Surgery Center 121
9955 Gillespie Drive, Suite 200
Plano, TX 75025
Ph: 469-606-0060
Fax: 469-606-0009
info@surgerycenter121.com

SURGERY CENTER 121

Medicare Secondary Payer (MSP)

Name: **Date of Birth:**

Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.

1. Are you receiving benefits from any of the following programs?
   Black Lung _____ Research Grant _____ Veteran Affairs _____

2. Was the illness/injury due to a work-related accident/condition?
   Yes____ NO____ date of injury/illness_____

3. Was illness/injury due to a non-work-related accident? _____ date of accident_____

4. Are you entitled to Medicare based on: ____age ____ disability ____end stage renal disease

5. Are you currently employed? _____

6. Is your spouse currently employed? _____

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? _____

8. Does the employer that sponsors your GHP employ 20 or more employees? _____

9. Are you currently a patient in a skilled nursing facility such as a nursing home? _____
   (Long form not required. Alert: if yes, bill SNF not Medicare)

I confirm that the above information is correct.

_____
Signature of Patient/Representative Date

_____
Relationship to patient

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STATE REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION:
Texas law requires the Texas Health Care Information Collection Submit to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds. The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care. If patients fail to identify their own race and ethnic backgrounds, hospital staff will use its best judgment in making the identification.

Question #1: Ethnic Background (mark the box that the patient believes most accurately identifies his/her ethnic background)

Is the patient . . .?
(1) Hispanic/Latino
(2) Not Hispanic/Latino
(2) Unknown
(3) Declined

Question #2: Race (mark the box that the patient believes most accurately identifies his/her race)

Is the patient . . .?
(1) American Indian/Eskimo/Aleut
(2) Asian or Pacific Islander
(3) Black
(4) White
(5) Native Hawaiian
(6) Other Includes all other responses not listed above.
(7) Decline

Patient Signature:_____ Date:_____

Advance Directive/Living Will: Yes or NO

Patient Social Security Number:_____

Patient Email:_____

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

_____CONSENT TO TREATMENT: I undersigned hereby consent to and authorize all diagnostic and therapeutic treatment performed at the Surgery Center considered necessary or advisable in the judgement of the attending physician. Any tissue or parts removed may be preserved and examined or disposed of by the Surgery Center in accordance with the accustomed practice of the facility. I understand I understand that my physician may order a blood test drawn from me for including but not limited to HIV (AIDS) and hepatitis antibodies. I consent to withdrawal only if an employee or physician has had an accidental exposure to my body fluids. I understand that I could obtain the results of these tests from my physician who can explain them. I authorize release of data necessary to process the testing and insurance claim and I understand there will be no charge to me for this test.

_____ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance, or other health plan to the Surgery Center.

_____RELEASE OF INFORMATION: A photocopy of the assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

_____FINANCIAL RESPONSIBILITY: I accept full responsibility for accounts with Surgery Center 121, whether paid by insurance or not.

_____ON DATE OF SERVICE: I have received written information and verbal confirmation of receipt and understanding of the following: Patients' Rights and Responsibilities. Grievance/Complaint Reporting Process, and Advance Directives.

_____I understand and agree, that at the time the patient has met the Surgery Center's Medical Criteria to leave the facility, I will have a responsible adult present to take me/patient home. I release the surgery center from any responsibility for events in violation of the agreement.

_____	_____	_____
Patient's Signature	Date	Witness

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TEMP ON ARRIVAL: _____

CORONAVIRUS (COVID-19) SCREENING FORM

In order to provide the utmost safety of our patients and team members, please answer the following questions:

Have you or the person(s) who will come with you on the day of your procedure traveled to or through mainland China with in the past 14 days? Yes No

If yes: Did anyone develop a fever or respiratory symptoms (cough, shortness of breath) that required hospitalization?

Yes No

Have you or the person(s) who will come with you on the day of your procedure traveled to or through Iran, Italy, South Korea, or Japan in the past 14 days?

