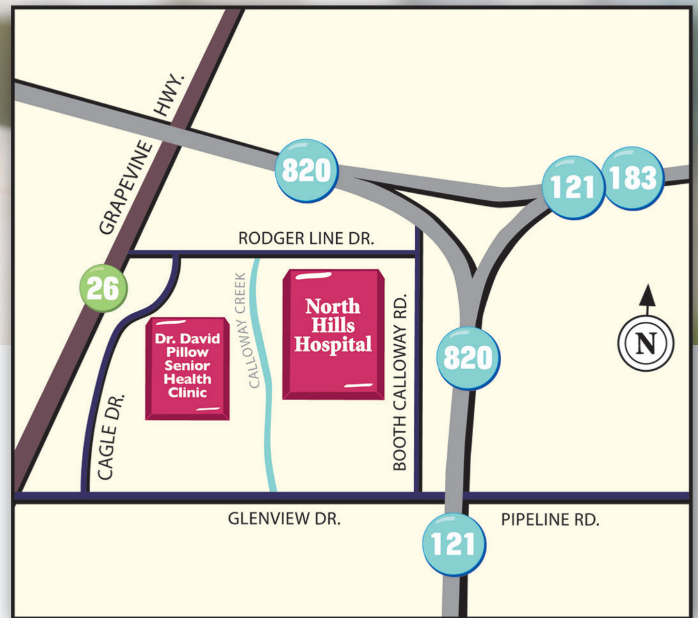
Specializing in *Seniors*



Dr. David Pillow Senior Health Clinic

Our Senior Health Clinic is located behind North Hills Hospital. We are best accessed by taking Cagle Drive off Glenview or Rodger Line Drive.

Call us today for an appointment at (817) 255-1940.

Dr. David Pillow
Senior Health Clinic
at North Hills Hospital

4300 Cagle Drive • Suite 200 • North Richland Hills, Texas 76180 • (817) 255-1940

Dr. David Pillow
SENIOR HEALTH CLINIC at NORTH HILLS HOSPTIAL
4300 Cagle Drive Ste 200
North Richland Hills, Texas 76180

To our New Patients:

On behalf of the staff at the Senior Health Clinic, we would like to welcome you as a new patient. Your new patient appointment is scheduled for _______on __________________.
At your first appointment we will be gathering a lot of demographic, medical and insurance information. Because of the lengthy appointment, it is imperative that you arrive on time. If you are late it may be necessary to reschedule your appointment.

Enclosed is a packet of information we will need you to fill out and mail back in the envelope provided before your appointment. We will review your completed patient information packet and make copies of your insurance cards. We also request you bring all medication including prescription medications, over the counter medications, herbs and vitamins with you to EACH APPOINTMENT. The physician and nurse will review your medications at each visit.

Our goal is to provide not only high-quality medical care, but to attend to our patient's and families' overall well-being. We have a social worker on staff to assist with access to community resources that are often times the key role in maintaining independence as we age. Please let us know if she can be of assistance.

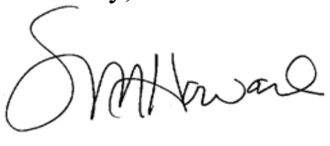
Because the Senior Health Clinic is an outpatient department of North Hills Hospital, the hospital bills a "facility fee" for each visit to this outpatient clinic. You will receive a bill from North Hills Hospital for the facility fee. This fee covers the cost of the clinic staff, supplies, equipment and space. You will also receive a separate bill from the physician. The physician's fee includes the physician's time and services as well as interpretation of testing performed in the clinic. All Medicare plans as well as supplemental policies recognize these charges and will pay once deductibles are met. You will be responsible for deductibles and or co-pays, depending on your plan coverage. The hospital as well as the physician billing service (Medical Edge) will bill all Medicare plans as well as secondary insurance providers.

