



WRITTEN NOTICE OF MEDICARE/TRICARE BENEFICIARY'S FINANCIAL OBLIGATION

Dear Medicare/TRICARE Patient:

This department, _____, is a hospital outpatient department of _____ (the "Provider"). Because it is a hospital-based department that is located off the hospital campus, Medicare/TRICARE requires us to inform you that you will incur a coinsurance liability 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 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 \$_____ to \$_____.

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/TRICARE 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/TRICARE 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/TRICARE coinsurance as permitted by law and that I have received a copy of this notice.

Patient Information Form

Please Provide Insurance and Identification Cards

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ SS #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Religion: _____ Race: _____

Is this a new address? Yes _____ No _____

Are you employed? Yes _____ No _____

If no, are you retired? Yes _____ No _____ Date of retired: _____

Are you covered under a medical plan with your employer? Yes _____ No _____

If yes, please provide your employer information.

Patient Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Are you covered under your spouse's medical plan? Yes _____ No _____

If yes, please provide spouse's employer information:

Spouse's Name: _____ SS#: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Spouse's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to Notify of Emergency:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Referring Physician: _____

For office use only:

Clerical Initial: _____

Breast Questionnaire Form

NAME: _____	Date: _____
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Date of Birth: _____	Referring Physician: _____
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Have you ever had a mammogram? Yes: _____ If yes, when: _____
 No: _____ (Baseline)

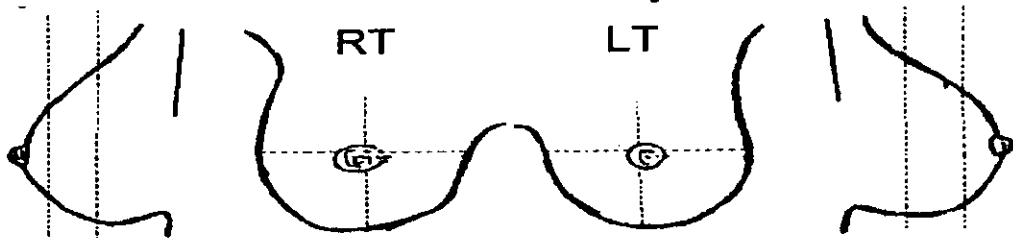
Was your last mammogram done at this facility? Yes _____ No _____

If no, please indicate where? _____

Please circle the appropriate response to the following questions:

1. Are you presently having:				
Pain or Tenderness?	Yes	No	Right	Left
Nipple Discharge?	Yes	No	Right	Left
Breast trauma or infections?	Yes	No	Right	Left
2. Do you currently have a breast lump? Is this a new lump?	Yes	No	Right	Left
3. Do you have breast implants?	Yes	No		
4. Have you had a breast operation or biopsy? <i>If yes, please describe:</i> _____	Yes	No	Right	Left
Was it benign (non-cancerous)?	Yes	No		
Was it malignant (cancerous)?	Yes	No		
<i>If malignant, please describe when and type of your treatment:</i> _____				
5. Are you currently taking female hormones?	Yes	No		
6. Have you ever given birth?	Yes	No		
7. Do you have family member with history of Breast Cancer? <i>If yes, please describe:</i> _____	Yes	No		

For Office Use Only



Comments: _____

Radiologist: _____	Technologist: _____	8 x 10	10 x 12
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DATE _____

X-RAY NO. _____

FOR ELECTIVE SCHEDULING OF RADIOLOGY PROCEDURE, THIS FORM MUST BE COMPLETED FOR / BY ALL FEMALES BETWEEN THE AGES OF 12 AND 50 OF AGE. WE MAKE EVERY EFFORT TO MINIMIZE RADIATION EXPOSURE IN ALL PATIENTS; HOWEVER, IF THERE IS ANY CHANCE THAT YOU COULD BE PREGNANT, SPECIAL LEAD SHIELDING MAY BE NECESSARY OR YOUR EXAMINATION DELAYED UNTIL YOU ARE NOT PREGNANT.

