

**NORTHWEST HILLS SURGICAL HOSPITAL
CONDITIONS OF REGISTRATION AND ADMISSION**

MEDICARE-PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payments under Title XVIII 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 related Medicare claim. I request that payment or authorized benefits be made on my behalf. I do have Medicare.

INFORMATION PRIVACY

NORTHWEST HILLS SURGICAL HOSPITAL will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

RELEASE OF MEDICAL INFORMATION

The patient may be eligible for receipt of health care benefits from the insurance companies or third party payors provided to NORTHWEST HILLS SURGICAL HOSPITAL by the patient.

The undersigned hereby authorizes NORTHWEST HILLS SURGICAL HOSPITAL to furnish information relating to all health care services provided to the Patient during this admission from the Patient's medical and other records or to furnish copies of the Patient's medical and other records to the insurance companies or third party payors identified by me, or to any agent or representative of said insurance companies or third party payors, for the purpose of obtaining payment on the account of the Hospital or any physician for services provided to the Patient with respect to this admission.

The undersigned further authorizes the Hospital to release copies of the Patient's medical or other records or to permit the review of the Patient's records at the Hospital by an agent or representative of said insurance companies or third party payors for purposes of conducting any medical audits, utilization reviews, or quality assurance reviews with respect to this admission.

The undersigned also authorizes the Hospital to release information from or copies of the Patient's medical and other records to any referring physician or to any home health agency, skilled nursing facility, or other health care facility to which the Patient may be transferred or referred.

VOLUNTARY HIV PATIENT TESTING

Texas Law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, the virus associated with AIDS, in the following situations:

- 1) If donations of blood, blood products, organ or tissues is contemplated; 2) If a healthcare worker is accidentally exposed to the patient's blood or bodily fluid such as through a needle stick or; 3) If a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or bodily fluids. This disclosure is to inform you that you will be tested if these situations occur during your hospitalization.

ASSIGNMENT OF INSURANCE BENEFITS/DISTRIBUTION OF OVERPAYMENT/OBLIGATION OF GUARANTOR

Each of the undersigned hereby authorizes all of (his/her) insurers, whether or not specified, to make payments of the Hospital insurance benefits directly to the Hospital rather than to said undersigned, but such payments shall not exceed the Hospital's regular charges for this period of hospitalization. The undersigned patient recognizes, however, that (he/she) remains financially responsible to the Hospital for charges not paid or covered by said insurers. Each of the undersigned insured also hereby authorizes any overpayment to the Hospital regarding the hospitalization which would otherwise be payable to said undersigned to be applied and credited against any previous balance due the hospital for which said undersigned is the responsible party.

I also irrevocably assign to the Hospital all rights, title and interest in benefits payable as a result any third party action against any other person, entity, or insurance company or out of recovery under the uninsured motorist provisions or the medical payment provisions of any insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.

I the undersigned guarantor, hereby guarantee full and prompt payment to the Hospital of all charges made as a result of services rendered the above-named patient during this hospitalization. I agree to pay the Hospital for said charges upon the failure of said patient any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court cost required in the collection of any unpaid accounts.

I hereby authorize the release of any medical information necessary to process this claim. I hereby authorize payment directly to NORTHWEST HILLS SURGICAL HOSPITAL, 6818 Austin Center Blvd., Suite 100, Austin, Texas 78731.

I understand that I am financially responsible for the charges not covered by this authorization.

RELEASE OF RESPONSIBILITY FOR PERSONAL BELONGINGS

This is to certify that I (or) the undersigned patient do hereby release NORTHWEST HILLS SURGICAL HOSPITAL from any liability concerning the loss or damage of my personal belongings including but not limited to: Dentures, Hearing Aid, Glasses, Contact, Clothing Accessories, Electric/Electronic Equipment, Cash**, Credit Cards**, Jewelry**.

**If you bring cash, credit cards, or jewelry to the hospital, please leave it with the person waiting for you.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

PATIENT/INSURED/GUARANTOR

BY

RELATIONSHIP

INSURED/GUARANTOR

ADMITTING EMPLOYEE

DATE

**NORTHWEST HILLS SURGICAL HOSPITAL
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INFORMATION RECEIPT ACKNOWLEDGEMENT**

In signing this document I am acknowledging that:

Please Initial Each Blank

I have received a copy of the Important Message from Medicare.

A representative of the NORTHWEST HILLS SURGICAL HOSPITAL has reviewed the billing process and that I have received a copy of the billing process.

I do do not hereby give NORTHWEST HILLS SURGICAL HOSPITAL permission to contact me at _____ for the next few days for post-operative follow-up. I have the following special requests:

I have been informed that NORTHWEST HILLS SURGICAL HOSPITAL meets the Federal definition of a physician-owned hospital (as specified in 42 CFR § 489.3) and that the list of the hospital's physician owners or investors is available upon request.

Federal law requires that the NORTHWEST HILLS SURGICAL HOSPITAL inquire if you have executed a Living Will and/or a Durable Power of Attorney for Health Care at this facility or any other health care facility including your physician's office. Please answer the following:

Yes No

Do you have a Living Will?

Are you providing a copy of your Living Will?

Do you wish to receive literature about a Living Will?

Do you have a Durable Power of Attorney for Health Care?

Are you providing a copy of your Durable Power of Attorney for Health Care?

Do you wish to receive literature about a Durable Power of Attorney?

By signing this form I acknowledge that I understand that I am not required to have an advanced directive, and I acknowledge the opportunity to receive written materials regarding my right to make advance medical decisions. I acknowledge having received a copy of my rights and responsibilities as a patient in this facility.

For Hospital Use Only Below

Driver's License

Photo ID

Insurance Card

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