# SURGICAL AND DIAGNOSTIC CENTER, L. P.
# PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ MARITAL STATUS: (Circle One) S M W D

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( )_____

DATE OF BIRTH: ___/___/_____ AGE: _____ SEX: ___ SS# ____-____-_____

ETHNICITY: (Circle One) HISPANIC/LATINO NOT HISPANIC/LATINO

RACE: (Circle One) AMERICAN INDIAN OR ALASKA NATIVE, BLACK OR AFRICAN AMERICAN,
ASIAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE
OTHER: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NATURE OF ILLNESS, ACCIDENT, OR INJURY AND DATE OF ONSET: _____
_____
_____
HAVE YOU HAD A PREVIOUS SURGERY AT THIS FACILITY? _____ IF SO, WHEN? _____
TYPE OF SURGERY TO BE PERFORMED: _____
FAMILY PHYSICIAN: _____ HOSPITAL PREFERENCE: North Hills Hospital
Baylor Medical Center at Grapevine
Harris Methodist HEB

## WHO TO CONTACT IN AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

NAME OF EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____

# SURGICAL AND DIAGNOSTIC CENTER, L. P.

**CONSENT TO ADMISSION AND TO TREATMENT:** I hereby give my consent to admission to Surgical and Diagnostic Center, L. P., and understand that my admission is necessary for the diagnostic and/or treatment that my physician or podiatrist has recommended to me. I understand that as a result of this admission, I will be undergoing surgery, pain block, or both, as Dr. _____ has recommended and explained to me. I hereby give my consent to treatment.

**ACKNOWLEDGEMENT OF RESPONSIBILITY**: I understand and agree that I am being advised that I must not operate a motor vehicle immediately after my discharge from Surgical and Diagnostic Center, L. P., and must otherwise comply with medical advice given to me upon my discharge. Accordingly, my personal discharge plan serves to confirm provisions that I have made to assure my personal safety, the safety of others, my compliance with applicable laws and regulations and my compliance with medical advice.
**ACKNOWLEDGEMENT:** I understand and agree that Surgical and Diagnostic Center, L. P., may at will notify the local police and Department of Public safety in the interests of public safety if there is any indication that I will attempt to operate a motor vehicle against medical advice and my personal discharge plan.

**RELEASE OF MEDICAL AND OTHER PERSONAL INFORMATION:** I hereby release Surgical and Diagnostic Center, L. P., its owners, directors, shareholders, employees, and agents and assign to release any and all medical information and other personal information about me for the following purposes:

To any third party necessary to secure/arrange for payment for the medical, paramedical, administrative and other services provided to me: and

To any physicians who may have been involved in my care previously, who are involved in my care currently or who may be involved in my care in the future.

To other third party persons or agencies such as but not limited to: Insurance companies, agents of insurance companies, attorneys, State and Federal agencies and courts of competent jurisdiction who may have a need to know some or all of the information about me, medical or otherwise.

**ADVANCED DIRECTIVE:** I understand and agree that the Texas Department of Health prohibits Surgical and Diagnostic Center, L. P. from honoring an advanced directive, or Do Not Resuscitate (DNR) and therefore the instructions contained therein.

Do you have a living will? Yes ____ No ____ If yes, where is it located? _____
_____

Do you have a durable power of attorney? Yes ____ No ____ If so, give name of whom you appointed:

_____

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign to Surgical and Diagnostic Center, L. P., all medical and/or surgical benefits to include but not limited to major benefits, MEDICARE benefits, private insurance coverage and any other applicable insurance to which I am entitled.

**GUARANTY OF PAYMENT FOR SERVICES:** I understand and agree that I am personally responsible for paying Surgical and Diagnostic Center, L. P., any an all fees for services provided in the Surgical and Diagnostic Center, L. P. I promise to pay Surgical and Diagnostic Center, L. P., promptly any and all such fees for services that are not covered by my insurance or other plan benefits, and services for injury sustained on the job in Texas. I understand that if all services provided are a result of a bona-fide injury sustained on the job in the state of Texas that this guaranty is not binding. However, I understand and agree that if services are provided under the assumption of Workers Compensation coverage and such coverage is not given to me, I will be personally responsible for payment and shall make such payment on demand.