(PARA RADIOGRAFIAS ELECTIVAS, ESTE QUETIONARIO DEBE DE SER COMPLETADO POR TODAS LAS MUJERES DE 12 A 50 ANOS DE EDAD. NOSOSTROS HACEMOS EL ESFUERZO DE USAR RADIACION MINIMA EN TODOS LOS PACIENTES. EN CASO DE QUE USTED ESTE EMBARAZADA O HAY POSIBILIDAD DE PEUED ESTAR EMBARAZADA PROTECCION ESPECIAL ES NECESARIA O SU EXAMEN PUEDE SER ATRAZADO HASTA QUE USTED NO ESTE EMBARAZADA.)

(NOMBRE) _____ (EDAD) _____
1. NAME _____ AGE _____

YES (SI) NO (NO)

2. HAVE YOU HAD HYSTERECTOMY? _____
(HA TEENIDO HISTERECTOMIA?) _____

OR ALREADY GONE THROUGH MENOPAUSE? _____
(MENOPAUSA?) _____

3. BEGINNING OF LAST MENSTRUAL PERIOD: _____ / _____ / _____
(PRINCIPIO DE SU ULTIMO PERIODO) MONTH (MES) DAY (DIA) YEAR (AND)

4. ARE YOU ON ANY TYPE OF BIRTH CONTROL? YES (SI) _____ NO (NO) _____
(ESTA USTED USANDO ALGUN TIPO DE ANTI - CONCEPTIVO?)

IF "YES" PLEASE CHECK BELOW: YES (SI) NO (NO)
(SO LO ESTA USANDO, POR FAVOR INDIQUE EL METODO?)

- A. BIRTH CONTROL PILLS (USA PASTILLAS ANTI - CONCEPTIVAS) _____
- B. I.U.D. (TIENDE DISPOSITIVO INTREATERINO) _____
- C. TUBAL LIGATION (TIENE LOS TUBOS LIGADOS) _____
- D. HUSBAND HAD VASECTOMY (ESPOSP A TENIDO VESECTOMIA) _____
- E. CONDOMS (CONDONES) _____
- F. DIAPHRAGM AND FOAM (DIAFRAGMA O ESPUMA) _____
- G. NORPLANT (TRASPLANTE) _____
- H. DEPO - PROVERA (TRAS EN SU CUERPO) _____
- I. SPERMICIDAL INSERT (U SANDO PROTENTION) _____
- J. PATCH (REMIENDO) _____
- K. NONE OF THE ABOVE (NINGUNO DE LO ANTERIOR) _____

IF NONE OF THE ABOVE: YES (SI) NO (NO)

5. HAVE YOU HAD SEX SINCE YOUR LAST PERIOD? _____
(HA TENIDO RELACIONES DESDE SU ULTIMA REGLA?) _____

6. ARE YOU PREGNANT? MAYBE (QUIZAS) _____
(ESTA USTED EMBARAZADA?) _____

PATIENT SIGNATURE (FIRMA DEL PACIENTS) _____ WITNESS _____
AUTHORIZATION TO SUSPEND GUIDELINES: Physician signature: _____ Date/time: _____



500 West Main
Lewisville, Texas 75057-3699

PATIENT IDENTIFICATION

**PREGNANCY QUESTIONNAIRE
(QUESTIONARIO)**



**Respiratory Pre-Screen for early identification of possible
TB, SARS, or Avian flu**

Have you had, or been in contact with someone who has had:

1. New onset of persistent cough for 2 weeks or more? YES NO
2. Family members or close contacts with TB or receiving treatment for TB? YES NO
3. Cough, sore throat, shortness of breath **AND** contact with domestic poultry?..... YES NO
4. Fever of 100.5° or greater **WITH** respiratory symptoms such as shortness of breath, Cough, and congestion YES NO
5. Travel outside of the United States within 10 days of respiratory symptoms beginning? YES NO

Signature of registrar _____

Date: _____ Time: _____

If yes to any of the above:

- Mask the patient with a surgical mask in registration
- Units / floors will place patient in a private room on droplet isolation.
- Nursing will assess patient further documenting electronically. If suspicion of TB, patient will be placed on airborne isolation in a negative airflow room. Staff will Use N-95 masks for all airborne isolation patients.