SINCE MEDICARE NOW PROVIDES MEDICARE SUMMARY NOTICES ONLY ON A QUARTERLY BASIS, YOU CAN OBTAIN MORE TIMELY INFORMATION ON EACH SERVICE BY REGISTERING WITH AND ACCESSING www.MyMedicare.gov .

If you have any questions regarding our services or these enclosures, feel free to call the office at (817) 255-1940 or contact me directly at (817) 255-1118.

We thank you for choosing North Hills Hospital Senior Health Clinic to address your health care needs and look forward to serving you.

Sincerely,



Stacey M. Howard, FACHE
Director/Senior Health Clinic at North Hills Hospital

PATIENT INFORMATION

FULL NAME: ______________________________ DATE OF BIRTH: ______________

SOCIAL SECURITY #: ______________________________ PHONE #: ______________
(Area code)

ADDRESS: ______________________________ APT#: ______________

CITY/STATE: ______________________________ ZIP: ______________

OCCUPATION/EMPLOYER: ______________________________ WK#: ______________

EMERGENCY CONTACT: ______________________________ RELATIONSHIP: ______________

ADDRESS: ______________________________

CITY/STATE: ______________ ZIP: ______________ PHONE#: ______________

INSURANCE INFORMATION

PRIMARY COVERAGE, CARRIER NAME:

GROUP #: ______________ POLICY #: ______________

SECONDARY COVERAGE, CARRIER NAME: ______________

GROUP #: ______________ POLICY #: ______________

IF YOUR RELATIVES/FRIENDS REQUEST INFORMATION PERTAINING TO YOUR DIAGNOSIS, TEST RESULTS, OR TREATMENT; PLEASE INDICATE THE NAME AND RELATIONSHIP TO WHOM YOU AUTHORIZE SUCH INFORMATION BE RELEASED:

NAME: ______________________________ RELATIONSHIP: ______________

NAME: ______________________________ RELATIONSHIP: ______________

NAME: ______________________________ RELATIONSHIP: ______________

NAME: ______________________________ RELATIONSHIP: ______________

CERTIFICATION AND AUTHORIZATION

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE IT TO THE SOCIAL SECURITY ASMINISTRATION, ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

PATIENT SIGNATURE ______________________________ DATE ______________

4300 Cagle Drive, Suite 200 • North Richland Hills, TX 76180 • 817-255-1940

NHH00320 (Rev. 01/10)

PATIENT IDENTIFICATION

DR.DAVID PILLOW SENIOR HEALTH CLINIC AT NORTH HILLS HOSPITAL
PATIENTS RIGHTS AND RESPONSIBILITIES -

As a patient at North Hills Hospital, you have the following rights, within the limits of the law, to:

1. Receive considerate and respectful care, provided in a safe, secure, non-threatening environment, and to be free from forms of abuse (mental, physical, sexual, or verbal), neglect, exploitation, or harassment.
2. Have your cultural, psychosocial, spiritual, personal values, beliefs and preferences respected.
3. Be cared for in an environment that preserves your dignity and positive self-image.
4. Receive pastoral care and other spiritual services as requested.
5. Be informed of your rights, and the rules and regulations governing your conduct, while in the hospital.
6. Access, request amendment, and receive an accounting of disclosures regarding your health information, and to have the information explained or interpreted to you within the limits of the law in a reasonable time frame.
7. Be involved in your care, treatment or service, including, but not limited to, the development and implementation of your plan of care, refusal of such care to the extent permitted by law and be informed of the medical consequences of such actions.
8. Formulate an Advance Directive (such as a Directive to Physicians or Medical Power of Attorney for Health Care) and appoint a surrogate to make health care choices on your behalf. You have the right to expect that the terms of your directive are followed to the extent permitted by law and to have provision of care that is not conditioned on the existence of an advance directive. The Chaplain is available to address any questions you may have.
9. Receive the necessary information from your physician to allow you to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information includes, but is not necessarily limited to, the specific procedure and/or treatment, the medically significant risks, benefits and alternatives involved, and the probable duration of incapacitation.
10. Have consent obtained prior to recording, photographing or filming, for purposes other than security, to request cessation of recording/photographing/filming. You have the right to rescind consent for use up until a reasonable time before the recording of film is used.
11. Know by name the physician responsible for the coordination of your care and the identities of others involved in providing your care.
12. Expect care that optimizes the comfort and dignity of the dying patient, including treatment of primary and secondary symptoms that respond to treatment (as desired by the patient or surrogate decision maker), effectively managing pain, and acknowledging the psychosocial and spiritual concerns of the patient and family regarding death and the expression of grief.
13. Receive information on the outcomes of care, including unanticipated outcomes.
14. Interpreter services if you have a speech or hearing impairment, require language interpretation, or reading assistance in order to understand or actively participate in your care. You have the right to have information communicated in a language you understand.
15. Have the right to express concerns/complaints concerning quality of care issues either verbally or in writing to the supervisor/ department manager, nursing staff, medical staff, patient advocate, Administration, Centers for Medicare and Medicaid Services, and The Joint Commission You have the right to a timely response to your concern/complaint and a resolution when possible. The expression of a concern or complaint does not compromise your care or future access to care.
16. Have the right to report your concerns/complaints directly to state regulatory agencies.
    a. If your concern is with a doctor, you may call the Texas State Board of Medical Examiners directly at 1-512-305-7010.
    b. If your concern is with the hospital, you may call the Texas Department of Health at 1-888-973-0022.
17. Expect that consideration is given to providing for your security and privacy. Communication and records pertaining to your care are treated as confidential within the limits of the law. Please refer to the Notice of Privacy Practices brochure.
18. Appropriate assessment and management of pain.
19. Have access to protective and advocacy services. Phone numbers are listed in the Patient Handbook.
20. Be informed of any research/educational projects affecting your care or treatment and to consent/refuse to participate. Your refusal to participate or discontinuing participation at any time does not compromise your access to care, treatment or services.
21. Exercise these rights, and receive effective and safe care, treatment or services, which are medically indicated, regardless of race, color, creed, gender, national origin, disability, age, or source of payment.
22. Have a family member, a representative of your choice, or your own physician be notified promptly of your admission to the hospital.
23. Be free from seclusion or restraints, of any form, which are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
24. Be cared for by healthcare professionals who have been educated about patient rights and their role in supporting them.
25. Have the hospital respond to your request for service, within its capacity, and provide evaluation, service or referral as indicated by the urgency of the case.

DR.DAVID PILLOW SENIOR HEALTH CLINIC AT NORTH HILLS HOSPITAL
PATIENTS RIGHTS AND RESPONSIBILITIES - 2 of 2

26. Be transferred to another facility, when medically permissible, as recommended or requested, after being informed of the risks, benefits and alternatives to transfer. The receiving institution must have accepted you for transfer.
27. Obtain information as to any professional relationships among individuals treating you, as well as the relationship between the hospital and other healthcare and education institutions, which may influence your care.
28. Obtain information regarding your diagnosis, treatment, prognosis, and plans for discharge and follow-up care in understandable terms.
29. Be informed as soon as possible if your provider is going to be delayed for a scheduled appointment and given the opportunity to reschedule.
30. Participate in decisions regarding ethical issues surrounding your care including issues of conflict resolution, withholding of resuscitation, forgoing or withdrawal of life-sustaining treatment and participation in investigational studies or clinical trials. You may ask your nurse or physician to consult the Ethics Committee for resolution of conflicts in decision-making regarding your care and may request to see a copy of the hospital's policy on ethical issue resolution and code of ethical behavior.
31. Examine and receive an explanation of your bill and to be informed of available payment options. You have the right to timely notice prior to termination of eligibility for reimbursement by any third-party payer for the cost of care.
32. That North Hills Hospital will meet the requirements of the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act, which requires program and facility accessibility. Actions alleged to be in violation of this act are placed in writing and given to an area supervisor. A response is provided if requested.
33. If you are 55 years of age or older, the message from Medicare outlining rights for the elderly are provided at the time of admission.
34. The patient's guardian, next of kin, or legally authorized representative shall exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient is incompetent, medically incapable, unable to communicate, or a minor.