With whom may we discuss your medical condition if you are unavailable? _____

If you have questions concerning whom to include, please speak to a nurse.

**I have carefully and fully read and understand the above releases, assignments, and policies.**

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Representative Relationship to Patient

_____
Surgical and Diagnostic Center, L. P. Representative

V1-2017

# DISCLOSURE OF FINANCIAL INTEREST

Texas Law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest.

Be aware that your physician may have a financial interest in Surgical and Diagnostic Center, L.P.

If you have any questions concerning this matter, feel free to contact our Patient Advocate at 817-282-1001.

Or you can discuss this matter with your treating physician.

_____ _____

Patient Signature Date

# Federal Health Insurance Portability and Accountability Act

I have received a copy of the Federal Health Insurance Portability and Accountability Act.

Patient Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

SDC Representative: _____ Date: _____

A good faith attempt to obtain written acknowledge of receipt of this Notice of Privacy Practices failed because:

- ○ The patient refused to sign.
- ○ Communication barriers prohibited obtaining the acknowledgement.
- ○ An emergency situation prevented us from obtaining acknowledgement.
- ○ Other (specify): _____ Date: _____

**Surgical & Diagnostic Center**
729 Bedford-Euless Road West, Ste. #100
Hurst, TX 76053
817-282-1001

# Financial Policy

Thank you for choosing Surgical & Diagnostic Center, L.P. (SDC). Our Goal is to provide you with the highest quality of care available today and we believe that good communication with our patients is of paramount importance. We ask you to please read the policy, ask us any question you may have, and sign in the space provided below.

**Payment Methods:** Payment and/or payment arrangements are expected at the time services are rendered. We accept cash, check, money order or various credit cards and if you prefer, we will be happy to make payment arrangements according to your needs.

**Insurance:** We are happy to bill your insurance carrier in a timely manner and we ask that you provide us with accurate information such as address, phone number, etc., along with proof of insurance and a Government issued Photo ID.

**Assignment of Benefits:** I hereby assign and convey directly to Surgical & Diagnostic Center, L.P. (SDC), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by SDC, regardless of its managed care network participation status. I also authorize SDC to appeal any denial, reduction, or adjustments of reimbursement to my group health plan, employee benefits plan, or health insurance as applicable. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize SDC to release all medical information necessary to process my claims. Further, I hereby authorize the release to SDC any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from SDC in order to claim such benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign to SDC any legal or administrative claim of chose an action concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medication I receive from SDC (including any right to pursue those legal or administrative claims or chose an action). This is an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal or administrative claims.

**Additional Information Regarding Implants:** If implants are used in your procedure you are financially responsible for any amounts not covered/approved by your insurance carrier.

Please check with your insurance carrier to determine any pre-existing or other limitations/restrictions you may have and report them to our office prior to your appointment. If there are any changes in your insurance, please give the details of these changes at least 24 hours prior to your appointment.

Should your insurance carrier for any reason issue payment to you or your representative directly for the services provided by Surgical & Diagnostic Center, L.P., you agree to endorse and deliver said payment to our offices either in person or by certified U.S. Mail, return receipt requested within 10 days of receipt of payment.

We are not currently contracted with any health insurance company as an In Network Provider. SDC is and Out of Network Provider.

**Non-Payment:** Patient accounts without satisfactory payment over 90 days may be turned over to a collection agency after 180 days with no payment. Returned checks will incur a $35.00 fee, payable immediately.

**Account or Claims Questions:** Questions regarding your account or insurance claim should be directed to our Billing office staff @ 817-510-1222

**Printed Name:**_____

**Signature:**_____ **Date:**_____