Medical Center of Lewisville
500 West Main • Lewisville, Texas 75057-3699
Respiratory Illness Pre-Screen

Patient Identification

Thank you for selecting the **Medical Center of Lewisville** for your healthcare needs. We sincerely hope your visit here is as pleasant as possible. We want you to feel free to contact us should you need any assistance.

PLEASE NOTE:

If your insurance requires pre-certification, it is primarily your responsibility to obtain the necessary certification. Most insurance payers require notification prior to service being rendered.

Depending on the services you are rendered, you may be receiving separate bills from a Pathologist, an Emergency Department Physician, or Radiologist. **Their phone numbers can be found on your copy of the consent forms.**

The **Medical Center of Lewisville** files insurance as a courtesy. If you do not have 100% insurance coverage, your estimated portion will be due at the time of service.

Any charges quoted to you prior to services are estimated and subject to change based on actual services rendered.

Outpatient Medicare patients: According to Medicare regulations, you are responsible for payment for any drugs (both prescription and non-prescription) furnished to you while an outpatient that could be considered self-administered. This regulation applies whether the physician or nurse administers them to you or you self-administer while at the hospital as an outpatient. These pharmaceuticals will be denied by Medicare as non-covered and will subsequently be billed to you.

PATIENTS INITIALS:

ATTENTION: PATIENT/RESPONSIBLE PARTY (ER PATIENTS ONLY) Does your insurance company assign you a primary care physician? If so, have you notified either your primary care physician or your insurance company that you are visiting the emergency department? Many insurance companies will deny your claim if you do not notify your primary care physician or your insurance company before or at least immediately after you come to the emergency department. To prevent the possibility of having your claim denied, please call either your primary care physician or your insurance company within 24 hours, or you could be held responsible for the entire bill.

PATIENTS INITIALS

N/A

HEALTH PLAN DENIALS Your health plan will only pay the hospital if the hospital services you receive are covered services under the terms and conditions of the health plan. If you are a member of a preferred provider organization, health maintenance organization or other managed care plan, your health plan may reduce or deny your benefits if:

- * The services are not medically necessary.
- * The services are not provided in a health plan hospital.
- * The services are not approved, ordered or performed by a health plan physician or
- * The service is not a covered service.

Health plans review hospital services to determine if the services are medically necessary. Generally, medically necessary means services which are:

- * Appropriate and necessary for the symptoms, diagnosis to treatment of a medical condition;
- * Within recognized standards of medical practice;
- * Not primarily for the convenience of the health plan member, the member's family or the health plan physician; and
- * The least costly of alternative supplies or levels of services, which can be safely and effectively provided to the patient.

The hospital cannot accept the financial risk for services which you request, or your physician orders, which are subsequently determined not to be medically necessary. Your financial agreement with the Hospital is to pay for all services you receive whether or not your health plan determines the services to be a covered or medically necessary.

The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's agent, insured or guarantor, and accepts it terms.

X

Patient, Insured or Guarantor Signature

Relation to Patient

X

Witness

Date



500 West Main
Lewisville, Texas 75057-3699

PATIENT IDENTIFICATION

Financial Information for Patients



ADMIN

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 necessary for treatment, payment or healthcare operations in accordance with state and federal law. 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, N/A 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 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.

Date	I, the undersigned, as the patient, or the parent, guardian, spouse, guarantor or agent of the patient, hereby certify I have read, and fully and completely understand this Consent for Use and Release of Information, and that I have signed this Consent for Use and Release of Information 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. <input type="checkbox"/> Patient is medically unable to sign the Consent for Use and Release of Information. <input type="checkbox"/> Patient Refused to Sign		
Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
Patient/Parent/Guardian	If other than patient, indicate Relationship	Spouse (if Married/Available)	Witness (to Signature only)



500 West Main
Lewisville, Texas 75057-3699

Consent for Use and Release of Information



ADMINS

Form A7412 (Rev. 01/06)

PATIENT IDENTIFICATION

MEDICAL RECORDS

Please read both sides before signing.

1. Consent to Treatment. I consent to the procedures which may be performed during 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. 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

3. 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)

4. Other Acknowledgements.

- a. Additional Provision for Admission of Minors.** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.
- b. This consent includes testing for communicable or blood-borne diseases, 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 _____

c. Legal Relationship Between Hospital and Physicians. 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.

