Patient Name _____ DOB ____/____/____ Age ____ Sex _____

SS# ____ - ____ - ____ Race _____ Marital Status _____ Religion _____

Patient Address:

Address _____
City/State/Zip _____
Home # (____) _____
Cell # (____) _____
Email Address: _____

Employer Name _____

Address _____
City/State/Zip _____
Work # (____) _____
Occupation _____

Next of Kin

Name _____
Address _____
City/State/Zip _____
Home # _____ Work # _____
Relationship _____

Person to Notify in case of emergency

Name _____
Address _____
City/State/Zip _____
Home # _____ Work # _____
Relationship _____

Guarantor (Insured / Responsible. Party)

Name _____
Address _____
City/State/Zip _____
Home # _____
Relationship _____
Social Security # ____ - ____ - ____

Employer Name _____
Address _____
City/State/Zip _____
Work # _____
Occupation _____

Primary Insurance Info.

Insurance Co. _____
Address _____
City/State/Zip _____
Telephone # _____
Subscriber Name _____
Relationship _____
Policy # _____
Group # _____

Secondary Insurance Info.

Insurance Co. _____
Address _____
City/State/Zip _____
Telephone # _____
Subscriber Name _____
Relationship _____
Policy # _____
Policy # _____

How did you learn about Green Oaks? _____

GREEN OAKS HOSPITAL
7808 Clodus Fields Drive • Dallas, TX 75251

REGISTRATION FORM - DALLAS CLINIC

PATIENT IDENTIFICATION

ADMINS

Conditions of Admission and Consent for Outpatient Care

In this document, "**Patient**" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I", "you", "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"**Provider**" means the hospital and may include healthcare professionals on the hospital's staff and/or hospital-based physicians, which include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

Legal Relationship between Hospital and Physicians. Most or all of the physicians performing services in the hospital are independent and are not hospital agents or employees. Independent physicians are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians.

1. Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and/or hospital staff. This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome ("AIDS"), and Hepatitis, if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. Consent to Treatment Using Telemedicine. I consent to treatment involving the use of electronic communications ("Telemedicine") to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

3. Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy. As part of the services provided, you may be treated with a medication that has not received FDA approval. You may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy.

4. Consent to Photographs, Videotapes and Audio Recordings. I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

5. Financial Agreement. In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient's account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the hospital's charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

6. Third Party Collection. I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer's denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider. Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings.

I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

7. Assignment of Benefits. Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment

received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

8. Governing Law; Forum. The patient, including patient's representative, and heirs or beneficiaries, and health care providers, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: 1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and 2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

9. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

10. Private Room. I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.

11. Outpatient Medicare Patients. Medicare does not provide coverage for "self-administered drugs" or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that aren't covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.

12. Communications About My Healthcare. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

13. Consent to Telephone Calls for Financial Communications. I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or yourEBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

14. Consent to Email or Text Usage for Discharge Instructions and Other Healthcare Communications. If at any time I provide the Providers an email or text address at which I may be contacted, I consent to receiving discharge instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number. These discharge instructions may include, but not be limited to:

post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

15. Other Acknowledgements.

Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

Records Retention. Unless my records are involved in litigation, the Provider may dispose of my medical records 10 years after the date of my last treatment here, or, for minors, the later of 10 years after the date of the patient's last treatment or the date of the patient's 20th birthday.

Additional Provision for Admission of Minors/ Incapacitated Patient. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

Insurance Network. I acknowledge that I have received notice that, based on the information available at this time, this facility IS/IS NOT a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g., radiologists, anesthesiologists, pathologists, neonatologists, and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure, or other services, may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

16. Patient Self Determination Act. I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). Please initial or place a mark next to **one** of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

17. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

18. Consent to Authorize Use of Email and Text for Patient Billing and Financial Obligations. By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information. I understand and acknowledge that my patient account number may appear in the email or text.

Acknowledge: _____ (Initial) I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge: _____ (Initial) I consent to use of text for Patient billings and financial obligation purposes.

19. Acknowledgement: I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: _____ (Initial)

20. Acknowledgement of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: _____ (Initial)

Date:	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.
Time:	

Patient/Patient Representative Signature:

X _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian
Neighbor/Friend
Sibling
Healthcare Power of Attorney
Guarantor
Other (please specify): _____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:
(required for Patients unable to sign without a representative or Patients who refuse to sign)

X _____

HCA Texas COA-COS 06.20.16

I hereby authorize my psychiatrist and/or members of Green Oaks Hospital treatment team to discuss my "health care information, including, but not limited to diagnoses, diagnostic lab studies and treatments" with the following:

NAME	RELATIONSHIP	PHONE NUMBER	RESCINDED
		Home: Work:	
NAME	RELATIONSHIP	PHONE NUMBER	RESCINDED
		Home: Work:	
NAME	RELATIONSHIP	PHONE NUMBER	RESCINDED
		Home: Work:	
NAME	RELATIONSHIP	PHONE NUMBER	RESCINDED
		Home: Work:	
NAME	Therapist	PHONE NUMBER	RESCINDED
		Office:	
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR PCP? ☐ Yes ☐ No PRIMARY CARE PHYSICIAN NAME	Primary Care Physician	PHONE NUMBER Office:	RESCINDED
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR OUTPATIENT PSYCHIATRIST? ☐ Yes ☐ No OUTPATIENT PSYCHIATRIST NAME	Psychiatrist	PHONE NUMBER Office:	RESCINDED

I understand that I can revoke this authorization at any time except to the extent that action has been taken on this authorization.

