



17685 TOMBALL PARKWAY
HOUSTON, TX 77064
PHN: 832-779-5433 FAX: 832-604-5433

3820 NORTH SHEPHERD DR. SUITE A.
HOUSTON, TX 77018
PHN: 281-766-8911 FAX: 832-742-9896

Patient Label

***PLEASE PRINT FRONT AND BACK**

NO INSURANCE/ SELF-PAY PATIENTS

Testing is performed at no cost to you. There is no charge with insurance or the federal program for uninsured patients.

I do not have Medical Insurance, Medicare, Medicaid or any Commercial or Government-funded Health Benefit Plan. I acknowledge that I must answer this question truthfully in order to have the cost of my test covered by the U.S. Department of Health and Human Services (HSS) Uninsured Program. If I have active insurance and fail to provide that information, I will be charged the price of the test.

Thank you for choosing Life Savers Emergency Room. We are a fully licensed freestanding emergency medical care facility providing full concierge emergency services including diagnostics, imaging and point of care lab testing. Life Savers ER was founded on the belief that each patient is an important customer and deserves the highest quality emergency medicine offered in an environment of efficiency, convenience, and comfort.

FEES

COVID-19 ANTIBODY TESTING rate is \$150. This fee covers antibody testing.

COVID-19 ANTIGEN SWAB TESTING rate is \$200. This fee covers Antigen swab testing.

Our standard ER patient rate is \$285 the initial patient fee will increase in accordance to the urgency and complexity of your medical complaint. This will be determined during the course of your treatment. Any diagnostic testing, treatment(s) and or procedure(s) will be an additional charge to the initial fee.

Life Savers Emergency Room will provide a Medical Screening Exam and stabilization regardless of ability to pay.

FEES WILL BE COLLECTED AT THE TIME OF THE VISIT AND A COPY OF YOUR DRIVER'S LICENSE WILL BE TAKEN. SHOULD THE VISIT BE MORE THAN THE INITIAL PAID AMOUNT, YOU WILL BE NOTIFIED BY OUR STAFF.

We accept cash, and all major credit cards. The self-pay rates apply only if payment is made at TIME OF SERVICE. Any unpaid balances will be billed at our Usual and Customary rate of pricing. Usual and Customary rates may be made available by contacting Life Savers Emergency Room at (832-779-5433 or 281-766-8911)

If you have concerns about your medical expenses, please feel free to discuss these concerns with your healthcare provider. Our business office staff will inform you of the cost and or/medical necessities relating to your treatment. You have every right to refuse a treatment and/or procedure. However, doing so may hinder treatment and/or limit an accurate diagnosis of your medical condition.

Again, THANK YOU for choosing Life Savers Emergency Room.

2021/06/13

Signature of Patient or Legal Guardian

Date

JOHN DOE

Print Patient Name



**Life Savers
EMERGENCY ROOM**

Always Open . Always Ready

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CONSENT TO TREATMENT

LIFE SAVERS EMERGENCY ROOM functions like a hospital based emergency room. Our mission is to provide prompt, friendly, caring and quality medical treatment for a wide array of emergency medical conditions.

Texas insurance laws guarantee that all fully-funded medical insurance plans must pay for all emergency medical claims. This is true for our facility as well. However, Life Savers Emergency Room does not contract with any carriers and cannot anticipate accurately what specific rates your carrier will apply to individual services. Life Savers Emergency Room may not have contractually agreed to accept a particular insurance carrier's reimbursement as payment in full for services provided. At the time of your visit, we will collect your emergency room copay and bill your insurance provider for your emergency room benefits. Individual plan deductibles and coinsurance notwithstanding, and any non-reimbursed balance will be your individual responsibility.

Consent to Treatment: I understand that independently contracted physicians will, at my request, order all tests and treatments at Life Savers Emergency Room. I understand that medicine and surgery are not exact sciences and that no guarantee or warranty has been made to me as to result or outcome. Knowing this, I consent to being a patient and agree to all necessary testing and treatment while I am a patient at Life Savers Emergency Room.

Assignment of Benefits: I authorize direct payment to be made by my insurance carrier to Life Savers Emergency Room, LLC , dba Life Savers ER, for any and all medical and surgical services rendered at Life Savers Emergency Room. I understand that if any of the services and charges are not covered by the insurance company, or if Life Savers Emergency Room is unable to verify eligibility, I am responsible for all charges incurred for services rendered. I also authorize the release of any medical records for the purpose of health care operations to be released to my insurance provider.

Accidental Exposure of Health Care Workers: I agree that if any healthcare worker is exposed to my blood or other bodily fluids, I will allow Life Savers Emergency Room at its option, to test my blood for diseases including but not limited to hepatitis, HIV, and syphilis. I understand that the result of these tests do not become a part of my medical record. I will be responsible for the charges for any such test.

Signature of Patient: _____

Date: 2021/06/13

Staff Witness: staff_witness1

If the consenting party is other than the patient:

My relationship to the patient is relationship_to_patient and I have signed this consent on his/her behalf.