Patients, parents/guardians, legally authorized representatives or surrogate decision makers have the following responsibilities:

1. To provide to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, perceived risks in our care, and other matters related to your health.
2. To report unexpected changes in your condition to the responsible practitioner.
3. To ask your doctor/nurse what to expect regarding pain and pain relief options, to work with your doctor/nurse in developing a pain management plan, to ask for pain relief when pain first begins, to help us measure your pain, and to tell us if your pain is not relieved.
4. To follow the treatment plan developed with your doctor and other caregivers and express any concerns you have about your ability to follow that plan. The hospital makes every effort to adapt the plan to your specific needs and limitations. You are informed of possible consequences of any unapproved changes or noncompliance in following the treatment plan.
5. To be responsible for your actions and the medical consequences if care, treatment, or services are refused.
6. To ask questions and request additional information/clarification when you do not understand your care, treatment, or services, or what is expected of you.
7. To follow hospital rules and regulations.
8. To consider the rights of other patients and personnel of the hospital, and assist in the control of noise, smoking, and the number of visitors.
9. To respect hospital property and the property of others.
10. To participate in those educational and discharge planning activities necessary to ensure you have adequate knowledge and support services necessary to provide you with a safe environment upon discharge from the hospital.
11. To fulfill the financial obligations of your health care.
12. To provide the hospital with a copy of your advance directive, if one exists.

CONSENT FOR USE AND RELEASE OF INFORMATION

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, ______________________________ or
(Name of Employer)
employer's designee when the services delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

<table>
<tr><td>Date</td><td colspan="2" rowspan="2">I, hereby certify I have read, and fully and completely understand this Authorization for Release of Information/Healthcare Information, and that I have signed this Authorization for Release of Information/Healthcare Information knowingly, freely and voluntarily.
❑ Patient is medically unable to sign the Consent for Use and Release of Information. ❑ Patient Refused to Sign</td></tr>
<tr><td>Time a.m. ❑
p.m. ❑</td></tr>
<tr><td colspan="2">Patient/Parent/Guardian</td><td>If other than patient, indicate relationship</td></tr>
<tr><td colspan="2">Spouse (if Married/Available)</td><td>Witness (to Signature only)</td></tr>
</table>

4300 Cagle Drive, Suite 200 • North Richland Hills, TX 76180 • 817-255-1940

1. Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or this outpatient episode of care, including emergency treatment or services, and which may include but are not limited to laboratory procedures, 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 understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. Financial Agreement. In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the Hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rule or statutes permit the hospital to recover.

3. Consent to Wireless Telephone Calls. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

4. Assignment of Benefits. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent right of recovery against the patient's insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health plan benefit and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital-based physicians elect to collect such payment. In the event the hospital and/or hospital-based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plans. I hereby appoint the hospital as my authorized representative to pursue, any administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). 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, other than the rendition of services by the hospital and/or hospital based physicians.

*Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.

5. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

6. Outpatient Medicare Patients. Medicare does not cover prescription drugs except for a few exceptions. According to Medicare regulations, you are responsible for any drugs furnished to you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to you by hospital personnel. Medicare requires

hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

7. Other Acknowledgements

a. <u>Additional Provision for Admission of Minors.</u> I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

b. <u>Legal Relationship Between Hospital and Physicians.</u> Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that 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 instances, 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 that is separate from the bill for hospital services.

c. <u>This consent includes testing for communicable or blood-borne diseases</u>, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection 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.