DATE	TIME
PATIENT / PARENT / GUARDIAN / CONSERVATOR X	IF OTHER THAN PATIENT, INDICATE RELATIONSHIP
SPOUSE (If Married / Available) X	WITNESS (To Signature Only) X

PATIENT IDENTIFICATION

GREEN OAKS HOSPITAL
7808 Clodus Fields Drive • Dallas, TX 75251

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION

COA

Patient Rights

I have been given information and instructions about my Patient Rights. My Patient Rights include the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan *of* care and receive care in a safe setting, free from verbal or physical abuse or harassment. I have received a copy of the Patient Rights Booklet. I have received information on how to complete a Mental Health Treatment Declaration regarding my mental health care treatment. I have also received information about the Hospital's grievance process.

Organ Donation

I understand that I may donate any *of* my organs or tissues for transplantation by completing an anatomical gift form. If I have signed an organ donor card, I understand that the hospital has requested a copy of this card.

Do Not Resuscitate (DNR)

It is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative measures or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Advance Directive or Health Care Power of Attorney.

I have read this document and I understand it. I have signed this Condition of Admission Addendum voluntarily. I have received no promises from anyone about the results of any medical/mental health treatment services.

☐ **Patient is medically unable to sign the Condition of Admission Addendum**

☐ **Patient Refused to Sign**

Date	Time
Patient/Parent/Guardian/Conservator **X**	If other than patient, indicate relationship
Spouse (If married/available) **X**	Witness **X**

PATIENT IDENTIFICATION

GREEN OAKS HOSPITAL
7808 Clodus Fields Drive • Dallas, TX 75251

CONDITION OF ADMISSION ADDENDUM

COA

Appointments:

Clinic hours are 8:00 a.m. to 4:00 p.m. Monday - Friday. Patient appointments are scheduled by calling our clinic during regular hours at 972-770-1032. Should you need to cancel an appointment, we ask for 24 hours' notice. If three (3) or more appointments are missed without notifying us of cancellation (e.g. same day no show), you may be discharged from our clinic. If you arrive late, you may be asked to reschedule your appointment. If you are a new patient and your new patient paperwork is not completed prior to your appointment, you could be asked to reschedule your appointment or your appointment time will be changed during the same day.

All disability forms will be reviewed and completed on a case by case basis. You must be a current patient with on-going care and compliant with your provider's treatment plan. Forms will not be completed during your appointment.

After Hour Emergency Situations: In an emergency, please call 911 or go to the nearest emergency room.

Prescription Refill Requests:

All requests for prescription refills must be made 48 hours in advance. You must have your pharmacy fax us for your refill request. In order to re-write a controlled drug prescription when it is not filled within the 21 day deadline, the original prescription must be returned to our clinic before a new prescription will be provided. If the controlled substance prescription or medication is lost, misplaced or stolen it must be reported to the police and will NOT be replaced without a copy of the police report. Controlled substance prescriptions will NOT be authorized for mail order. Do NOT call Green Oaks Hospital for refills. They will NOT be able to assist you.

Pharmacy Information:

Preferred Pharmacy Name: _____ Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number _____

Prescription Order Pick-Up:

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient initials) I wish to designate the following family member/friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date / Time _____

Patient Name (Printed) _____ DOB: _____

GREEN OAKS HOSPITAL 7808 Clodus Fields Drive • Dallas, TX 75251
(972) 991-9504

PATIENT IDENTIFICATION

OUTPATIENT CLINIC
PHARMACY, PRESCRIPTION & APPOINTMENT INFORMATION

PINS

AN IMPORTANT MESSAGE TO THE PATIENT / PARENT / GUARDIAN:

If you or a loved one notice these warning signs listed below, seek help immediately and or call one of the available suicide telephone hotlines listed here. Please know that if you have access to firearms or know your loved one has access to firearms, it is important to secure those safely away from reach NOW. * **TWO** telephone numbers are provided for you today.

1. A ***national toll-free SUICIDE PREVENTION HOTLINE NUMBER available 24 hours per day, 7 days per week and serves English & Spanish speaking callers.***

Suicide Prevention Lifeline: 1-800-273-TALK (8255)

2. **A local number: Adapt Crisis Line 1-888-905-0595**

» I understand that driving can be dangerous if I am not fully alert and oriented and I will not drive if I feel impaired.