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)

Date	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.
Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	

<p>Patient/Authorized Representative Signature:</p> <p>X _____</p> <p>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):</p>	<p>Witness Signature and Title:</p> <p>X _____</p> <p>Additional Witness Signature and Title: (required for patients unable to sign without a representative or patients who refuse to sign)</p> <p>X _____</p>
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PATIENT IDENTIFICATION

Consent for Outpatient Services

5. Financial Agreement. In consideration of the services to be rendered to the patient, 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.

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. You may request information about these programs from the hospital.

As a courtesy to you, the hospital may bill your insurance company, but is not obligated to do so. Regardless, you agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You agree to pay any services that are not covered by your 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 your insurance plan requirements. You also agree that if the hospital must initiate collection efforts to recover amounts owed by you, then in addition to amounts incurred for the services rendered you will pay: (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.

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.

6. Medicare Patient Certification and Assignment of Benefit. I certify that the 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.

7. 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. 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

benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled 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. This assignment shall be for the purpose of granting the hospital and/or hospital based physicians an independent right of recovery against the patient's insurer or health benefit plan, but shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. 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. I hereby appoint the hospital as my authorized representative to pursue, if it so chooses, all 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 their companies.*

Continue reading and sign on reverse side.

Consent for Outpatient Services

NOTICE TO PATIENTS CONCERNING COMPLAINTS

HOSPITAL

Medical Center of Lewisville is committed to providing quality healthcare and your opinions regarding the care you receive are important to us. If you have concerns during your stay, please contact your nurse or ask to speak to the Unit Manager. After hours or on weekends, you may dial the hospital operator and ask them to contact the Nursing Supervisor for you.

If you should have a problem after you leave the hospital, or if you are not satisfied with the resolution of your problem, you may write the Director of Patient Relations or the hospital administrator at Medical Center of Lewisville, 500 West Main Street, Lewisville, TX 77057, or you may call 972-420-1855 or 972-420-1548. Your concern will then be referred to the appropriate department manager or administrator for resolution.

You may also file complaints with the Texas Department of Health, 13101 South Bowen, Suite #200, Arlington, TX 76013 or by calling 817-264-4500,

PHYSICIANS

If you have a concern or complaint regarding your physician, we encourage you to contact your physician and explain your concerns. If you are not satisfied with the resolution, you may file complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Center Creek Drive, Suite 300, PO Box 149134, Austin, Texas 78714-9134. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9395.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Any concerns or issues regarding safety or quality of care may be referred to JCAHO addressed to: Division of Accreditation Operations, Office of Quality Monitoring Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181 or Faxed to 630-792-5636 E-mailed to complaint@jcaho.org.

We assure you that by expressing a concern or complaint, you will in no way affect the care received or further access to care and services at Medical Center of Lewisville.

Medical Center of Lewisville and its staff are not responsible for lost or stolen items. Please send any items of value home with family members.



500 West Main
Lewisville, Texas 75057-3699

PATIENT IDENTIFICATION

NOTICE TO PATIENTS CONCERNING COMPLAINTS



ADMIN

Patient's Rights & Responsibilities

The Patient/Parent/Guardian is entitled to:

1. Receive care, treatment, and services.
2. Considerate and respectful care that respects your cultural, psychosocial, spiritual, personal values, beliefs, and preferences and supports your right to personal dignity.
3. Have an Advanced Directive, such as a Directive to Physicians or Medical Power of Attorney, concerning treatment or to designate a surrogate decision maker, with the expectation that the hospital will honor the directive to the extent permitted by law.
4. Be involved in decisions about care, treatment, and services. Participate in decisions regarding ethical issues surrounding your care, including issues of conflict resolution, withholding resuscitation, and forgoing or withdrawal of life-sustaining treatment. You may ask your nurse or physician to consult the Ethics Committee for resolution of conflicts in decision making regarding your care. You may request to see a copy of the hospital's Ethical Issue Resolution Policy and the Code of Ethical Behavior Policy, if desired.
5. Access, request amendment to, and receive an accounting of disclosures regarding your own health information as permitted under law.
6. Have your family, as appropriate and allowed by law, with permission of the patient or surrogate decision maker, involved in care, treatment, or treatment decisions.
7. Know by name the physician responsible for the coordination of your care and the identities of others involved in providing your care.
8. Consent to or refuse a treatment, as permitted by law, throughout the hospital stay and to be informed of the medical consequences of such action. If the patient refuses a recommended treatment, he/she will receive other needed and available care.
9. Receive information about charges for which you will be held responsible. Obtain information as to any professional relationships among individuals treating as well as the relationship between the hospital and any other healthcare and educational institutions which may influence your care.
10. Obtain information from physicians and other caregivers in understandable terms concerning diagnosis, treatment, prognosis, and plans for discharge and follow-up.
11. Know the outcomes of care provided, including unanticipated outcomes. Have every consideration of privacy and to expect that all communications and records pertaining to your care will be treated as confidential by the hospital, except where disclosure is required by law.
12. An environment that preserves dignity and contributes to a positive self-image.
13. Be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
14. Effective pain management.
15. The right to access protective and advocacy services.
16. Personal security and security of property.
17. Consent or refuse to participate in any treatment that is considered experimental in nature, and to have these studies fully explained to the patient.
18. The right to pastoral and other spiritual services.

The Patient/Parent/Guardian Also Has the Following Rights as Required by the Healthcare Financing Administration:

- * Right to file a grievance. You may ask to speak to the nursing supervisor if you have a concern, or you may call the operator to speak to a patient advocate representative
- * Right to participate in the development, implementation and revision of his or her plan of care. This plan will include the patient's psychological and medical needs
- * Right to formulate an advance directive and have hospital staff and practitioners who provide care comply with the directive
- * Right to have a family member or representative of your choice or own physician notified promptly of your admission to the hospital
- * Right to receive care in a safe setting
- * Right to be free from all forms of abuse or harassment
- * Right to confidentiality of your clinical records
- * Right to access information contained in your clinical records within a reasonable time frame. Right to be free from seclusion or restraints of any form that are not medically necessary



500 West Main
Lewisville, Texas 75057-3699

PATIENT IDENTIFICATION

Patient's Rights & Responsibilities



ADMIN

Form 906-030a (Rev. 05/05)

CONDITIONS OF PARTICIPATION:

Standard: Exercise of Rights

The patient has the right to participate in the development and implementation of his or her plan of care.

The patient or his or her representative (as allowed by State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

The patient has the right to formulate advance directive and to have hospital staff and practitioners who provide care in the hospital comply with these directions, in accordance with applicable law. The patient has a right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

Standard: Privacy and Safety

The patient has the right to personal privacy.

The patient has the right to receive care in a safe setting.

The patient has the right to be free from all forms of abuse or harassment.

Standard: Confidentiality of Patient's Records

The patient has the right to the confidentiality of his or her clinical records.

The patient has the right to access information contained in his or her clinical records within a reasonable time frame.

Standard: Restraint for Acute Medical & Surgical Care

The patient has the right to be free from restraints of any form that are not medical necessary or are used as a means of coercion, discipline, convenience or retaliation by the staff.

PATIENT RESPONSIBILITIES

The Patient/Parent/Guardian has the following responsibilities:

- Ask questions about specific problems and request information when you do not understand your illness or treatment.
- Provide accurate and complete medical information to physicians and other caregivers.
- Provide the hospital with a copy of your written advance directive if you have one.
- Follow the treatment plan recommended by physicians and other caregivers, or if treatment is refused, you are responsible for your actions and the medical consequences.
- Consider the rights of all hospital personnel and other patients and ensure that your visitors are considerate in the control of noise, limiting numbers of visitors, and abstaining from smoking.
- Respect hospital property and the property of other patients.
- Follow all hospital policies affecting patient care and conduct.
- Provide necessary information.
- Meeting financial commitments.

CRISIS HOTLINE

Denton County Community Resources
24 HOUR CRISIS HOTLINE (Mental Health Issues)
1-800-762-0157



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ADMIN

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Official at 972-420-1076.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel, agents of the hospital, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

ORGANIZED HEALTH CARE ARRANGEMENT:

This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We at Medical Center of Lewisville take our obligation to protect your privacy very seriously. Please read the list of uses and disclosures and understand that we make every effort to provide information to only those individuals with a demonstrated need to know. We will abide by the terms of this notice.