Please initial: Agree_____ Disagree __________

d. <u>Insurance Network Acknowledgement.</u> I acknowledge that I have received notice that, based on the information available at this time, this facility **<u>IS/IS NOT</u>** a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g. radiologists, anesthesiologists, pathologists, neonatologists and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure or other services may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _________________ (Initial)

8. Patient Self Determination Act.
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to **one** of the following applicable statements:

❑ I executed an Advance Directive and have been requested to supply a copy to the hospital

❑ I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive

❑ I have not executed an Advance Directive and do not wish to execute one at this time

9. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital 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 the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: ______________ (Initial)

Date: _________________ Time: _________________

I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Consent for Outpatient Services and Authorization for Medical treatment, and that I have signed this Consent for Outpatient Services and Authorization for Medical Treatment 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. This agreement is in effect and applies to care and treatment received during this outpatient episode of care. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Authorized Representative Signature:

X ____

Witness Signature and Title:

X ____

If you are not the patient, please identify your Relationship to the patient.
(Circle or mark relationship(s) from list below):

❑ Spouse ❑ Parent ❑ Legal Guardian ❑ Neighbor/Friend ❑ Sibling ❑ Healthcare Power of Attorney

Other (please specify): ____

Additional Witness Signature and Title:
(required for patients unable to sign without a representative or patients who refuse to sign)

X____

SENIOR HEALTH CLINIC
WRITTEN NOTICE OF MEDICARE BENEFICIARY'S FINANCIAL OBLIGATION

Dear Medicare Patient:

The SENIOR HEALTH CLINIC is a hospital outpatient department of NORTH HILLS HOSPITAL (the "Provider"). Because it is a hospital-based department that is located off the hospital campus, Medicare requires us to inform you that you will incur a coinsurance liability (FACILTY FEE) to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital-based and to provide you with a notice of your potential financial liability for the hospital service(s).

At this time, we can provide you with the following information on the estimated amount of your coinsurance liability.

- Based upon current information regarding the type and extent of the services scheduled, your coinsurance liability for the hospital service(s) is **estimated** to be $___________; or,

- Since we do not know the exact type and extent of services (OR WHAT YOUR INSURANCE COMPANY WILL PAY) that you may need, we are unable to provide you with an estimate of your liability at this time. However, the typical charge incurred by a beneficiary based on all visits to this department or facility normally ranges from $60 to $80. Medicare recognizes the facility fee charge and most supplementals will pay the remaining balance of the facility fee charges leaving you no financial responsibility once your yearly deductibles are met.

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and also subject to final determination by the Medicare program.

If you are enrolled in a state medical assistance program such as Medicaid or Medi-Cal, your coinsurance liability may be reduced or eliminated by law.

Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

I acknowledge that I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law and that I have received a copy of this notice.

Patient's Signature ____ Date ______________________

Witness Signature ____ Date ______________________

HCA Government Programs
Oct. 2002
Revised December 2004
NHH00356 (Rev. 3/10)

NOTICE OF ACKNOWLEDGEMENT
Patient Rights, Ethics, and Advance Directive

Patient Name:______________________________________ Date of Birth: ________________________________

An **Advance Directive** is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision-making capability. Advance Directives are the following written instruments: the Living Will and the Durable Power of Attorney for Health Care. The instrument may be revoked at any time. Should it be revoked, a notation of date and time must be made to the patient's medical record.

1. Do you have a Living Will (Directive to Physicians)? ❑ Yes ❑ No
If yes, is it up to date? ❑ Yes ❑ No Where is the copy located? ___________________________________

Do you have a Durable Power of Attorney for Health Care? ❑ Yes ❑ No
If yes, is it up to date? ❑ Yes ❑ No Where is the copy located? ___________________________________

Principal Agent: ____ Phone: _________________________________
Address:____
Alternate Agent: ____ Phone: _________________________________
Address:____

If you have Advance Directives, what are your wishes regarding end of life decisions (e.g., life support machines, tube feedings, etc.)? ____
____
____

An Out-of-Hospital Do-Not-Resuscitate (DNR) order is a medical order by the doctor that allows terminally ill patients to refuse specific life-sustaining treatments outside the hospital. It will tell health providers not to use CPR or other life-sustaining techniques.