Yes No

If yes: Did anyone develop a fever or respiratory symptoms (cough, shortness of breath) that required hospitalization? Yes No

Have you or the person(s) who will come with you on the day of your procedure had a severe acute "lower respiratory illness requiring hospitalization with no source of exposure or alternative explanatory diagnosis (i.e. influenza, pneumonia)? Yes No

Have you or the person(s) who will come with you on the day of your procedure been in close contact with anyone who has a confirmed case of COVID-19 in the past 14 days?

Yes No

If yes: Did anyone develop a fever or respiratory symptoms (cough, shortness of breath)

Yes No

Signs and Symptoms:

Typical signs and symptoms of-infection are:
These symptoms may or may not be present in varying degrees

Fever
Cough
Shortness of breath

SIGNATURE: _____
DATE: _____

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PRIVACY NOTICE ACKNOWLEDGMENT
AND RELEASE OF INFORMATION AUTHORIZATION

Name: _____

Date of Birth: _____

PRIVACY NOTICE ACKNOWLEDGMENT: By signing this form, I acknowledge that I have been informed of Surgery Center 121's Privacy Notice, which describes the ways in which the facility may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that a copy of this Notice is available and will be provided to me upon request. I am aware that I am encouraged to contact the Privacy Officer designated on the Notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Privacy Notice.

RELEASE OF INFORMATION AUTHORIZATION: Surgery Center 121 may use the following methods of communication regarding information related to my personal health, treatment, or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

By phone at :

☐ Home:

☐ Cell:

☐ Work: _____

☐ Surgery Center 121 may leave a message on my voicemail/answering machine

☐ Surgery Center 121 may speak to anyone who answers the phone

☐ Surgery Center 121 may only speak to:

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name of Individual	Relationship	Phone #

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This authorization is: (Check one)

☐ Restricted; Health care information relating to the following treatment, condition, or dates of treatment:

☐ Unrestricted; All health care information

This authorization is: (Check one)

☐ Time-Related and is to expire on: _____ (Date)

☐ Event-Related and is to expire when:

(Event)

☐ Valid until revoked

I understand that I may revoke this consent at any time by giving the facility written notice of my desire to do so. I also understand that I cannot restrict information that may have already been shared based on this authorization.

By my signature below, I acknowledge receipt of this disclosure and authorize discussion of my health care and related issues as indicated above.

_____ _____
Signature of Patient (or Legal Representative) Name of Patient

_____ _____
Relationship (if other than self) Date

INABILITY TO OBTAIN ACKNOWLEDGMENT(*To be completed only if no signature is obtained)*

☐ Patient lacks the ability to understand the Notice of Privacy Practices

☐ Other:

Signature _____ Date
(Facility Representative)

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RESPONSIBLE DRIVER ACKNOWLEDGMENT

Patient's Name: _____

Date of Birth:_____

In order to ensure patient safety, Surgery Center 121's policies require that all patients receiving sedation be accompanied by a responsible adult who is able to drive the patient home following surgery and that drivers remain at the facility until the patient is ready to be discharged. In the event that a driver is not able to remain at the facility for the entirety of the patient's stay, please let us know and we will be happy to assist in rescheduling the procedure for a later date.

As the patient's driver, I hereby acknowledge that I am aware of Surgery Center 121's Responsible Driver policy requiring that I must remain at the facility until the patient is ready to be discharged. I understand that if I must leave the facility, the surgical procedure will be cancelled and rescheduled for a later date. I also understand that it is usual and customary to bill insurance for surgical procedures that are cancelled and that the patient will be held financially responsible for any deductibles or coinsurance not covered by insurance.

Driver's Name: _____

Driver's Signature: _____

Driver's phone number: _____

As the patient, I hereby acknowledge that I am aware of Surgery Center 121's Responsible Driver policy requiring that my driver remain at the facility until I am ready to be discharged. If my driver must leave the facility, my surgical procedure will be cancelled and rescheduled for a later date. I also understand that it is usual and customary to bill my insurance for surgical procedures that are cancelled and that I will be held financially responsible for any deductibles or coinsurance not covered by my insurance.

Patient's Name: _____

Patient's Signature: _____

Date: _____