USES AND DISCLOSURES:

How we may use and disclose Health information about you -- The following categories describe examples of the way we use and disclose health information:

- For Treatment:** We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the hospital also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital. Example: If you were transferred to another facility from Denton Regional, the receiving physician would receive relevant health information.
- For Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.
- For Health Care Operations:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients into reports to help us evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other hospitals to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information to those with an identified need:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fund raising efforts;
- To inform Funeral Directors consistent with applicable law upon patient expiration;
- For Population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates:

There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory:

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. The information may include your name, location in the hospital, your general condition (e.g., good, fair; etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care:

We may release health information about you to a designated friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.



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PINS

Research:

We may disclose information to researchers when an institutional review board, that has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research and granted a waiver of authorization requirement.

Future Communications:

We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

Affiliated Covered

Protected health information will be made available to hospital personnel at local HCA affiliated hospitals as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

Food and Drug Administration	Correctional Institutions Workers Compensation
Health Oversight Agencies	Funeral Directors, Coroners and Medical Directors
National Security and Intelligence Agencies	Organ and Tissue Donation Organizations Military Command Authorities Public Health or Legal
Protective Services for the President and Others	Authorities charged with preventing or controlling disease, injury or disability

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena

State-Specific Requirements

Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

Inspect and Copy:

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Amend:

If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures:

You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

Request Restrictions:

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home or by U.S. Mail. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice:

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the hospital and include the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



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PINS

NOTICE TO PATIENT REGARDING YOUR RIGHT TO MAKE ADVANCE HEALTH CARE DECISIONS

Federal law requires that we give you information about your right to accept or refuse medical treatment and to make health care decisions. Right now, you may be able to make your own health care decisions. However, you may not always be able to make such decisions. By giving advance directions, you can tell your doctor and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you, just in case you are no longer able to make such decisions yourself.

You can name a person to make medical treatment decisions for you by naming someone to have a Medical Power of Attorney for you. This person is allowed to make health care decisions for you, but only after your doctor believes that you are no longer able to make your own decisions.

You can also leave advance direction about life support in the event of terminal illness or irreversible condition. This is called a "Directive to Physicians and Family or Surrogate" and is often referred to as a "Living Will". A Directive to Physician tells your physician and family about the types of life support that you want to be provided or withheld in the event you have a terminal or irreversible condition and are no longer able to make decisions yourself.

The Medical Power of Attorney applies to all types of health care decisions including decisions to withhold or withdraw life-sustaining procedures in the event of terminal illness.

The Directive to Physician (Living Will) only deals with a terminal or irreversible condition and the withholding or withdrawal of life-sustaining procedures.

If you already have a Directive to Physician, or Medical Power of Attorney, please tell your doctor and this hospital. We need to put a copy of the document in your medical chart so that it is available to all health care providers. If you want more information on how to make a Directive to Physician or Medical Power of Attorney please feel free to ask either your physician, trained hospital personnel, or your attorney.

It is the policy of this hospital to honor a patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care directions in order to receive care at this hospital.

Your attending physician may have limitations or reservations regarding your Advance Directives. You are encouraged to discuss these forms and any questions or concerns regarding health care decisions with your physician.

Should there be any disagreement between your physician and you, the matter may be referred to our Ethics Committee or you may request to be transferred to the care of another physician.

Also, in the event of a terminal or irreversible condition, you may orally make an Advance Directive in the presence of your attending physician and two (2) witnesses should you choose not to execute a written document in advance.

You may phone or write the Texas Department of Health, Facility Compliance Division, 1100 West 49th Street, Austin, Tx. 78756, or call (888) 973-0022 to ask question or report complaints about these advance directive policies.

If you would like to receive a pamphlet which gives more information on Advance Directive and/or copies of the forms to execute Advance Directives, please ask your nurse for further assistance.



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Right to Make Advance Health Care
Decisions



ADMIN

Form 906-080 (Rev. 09/05)

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