2. Has your doctor signed an Out-of-Hospital DNR order form for you? ❑ Yes ❑ No
If so, where is a copy located? ____

If you have an Advance Directive or Out-of-Hospital DNR Order, it will be your responsibility to provide a copy to the Senior Health Clinic.
Additional information on Advance Directives or Out-of-Hospital DNR orders is available to you at any time upon your request from The Senior Health Clinic.

3. I have received the Statement of **Patient Right and Responsibilities**: ❑ Yes ❑ No

____ ___________________________
Signature of Patient or Representative **Date**

4300 Cagle Drive, Suite 200 • North Richland Hills, TX 76180 • 817-255-1940

PATIENT IDENTIFICATION

SENIOR CLINIC
CONSENT FOR MESSAGES AND PHOTGRAPHS

Paul K. Kim, M.D.

Gurpreet K. Gill, M.D.

Jennifer James, M.D.

Rey Marquino, M.D.

Vasu Nalajala, M.D.

Dear Patient,
As you may be aware, many times we are unable to contact you at home. If you Agree and give us consent by signing the statement below, we will leave important medical information on your voicemail or answering machine.

I, ____ give my consent for a representative of the North Hills Senior Clinic to leave information regarding appointments, lab and/or test results and other medical related information on my voice mail or answering machine. Please leave that information at the following phone number:

____

I also give my consent for a representative of the North Hills Senior Clinic to take my photograph and place the photo in my chart, for identification purposes only.

____ ______________________________

Patient Signature Date

____

Patient Date of Birth

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PATIENT IDENTIFICATION

New Patient Admission Assessment & History

Senior Health Clinic

Date:________________ Name: ____ Date of Birth:________________

Do you live alone? ❑ Yes ❑ No If "no" with whom do you live? ________________________________

What problems or symptoms are you experiencing that prompted you to come to the Senior Health Clinic?

____

____

ALLERGIES - Antibiotics, Medications, Vaccinations, Other:

____

____

IMMUNIZATIONS, ETC.

❑ Tetanus Shot Date: ________________ ❑ Flu Vaccine Date: ________________

❑ Pneumonia Vaccine Date: ________________ ❑ TB Test Date: ________________

PAST MEDICAL / FAMILY / SOCIAL HISTORY

MEDICAL CONDITIONS - Please check current or past illnesses:

❑ Congestive Heart Failure	❑ Heart Attack	❑ Cancer	❑ Arthritis
❑ Asthma	❑ Pneumonia	❑ Bronchitis	❑ Other ________
❑ Diabetes	❑ Kidney Problems	❑ Liver Disease	________

PREVIOUS SURGERIES:

❑ Cataracts	Year: ______	❑ Breast	Year: ______	❑ Hernia	Year: ______
❑ Tonsillectomy	Year: ______	❑ Hysterectomy	Year: ______	❑ Heart By Pass	Year: ______
❑ Appendectomy	Year: ______	❑ Ovarian Surgery	Year: ______	❑ Pacemaker	Year: ______
❑ Prostate Surgery	Year: ______	❑ Gall Bladder	Year: ______	❑ ____________	Year: ______
❑ Orthopedic Surgery	Year: ______	❑ Hemorrhoids	Year: ______		

FAMILY HISTORY:

Any chronic or hereditary illnesses?

