ULTRASOUND

PATIENT HISTORY & CONSENT

Date: ________________________

Patient Name: ____DOB: ____________________

BODY PART TO BE EXAMINED: ____

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE REASON FOR YOUR EXAM TODAY AND CURRENT SYMPTOMS

(IfAny):____

____

____

____

Approximate date symptoms began: ______________________ Duration of symptoms: ____________________

PLEASE LIST ANY PREVIOUS SURGERIES AND DATE PERFORMED: ____

____

____

Have you had previous exams of the area to be scanned today? **X-RAY** ☐ **CT** ☐ **MRI** ☐ **US** ☐

Performed at which Facility and Approximate Date: ____

FEMALE PATIENTS ONLY:

Is there any possibility you could be pregnant? ☐ **YES** ☐ **NO**

First day of last menstrual cycle: ____________________________

I attest that the information provided is correct to the best of my knowledge. I have read and understand the contents of this form. All of my questions regarding the Ultrasound exam that I am about to undergo, have been answered to my satisfaction.

______________________________	____________________	____________
Patient Signature	**Today's Date**	**Tech Initials**
______________________________	____________________	____________
Guarantor Signature	**Today's Date**	**Tech Initials**
______________________________	____________________	____________
Witness Signature	**Today's Date**	**Tech Initials**

TECHNOLOGIST USE ONLY

NOTES: ____

____

Technologist Signature: ____

Left Blank

Authorization for Medical Treatment – Outpatient

1. CONSENT FOR MEDICAL PROCEDURES AND TREATMENT: Permission is hereby granted to Aspire Hospital Outpatient Services for such medical procedures, including the taking of photographs and/or videos for treatment only, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments, examinations, emergency services, or hospital care.
2. CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING: I give my consent to have testing for blood-borne infectious disease, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV). This test is required in the following situation(s): (1) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick, or (2) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you will be tested if any of these situations occur during your visit.
3. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given the opportunity to review the Hospital's Notice of Privacy Practices. I understand that if I have question or complaint, I may contact the hospital's HIPAA Privacy Officer.
4. PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.
5. ASSIGNMENT OF BENEFITS: This assignment of benefits allows the Hospital and/or hospital based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and or hospital based physicians proved to me, my minor child, or other person entitled to health care benefits for this visit. In consideration of the services to be rendered, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates that are usual, customary, and reasonable for services rendered. Thus the entire account balance including those charges filed with the insurance company, remains the patient's responsibility; I understand that there are providers that will bill me separately and that I am financially responsible to each provider for allowed charges not covered by this assignment.
6. MEDICARE PATIENT CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.
7. RELEASE FROM RESPONSIBILITY FOR VALUABLES: It is understood and agreed that the hospital does not maintain a safe for the safekeeping of money and valuables and that the hospital shall not be liable for loss or damage to any money, personal valuables, or personal property.
8. PHYSICICAN OWNED HOSPITAL: Aspire Hospital, LLC believes that you are entitled to make informed decisions regarding your medical care. To assist you in making those decisions, the Hospital herby notifies you that it meets the federal definition of physician owned hospital pursuant to 42 C.F.R 489.3. As per the code of Federal Regulations you are hereby informed that a list of the Hospital's physician owners and investors is available to you upon request from the Admitting Office.

I hereby certify ad state that I have read, and that I fully completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

____ ________________________________

Signature of Patient / Parent / Guardian / Conservator Date / Time

____

If other than Patient, Indicate Relationship

____ ________________________________

Signature of Witness Date / Time

Revised 7/19/17 JAH

2006 S. Loop 336 W. Ste. 500, Conroe, TX 77304
Phone: 936-647-3500 Fax: 936-647-3479

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Please complete the following for your____.
Name or description of procedure(s) being performed

If you do not have any one that you would like us to release information to please initial here: ________.

I, ____ hereby freely and
Name of Patient Date of birth
voluntarily authorize Aspire Hospital, LLC to release/obtain the following to/from:

____
Name of Person/Facility

____
Address

____
City, State, Zip Code Phone number

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that the federal regulation (42 CFR Part 2) prohibit their making any further disclosure without written consent, or as otherwise permitted by such regulations. This information to be released includes but is not limited to:

□ Radiology Reports/Images □ Other___________________

Date of Procedure/Hospitalization: ____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Aspire Hospital, LLC. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making them available to the hospital for services provided. This authorization will expire in 90 days from the date shown below unless another date is specified. Specification of the date, event or condition upon which consent expires: ______________
Date &Time

Patient/Resident <u>MUST</u> sign release regardless of age if alcohol and/or drug treatment involved.

____________________________________ ___________________________
Patient Signature Date & Time

____________________________________ ___________________________
Parent, Guardian, or Representative Signature Date & Time

____________________________________ ___________________________
Aspire Representative Signature Date & Time

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Estimated Patient Financial Responsibility

Name of Patient:	Patient Account Number:	DOS:
Estimated Balance Due:	Amount Owed Today:	

I acknowledge that, for this procedure, I am the patient named and/or guarantor (i.e. financially responsible for the patient named).

As such, I agree to the following: **(Please read and initial boxes)**

☐ I agree to pay $__________today. ☐ Please set me up on a payment plan after insurance has been billed.

☐ I agree to pay my share of the balance upon receipt of bill.

☐ I understand this is an **estimated amount for this procedure based on the verification of my insurance benefits**. Any additional balance owed after this payment will be billed directly to me.

☐ I understand I will receive an additional bill from ***Bryan Radiology Associates*** for the interpretation of my procedure.

By my signature below, I acknowledge that I have read and agreed to the above Payment Agreement. I understand that this is a courtesy being extended by the hospital.

Signature of Patient or
Guarantor:____Date:_____________________

Relationship to Patient:____

Signature of Witness: ____ Date: _____________________

MEDICARE QUESTIONAIRE

Circle correct response

Are you receiving black lung benefits?	Yes	No
Are services to be paid by a government research program?	Yes	No
Has the Dept. of Veteran's Affairs authorized and agreed to pay for your care at this facility?	Yes	No
Was illness/injury due to work related accident/condition?	Yes	No
Are you entitled to Medicare based on end stage renal disease?	Yes	No
Are you entitled to Medicare based on age or disability?	Age	Disability
Are you currently employed or retired?	Employed	Retired
Do you have a group health plan coverage based on your own or your spouse's current employment?	Yes	No

Print Name	
Patient Signature	Date

OP Medicare Questionnaire

Last Revised: 7/18/17 JAH