Post Oak Emergency Room

PATIENT REGISTRATION

Name:_____**Date**:_____

Birth Date:_____**Sex**: [ ]Female [ ] Male

Address:_____**Apt**_____**City**:_____**State**:____**Zip**:_____

Cell Phone:_____ **Work Phone**:_____

Email address: _____

Reason forVisit: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Black orAfricanAmer ☐ Amer. Indian or Eskimo ☐ Asian or native- Hawaiian or Pacific islander ☐ Other

INSURANCE INFORMATION (if insurance card not present)

Primary Insurance_____
ID Number_____ **Group Number** _____
Subscriber Name_____ **Subscriber Birth Date**_____
Relationship to Patient _____**Subscriber Social Security**_____

I hereby authorize Post Oak ER to appeal my claims with above listed insurance on my behalf, as my Designated Representative. As part of the appeal, I hereby authorize my Carrier/insurance to communicate with Post Oak ER in all aspects of the appeal. I understand these communications may contain all medical and financial information about my treatment relating to my examination. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

Signature: _____

For Staff Use Only: ☐ ID Card Scanned ☐ Insurance Card Scanned Staff Initials: _____

Post Oak Emergency Room

Pt initials:

_____ Welcome to our Emergency Room. Please note that we are not an Urgent Care and we provide a higher level of service and care than an Urgent Care. This facility charges rates comparable to a hospital emergency room and may charge a facility fee.

_____ This facility or physician providing medical care may not be a participating provider in your health benefit plan provider network. However, by state law your health insurance company is required to pay for your ER visit at in-network benefit level.

_____ There will be two separate bills for the services you receive. One is from the emergency room and one is for the professional services. An itemized statement is available upon request.

CONSENT FOR TREATMENT

AUTHORIZATION FOR TREATMENT

_____ I hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment, including CT procedure with or without iodine contrast, to evaluate and stabilize medical conditions of a recent onset and severity by the physician or physicians in charge of the case, their assistants and designees as necessary in their judgment, and employees and agents of Post Oak Emergency Room. This consent is valid during the course of my treatment unless revoked by me in writing. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition. I hereby voluntarily consent to such medical care necessary to treat my medical conditions. My current condition, sickness, or injury is of such a nature that failure to get immediate medical care could place my health in serious jeopardy; result in serious impairment of bodily functions; result in serious dysfunction of a bodily organ or part; result in serious disfigurement; or for a pregnant woman, result in serious jeopardy to the health of the fetus.

CONSENT FOR BLOOD TESTING

_____ I voluntarily consent to have my blood tested to determine the presence of any communicable disease to the extent allowed by law, such as Human Immunodeficiency Virus (HIV) and/or Hepatitis B and/or Hepatitis C. I understand that the results of these tests will be kept confidential and I will be informed of the results. If any of the tests are positive, I understand that Post Oak Emergency Room and the laboratory are required by law to report the results to the appropriate agency.

WAIVER OF RESPONSIBILTY FOR VALUABLES

_____ I understand Post Oak Emergency Room is not responsible for loss of or damaged to, personal effects, purses, dentures, property or valuables, including but not limited to rings, watches, furs, and money. Post Oak Emergency Room does not provide safe keeping of personal effects, therefore said effects should remain or be sent home.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS AND CAUSES OF ACTION

_____ In consideration of services rendered I hereby irrevocably assign and transfer to Post Oak Emergency Room for myself and my dependents, all rights, title, and interest in the benefits payable for services rendered by Post Oak Emergency Room provided in any insurance policy(s) under which I or any of my dependents are insured. Said irrevocable assignments and transfers shall be for the purpose of granting Post Oak Emergency Room an independent right of recovery on any policy(s) of insurance to which benefits may be payable for this admission or medical services, but shall not be construed to be an obligation of Post Oak ER to pursue any such right to recovery. I further authorize direct payment to the physician/surgeon or any other provider who may have medical and/or surgical benefits applicable to my treatment. I hereby authorize and direct all insurance company(s) under which I am insured to pay directly to Post Oak Emergency Room all benefits due under said policy(s) by reason of service rendered therein. I will pay Post Oak Emergency Room for all charges incurred, or alternatively, for all charges in excess of the sum actually paid by said policy(s). I also irrevocably assign Post Oak Emergency Room all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance policy(s) under which I may be entitled to recover.

_____ In consideration of services rendered I hereby irrevocably assign and transfer to Post Oak Physician Group for myself and my dependents, all rights, title, and interest in the benefits payable for services rendered by Post Oak Physician Group

provided in any insurance policy(s) under which I or any of my dependents are insured. Said irrevocable assignments and transfers shall be for the purpose of granting Post Oak Physician Group an independent right of recovery on any policy(s) of insurance to which benefits may be payable for this admission or medical services, but shall not be construed to be an obligation of Post Oak Physician Group to pursue any such right to recovery. I further authorize direct payment to the physician/surgeon or any other provider who may have medical and/or surgical benefits applicable to my treatment. I hereby authorize and direct all insurance company(s) under which I am insured to pay directly to Post Oak Physician Group all benefits due under said policy(s) by reason of service rendered therein. I will pay Post Oak Physician Group for all charges incurred, or alternatively, for all charges in excess of the sum actually paid by said policy(s). I also irrevocably assign Post Oak Physician Group all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance policy(s) under which I may be entitled to recover.

AUTHORIZATION TO RELEASE INFORMATION AND COMPLETE FORMS

_____ I hereby authorize Post Oak Emergency Room to release any and all medical records, statements, or any other information in connection with this admission, including, but not limited to completion of claim forms on my behalf, in order to facilitate in the payment of medical bills incurred for this admission. I further authorize my employer or any other person, company, or entity to release any information which may be necessary to determine the benefits payable under my insurance policy(s) which may provide coverage for this admission. I hereby agree to and do indemnify and release Post Oak Emergency Room for any and all responsibility or liability relative to the release of such information. I give consent to Post Oak ER to send lab results by text message or email.

POWER OF ATTORNEY – (only for purpose of contacting and collecting from insurance company)

_____ I hereby irrevocably designate, authorize and appoint the Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the purpose of receiving all payments due under my policy/medical care plan on account of the medical services and care rendered or to be rendered. In the event that my health insurance plan or any other responsible party does not accept my assignment or my assignment is deemed invalid, I execute this power of attorney and appoint and authorize the Provider to file suit and/or participate in arbitration in order to collect payment for my medical services. I specifically authorize the Provider to file directly against the carrier in my name or in the Provider's name as a medical provider rendering services to me. This power of attorney shall automatically terminate as soon as the Provider has received payment in full.

ERISA AUTHORIZATION

_____ I hereby designate, authorize, and convey to the Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. Section 2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from the Provider and, to the extent permissible under law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. As my Authorized Representative under ERISA, the Provider shall have the right to act on my behalf, including but not limited to, submitting any and all appeals when my insurance company denies me benefits to which I am entitled, submitting any and all requests for benefit information from my insurance company, and initiating formal complaints to any state or federal agency that has jurisdiction over my insurer and/or benefits.
This Assignment of Benefits Form applies and extends to subsequent visits and appointments at Post Oak Emergency Room. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

I understand that I can be provided written copies of the following information upon request:

_____ Patient Rights and Responsibilities

_____ Notice of Protected Health Information

_____ Complaint/Grievance procedure

I certify that I have carefully read, understand and agree to the above terms, agreements, authorizations, and irrevocable assignments, and any questions have been fully answered.

Signature:_____ **Date:** _____