____

____

Please list all prescriptions, medications, herbs, vitamins, and over-the-counter medications:

____

____

____

____

____

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NEW PATIENT ADMISSION ASSESSMENT AND HISTORY

Name ____________________ Date of Birth ____________

REVIEW OF SYSTEMS

Please Check Questions:	[✓] no problem	[✓] problems you are having now or		[✓] other & explain below		
GENERAL/CONSTITUTIONAL	[ ] no problem	[ ] fever/chills	[ ] poor appetite	[ ] difficulty sleeping	[ ] tired	[ ] other
EYES	[ ] no problem	[ ] discharge	[ ] blurred vision			[ ] other
EAR	[ ] no problem	[ ] pain	[ ] decreased hearing	[ ] itching		[ ] other
NOSE	[ ] no problem	[ ] pain	[ ] drainage fluid	[ ] congestion		[ ] other
THROAT	[ ] no problem	[ ] pain	[ ] hurts to swallow	[ ] swelling		[ ] other
HEART & BLOOD VESSELS	[ ] no problem	[ ] chest pain	[ ] bad circulation	[ ] varicose vein		[ ] other
RESPIRATORY	[ ] no problem	[ ] cough	[ ] difficulty breathing		[ ] wheezing	[ ] other
ESOPHAGUS	[ ] no problem	[ ] painful swallowing		[ ] difficulty swallowing		[ ] other
STOMACH	[ ] no problem	[ ] heartburn	[ ] nausea	[ ] vomiting		[ ] other
INTESTINES, COLON	[ ] no problem	[ ] pain	[ ] constipation	[ ] diarrhea	[ ] bleeding	[ ] other
PELVIC	[ ] no problem	[ ] problem with period		[ ] vaginal discharge	[ ] sex painful	[ ] other
URINATION	[ ] no problem	[ ] painful	[ ] blood	[ ] frequent	[ ] weak stream	
	[ ] hard to get started	[ ] lose it with cough or sneeze				[ ] other
MUSCLES & BONES	[ ] no problem	[ ] arthritis	[ ] neck pain	[ ] arm problem	[ ] leg problem	[ ] other
NEUROLOGIC	[ ] no problem	[ ] headache	[ ] weak	[ ] memory loss	[ ] numb	[ ] other
SKIN	[ ] no problem	[ ] rash	[ ] color change	[ ] abnormal sweating		[ ] other
BREASTS	[ ] no problem	[ ] pain	[ ] lumps	[ ] other		
PSYCHIATRIC	[ ] no problem	[ ] depression	[ ] nervousness/anxiety	[ ] hallucinations	[ ] anger	
	[ ] forgetful	[ ] mood swings	[ ] confusion/disorientation			[ ] other
ENDOCRINE	[ ] no problem	[ ] abnormal thirst	[ ] cold all the time	[ ] hot all the time		
	[ ] abnormal weight loss or gain		[ ] abnormal hair loss or gain			[ ] other
BLOOD	[ ] no problem	[ ] anemia	[ ] easy bruising			[ ] other
LYMPH NODES	[ ] no problem	[ ] painful	[ ] swollen			[ ] other
ALLERGIES	[ ] no problem	[ ] hives	[ ] food allergies	[ ] low resistance of infections		
	[ ] hay fever					[ ] other

List other details or additional information pertaining to your health.

____

____

____

____

For Office use only:
Acknowledgment: I have reviewed the systems review with the patient.

Nurse's Signature ______________________ Date ____________

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NEW PATIENT ADMISSION ASSESSMENT AND HISTORY

Name ______ Date of Birth ______

Functional Assessment: Do you have/use any of the following?

- ❑ Dentures
- ❑ Partial Plate ❑ Upper ❑ Lower
- ❑ Glasses
- ❑ Contacts
- ❑ Hearing Aid
- ❑ Alcohol
- ❑ Cigarettes or other tobacco
- ❑ Walking Aid
- ❑ Artificial Limb
- ❑ Artificial Eye
- ❑ Transfusion
- ❑ TB Exposure
- ❑ Other: ______

Senior Nutritional Assessment If you answer "YES" to any of the questions below, please circle the number next to the question.