Signature of Relative/Legal Guardian: _____

Date: 2021/06/13

Staff Witness: staff_witness2



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FINANCIAL INFORMATION

At the time of service, we will make a copy of (one or the other) your Government Issued Driver's License, ID, Passport, Visa and Insurance card.

Please note that we are an independent, fully licensed, Freestanding Emergency Medical Care Facility.

Shortly after your visit, you will be receiving an Explanation of Benefits (EOB) from your insurance company. Please remember that your EOB is an Explanation of your Benefits, and is **not a bill**. We submit our bills to your insurance company as out of network, through all Emergency Medical Care Facilities are legally in network. Any portion of your bill that is the patient responsibility will be adjusted to in network rates when our billing company sends your statement.

You may **PAY** your **BALANCE** at **ANY Life Savers Emergency Room Located at 17685 TOMBALL PARKWAY HOUSTON, TX 77064 or 3820 N. SHEPHERD DR. SUITE A HOUSTON, TX 77018** or remit by mail.

Please include your account number on your check. For your convenience, Life Savers Emergency Room also accepts all major credit cards.

An itemized statement of your visit is available upon request to our Billing Department.

Questions concerning payment arrangements or collections should be directed to our Billing Department at: 832-592-1133 or 713-429-4666

2021/06/13

Signature of Patient or Legal Guardian

Date

John Doe

Printed Patient Name

If the signing party is other than the patient (please check box)

I am the Qualified Personal Representative (QPR) or Legal Guardian



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FINANCIAL NEED BASED / SELF-PAY PATIENTS

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Our basic patient rate is \$285 The initial patient fee will increase in accordance to the urgency and complexity of your medical complaint. This will be determined during the course of your treatment. Any diagnostic testing, treatment(s) and or procedure(s) will be an additional charge to the initial fee.

Life Savers Emergency Room will provide a Medical Screening Exam and stabilization regardless of ability to pay.

THE BASIC RATE OF \$285 WILL BE COLLECTED AT THE TIME OF THE VISIT AND A COPY OF YOUR DRIVER'S LICENSE WILL BE TAKEN. SHOULD THE VISIT BE MORE THAN THE INITIAL \$285 , YOU WILL BE NOTIFIED BY OUR STAFF.

We accept cash, and all major credit cards. The self-pay rates apply only if payment is made at TIME OF SERVICE. Any unpaid balances will be billed at our Usual and Customary rate of pricing. Usual and Customary rates may be made available by contacting Life Savers Emergency Room at (insert phone number)

If you have concerns about your medical expenses, please feel free to discuss these concerns with your healthcare provider. Our business office staff will inform you of the cost and or/medical necessities relating to your treatment. You have every right to refuse a treatment and/or procedure. However, doing so may hinder treatment and/or limit an accurate diagnosis of your medical condition.

Again, THANK YOU for choosing Life Savers Emergency Room.

Signature of Patient or Guardian

2021/06/13

Date

John Doe

Print Patient Name



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Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Life Savers Emergency Room, the following rights, now power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, medical care Support Company or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive irrevocable right to receive payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court cost, and interest from judgement, upon violation. I further instruct the provider to make all checks payable to Life Savers Emergency Room, and send all checks to Life Savers Emergency Room .

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to Life Savers Emergency Room, and to send any and all checks to Life Savers Emergency Room.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim in my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to Life Savers Emergency Room.

Patient Signature

2021/06/13

Date

If the consenting party is other than the patient:
I am the Qualified Personal Representative (QPR) or Legal guardian of : _____

John Doe

Patient Name

Signature of Qualified Personal Representative

John Doe

Printed Name of Qualified Personal Representative

relationship_to_patient
Legal Authority to Act on Behalf of the Patient
(Relationship to patient)



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Patient Label

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Facility: Life Savers Emergency Room

Patient: Jone Doe

I request and authorize Lifesavers Emergency Room to release healthcare information of the patient named above to:

Doctor

Office

Name : doctor_office_name

Address: address

City: city State: state Zip: zip

Phone: phone EXT: ext Fax: fax

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: healthcare_information_relate

All healthcare information

Other: other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I decline authorization to release healthcare information.

**Patient
Signature:** _____

**Date
Signed:** 2021/06/13

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.



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LIFE SAVERS EMERGENCY ROOM AND THE MEDICAL STAFF'S NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

***PLEASE PRINT FRONT AND BACK**

This notice describes your legal right regarding your health information and will inform you of the legal duties and privacy practices of Life Savers ER and its Medical Staff Members only with respect to health information created for services generated at Life Savers ER. If you received services by your physician or other health care providers at a different location, you may want to ask about the office or clinic's health information privacy policies and notices, as they could be different.

Life Savers Emergency Room is providing this notice of Privacy Practices in one document for your convenience. Life Savers Emergency Room and its Medical Staff Members are independently responsible for complying with this Notice.

We are not responsible for each other's actions and do not have equal control over the other's business.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have DECLINED a Copy of this NOTICE, please INITIAL here and SIGN below: initial here
Initial Here

If you have any questions regarding any information set forth in this Notice of Privacy Practices, please do not hesitate to call us at 832-779-5433 or 281-766-8911.

