

NW SURGERY CENTER
5215 Hollister St, Houston, TX 77040
713-462-3194

PATIENT INFORMATION

(Please return completed form to NW Surgery Center on the day of your procedure)

LAST NAME FIRST NAME MI

ADDRESS

CITY ST ZIP

HOME PH# PAGER # CELL #

DATE OF BIRTH SS# Male Female Single Married Divorced Widowed

EMPLOYER

EMPLOYER'S ADDRESS

CITY ST ZIP

PHONE FAX

DATE OF INJURY IF APPLICABLE

INJURY RELATED TO Employment Auto accident Other accident: (please specify)

SURGEON:

RESPONSIBLE PARTY IF OTHER THAN PATIENT OR EMPLOYER:

LAST NAME FIRST NAME MI

ADDRESS

CITY ST ZIP

HOME PH# PAGER # CELL #

DATE OF BIRTH Male Female Single Married Divorced Widowed

DRIVERS LICENSE # (Please bring with you) SS#

EMPLOYER

EMPLOYER'S ADDRESS

CITY ST ZIP PHONE

PRIMARY INSURANCE (please bring card with you for photocopy)

POLICY HOLDER'S NAME RELATIONSHIP TO PATIENT Self Spouse Parent Other

INSURANCE CO. PHONE #

ADDRESS

POLICY ID# GROUP #

SECONDARY INSURANCE (please bring card with you for photocopy)

POLICY HOLDER'S NAME RELATIONSHIP TO PATIENT Self Spouse Parent Other

INSURANCE CO. PHONE #

ADDRESS

POLICY ID # GROUP #

ACCIDENT DETAILS FORM

(Please fill out completely and sign below)

Patient's name: _____ Today's Date: _____

Insured's name: _____

Insured's relationship to Patient: Self Spouse Parent Other: _____

Is today's visit related to an Accident or Injury? No Yes

Auto Accident? No Yes State/Country where accident occurred: _____

Work Related? No Yes

Date Accident / Injury occurred: _____

Place Accident / Injury occurred: _____

Give details of Accident / Injury: _____

Signature

Relationship to Patient

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DISCLOSURE OF OWNERSHIP INTEREST

NW Surgery Center is owned by a Limited Liability Partnership, which is partially owned by local physicians, one of who may be your physician. These physicians have become owners as a result of their commitment to quality healthcare and services to their patients.

You should know that the NW Surgery Center might have a financial relationship with your physician. You have the right to choose an alternative source of service. Please contact your surgeon to obtain alternative sites where he/she has privileges to practice.

By your signature below, you acknowledge receipt of information regarding Disclosure of Ownership Interest on the date indicated.

Patient's Signature: _____ Date: _____

If Agent, Relationship to Patient: _____

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PATIENT RIGHTS

The Surgery Center adopts and affirms as policy the following rights of patient/clients who receive services from our facility.

This policy affords you, the patient/client the right to:

1. Treatment without discrimination as to race, color, religion, sex, national origin, political belief, or handicap.
2. It is our intention to treat each patient as a unique individual in a manner that recognizes his or her basic human rights.
3. Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
4. Receive, upon request, the names of all personnel participating in your care.
5. Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
6. Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other appropriate treatment methods, if any.
7. The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The Surgery Center will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
8. Upon request, the facility will assist you in formulating advance directives and appointing a surrogate to make health care decisions on your behalf, to the extent permitted by law. Access to health care at this facility will not be conditioned upon the existence of an advance directive.
9. Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
10. Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment contract.
11. A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
12. Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
13. The identity, upon request, of all health care personnel and health care institutions authorized to assist in your treatment.
14. Refuse to participate in research. Human experimentation affecting care or treatment shall be performed only with your informed consent.
15. Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
16. Know the facility's rules and regulations that apply to your conduct as a patient.
17. Any unanswered concerns on the part of patients or family relative to ethical issues can, with sufficient notice, be referred to our Compliance Committee for advice.
18. Complaint or criticisms will not serve to compromise future access to care at this facility. Staff will gladly advise you of procedures for registering complaints. Texas Department of Health, Health Facility Licensing and Compliance Division, 1100 West 49th Street, Austin, Texas 78756, phone (888) 973-0022 Complaints may be registered with the department by phone or in writing.

Patient's Signature

Witness' Signature