YES

(2) I changed the kind and/or amount of food I eat due to an illness or condition.
(2) I eat fewer than two meals per day.
(2) I eat few fruits, vegetables, or milk products.
(2) I have three or more servings of beer, liquor, or wine almost every day.
(2) I have tooth or mouth problems that make it hard for me to eat.
(4) I don't always have enough money to buy the food I need.
(1) I eat alone most of the time.
(1) I take three or more different prescribed or over-the-counter drugs per day.
(2) I have lost or gained 10 pounds or more in the last six months without trying to.
(2) I'm not always physically able to shop, cook, or feed myself .

Nutritional Scale

0-2 = Good 3-5 = You are at moderate nutritional risk 6 or more = Ask for help to improve nutritional health.

Have you ever received nutritional education? ❑ No ❑ Yes

If yes, explain type of nutritional education:
Type ______ When ______
(i.e. diabetes, low sodium, etc.)

Pain Assessment

Are you experiencing any pain? ❑ No ❑ Yes Location of pain: ______

Please rate the degree of pain you are experiencing (Circle One):

1 2 3 4 5 6 7 8 9 10
(Very Mild) (Moderate) (Worse Ever)

How long have you had this pain? ______

What do you currently do to manage your pain? ______

Learning Assessment

Patient's primary language: ______ ❑ No interpreter is needed.

❑ A friend or family member is available to interpret for patient. Relationship: ______

❑ A hospital interpreter is needed.

The primary person(s) to be taught are:

❑ Patient ❑ Family: ______ ❑ Other: ______ ❑ Phone ______

Do you give permission for the Senior Health Center to release information about your health, test results & treatment plan to the person(s) listed above: ❑ No ❑ Yes

Only release information to: ______ Signature: ______

Possible obstacles to learning: ❑ Speech ❑ Hearing ❑ Vision ❑ Physical limitation ❑ Cognitive limitations

What is the easiest way for you to learn? ❑ Listening ❑ Reading ❑ Pictures/Video ❑ Demonstration

Please describe your current health status: ______

Do you have any cultural or religious beliefs or practices that may impact your healthcare decisions? ❑ No ❑ Yes

If yes, please explain: ______

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An Affiliate of HCA

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NEW PATIENT ADMISSION ASSESSMENT AND HISTORY

* P F *

Name ____________________ Date of Birth ____________________

For Women Only

Date of last period: ____________________

☐ Hysterectomy ☐ Menopause

Date of last Mammogram: ____________________

Date of last Pap smear: ____________________

Date of last bone density measurement: ____________________

Age at birth of first child: ____________________

# of children you gave birth to: ____________________

C-Sections ____________________

Vaginal deliveries ____________________

Please check box below if it applies to you:

☐ I currently supplement my diet with calcium

☐ I am currently taking estrogen or similar hormones

Do you have a family history of any of the following types of cancer:

☐ Breast ☐ Cervical ☐ Uterine ☐ Ovarian ☐ Other ____________________

Signature of person completing this form Relationship to Patient Date

For Office Use Only

Learning Assessment: Goals of Learning Assessment: Patient and/or significant other(s) will verbalize understanding and return accurate demonstration or verbalization of the following when applicable:

1. Safe and effective use of medications; including food/drug interactions.
2. Safe and effective use of medical equipment received from the Senior Health Center.
3. Knowledge necessary to restore/maintain/improve health.

Nursing assessment of knowledge base: ☐ None ☐ Limited ☐ Good ☐ Comprehensive

Recommendations to facilitate teaching:

☐ None identified ☐ Recommendations: ____________________

Abuse/Neglect Screening: Does patient exhibit signs of abuse and/or neglect: ☐ No ☐ Yes

Comments: ____________________

Acknowledgment: I have reviewed this Admission Assessment & History in its entirety, including: Allergies, Childhood Illnesses, Current/Past Illnesses, Surgical History, Family History, Systems Review, Functional Assessment, For Women Only, Other Information, Learning Assessment, Nutritional Assessment, and Abuse/Neglect Screening.

Signature & Title ____________________ Date ____________________

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NEW PATIENT ADMISSION ASSESSMENT AND HISTORY