Signature of Patient

2021/06/13

Date

If the consenting party is other than the patient:

I am the Qualified Personal Representative (QPR) or Legal guardian of: _____
and sign on his/her behalf.

John Doe

Patient Name

JoneDoe

Printed Name of QPR or Legal Guardian

Signature of QPR or Legal Guardian

relationship to patient

Legal Authority to Act on Behalf of the Patient
(Relationship to patient)

staff witness

Staff Witness

Note: In the case of an Obstetrical Patient, this signed acknowledgement for receipt of the Notice of Privacy Practices also serves as receipt of Privacy Practices on behalf of the newborn(s).



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LIFE SAVERS ER PATIENT PAYMENT POLICY & AGREEMENT

In consideration of my particular Medical needs and Care expenses to be incurred solely based on such Medical needs, and my financial ability to pay for such recommended Medical services without or even with applicable Insurance Coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage.

I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:

declare_financial_difficulty

I will pay Full or any charges for my medically necessary care expenses.

If the responsible party or the responsible party insurance does not cover some or all of the my medically necessary care expenses or if my claim is denied. I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs.

Patient Name: John Doe

Signature of Patient: _____

Date: 2021/06/13

Staff Witness: staff

Date: 2021/06/13



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PATIENT'S RIGHTS AND RESPONSIBILITIES

Lifesavers Emergency Room Patients have the right to:

- be informed of their rights and responsibilities
- have a family member, chosen representative and/or their physician promptly of arrival to the Life Savers Emergency Room
- receive treatment and medical services without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.
- be treated with consideration, respect, and recognition of their individuality.
- be informed of the names and functions of all physicians and other healthcare professionals providing their direct care.
- Receive the services of a translator or interpreter to facilitate the communication between the patient and the hospital's healthcare professionals.
- Receive visitors that they designate, including, but not limited to, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and they have the right to withdraw or deny this visitation consent at any time.
- participate in the development and implementation of their plan of care as well as make informed decisions regarding their care.
- be informed of their health status, involved in care planning and treatment, and allowed to request or refuse treatment.
- be included or to refuse to be included in experimental research.
- Have a full explanation if they are being transferred to another facility.
- be informed if the hospital has authorized other institutions to participate in their treatment. Patients have the right to know the identity and function of these institutions, and to refuse to allow the institutions to participate in their treatment.
- formulate advance directives and have physicians and other healthcare professionals comply with these directives.
- be informed by their physician and other health care professionals about any continuing health care requirements after their discharge.
- receive assistance from their physician and other healthcare professionals about any continuing healthcare requirements after their discharge.
- receive assistance from their physician and appropriate healthcare professionals in arranging for required follow-up care.
- have their medical records kept confidential as well as have access to their medical records within a reasonable time frame.
- be free from all forms of abuse and harassment.
- receive care in a safe setting.
- examine and receive an explanation of their bill and may receive information relating to financial assistance available.
- be informed in writing about the hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address and telephone number of where to file complaints with the Department of Health and Human Services.

Patients have the responsibility to

- provide information, follow instructions, follow the facility's rules and regulations, ask questions and meet financial obligations.

Should you have a complaint or grievance related to Life Savers Emergency Room, you may request to speak with the facility's Patient Representative or Administrator

If your complaint is not resolved to your satisfaction, you may contact:

Department of State Health Services
Health Facility Compliance Group (MC 1979)
Texas Department of State Health Services

Complaint hotline:
(888) 973-0022

Patient Signature

2021/06/13

Date

signed behalf of patient
Signed behalf of patient

relationship to patient
Relationship

2021/06/13
Date



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SCREENING FOR COVID-19 QUESTIONNAIRE

	QUESTIONS	YES	NO
1	<ul style="list-style-type: none"><input type="radio"/> DO YOU HAVE A FEVER? *ABOVE 100.4 F (38 C)<input type="radio"/> DO YOU HAVE A COUGH?<input type="radio"/> HAVE YOU BEEN AROUND ANYONE WITH A COUGH, SHORTNESS OF BREATH, FEVER OR FLU-LIKE SYMPTOMS?<input type="radio"/> DO YOU HAVE OTHER HEALTH CONDITIONS? DIABETES, LUNG DISEASE, HEART DISEASE, PREGNANCY?	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
2	<ul style="list-style-type: none"><input type="radio"/> HAVE YOU TRAVELED TO ANY INTERNATIONAL COUNTRIES? CHINA, JAPAN, SOUTH KOREA, ITALY, IRAN OR EUROPE?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3	<ul style="list-style-type: none"><input type="radio"/> HAVE YOU BEEN AROUND ANYONE DIAGNOSED WITH COVID-19?<input type="radio"/> HAVE YOU BEEN AROUND ANYONE INVESTIGATED FOR COVID-19?	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
4	<ul style="list-style-type: none"><input type="radio"/> HAVE YOU TRAVELED WITHIN THE U.S TO AN ENDEMIC AREA WITHIN THE LAST 2 WEEKS?<input type="radio"/> HAVE YOU TRAVELED WITHIN THE U.S TO A NON-ENDEMIC AREA WITHIN THE LAST 2 WEEKS?	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>