» I understand that managing my medications may be difficult if I am distracted, angry, or confused and I will ask for help with managing my medications if needed.

» I understand that the first few days after discharge from my recommended treatment, it is important that I am not alone and I will call one of the numbers below if I am feeling lonely, unsafe, or need someone to talk to.

» I understand that I should not use drugs, alcohol, medications not currently prescribed to me, or get pregnant while taking psychotropic medications and that all medications need to be safely stored or disposed of.

WHO WILL I CALL IF I NEED ASSISTANCE? _____NAME _____PHONE #_____

Suicide risks and warning signs - Please call for help immediately if you experience the following warning signs:

* Seeking access to guns, pills, other
* Talking or writing about death/dying or suicide when out of the ordinary
* Feelings of hopelessness
* Feeling rage or seeking revenge or uncontrolled anger
* Acting reckless - seemingly without thinking
* Feeling trapped as there is no way out
* Increasing alcohol or drug use
* Withdrawal from family, friends and society
* Always anxious, agitated, unable to sleep or sleeping all the time
* Dramatic mood changes
* Seeing no reason for living or having no sense of purpose in life
* Giving away possessions to others that are of importance to the individual

I HAVE RECEIVED MY SUICIDE RISK PREVENTION DISCHARGE EDUCATION ABOVE AND I UNDERSTAND WHAT I HAVE BEEN EDUCATED ON THIS FORM AND I HAVE BEEN ABLE TO ASK ANY QUESTIONS I MAY HAVE.

Signature of Patient / Parent / Guardian: _____ Date: _____

GREEN OAKS HOSPITAL 7808 Clodus Fields Drive • Dallas, TX 75251
(972) 991-9504

PATIENT IDENTIFICATION

PATIENT EDUCATION
SUICIDE RISK PREVENTION

PINS

Copy to Patient / Signed Copy to Medical Record

Patient History

Patient Name: _____ Date: _____

Occupation: _____ Educational Level: _____

Marital Status (please circle one) S M W D Sep

Medication

Please list all current medications and include all over the counter and herbal medications.

Medication	Dose	Frequency

Do you have allergies to medication and/or food? ☐ No ☐ Yes

Medication / Food	Reaction

Please review the following and check any *current* symptoms that pertain to you.

☐ Depressed Mood	☐ Inflated Self Esteem
☐ Sleep Problem	☐ Don't Seem to Need Sleep For Days
☐ Change in Appetite	☐ Racing Thoughts
☐ Decrease Interest	☐ Excessive Talking
☐ Decrease Energy	☐ Spending Spree
☐ Difficulty in Concentration	☐ Distractibility
☐ Guilt	☐ Impulsive Behavior
☐ Irritability	☐ Trying To Do Way Too Much
☐ Crying Spells	☐ See / Hear Things That May Not Be Real
☐ Excessive Worrying	☐ Suspect / Believe Things That May Not Be Real
☐ Often Tense / Keyed Up	☐ Can Not Stop Repetitive Thoughts
☐ Panic Attack	☐ Can Not Stop Repetitive Behavior
☐ Intrusive / Recurrent Memory of Past Time	☐ Hyper Vigilant

Past Psychiatric Treatment

Have you seen a psychiatrist in the past? ☐ No ☐ Yes

If yes, when and Psychiatrist's name: _____

Have you seen a therapist in the past? ☐ No ☐ Yes

If yes, when and Therapist's name: _____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, when and where were you hospitalized? _____

Have you taken any psychiatric medications in the past? ☐ No ☐ Yes

If yes, what are the names of the medications? What were the benefits of taking it? Did you experience any side effects? _____

_____

_____

_____

Tobacco / Alcohol / Drug Use

Do you use tobacco? ☐ No ☐ Yes

If yes, what is the amount and how often? _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, what is the amount and how often? _____

Do you use street and/or prescription drugs (not prescribed to you)? ☐ No ☐ Yes

If yes, what are the names of the street and/or prescription drugs. What are the amounts and how often are they taken?

_____

_____

Medical History

Do you have a primary care physician? ☐ No ☐ Yes

If yes, what is your primary care physician's name? _____

Birth Control? ☐ No ☐ Yes ☐ Other

Do you suffer from any of the following medical problems?

☐ Hypertension	☐ Kidney Disease	☐ Stomach Ulcers
☐ Cong. Heart Failure	☐ Diabetes	☐ Head Injury
☐ Heart Disease	☐ Thyroid	☐ Seizure
☐ Chronic Pain	☐ Asthma	☐ Stroke
☐ High Cholesterol	☐ Liver Disease	☐ Neurological (Other)
☐ Other Medical Problem (Explain):		

Please explain any family medical history _____

_____

_____

If any, please explain family psychiatric history _____

_____

_____

Have you ever been hospitalized for medical reasons or had surgery? ☐ No ☐ Yes

If yes, please explain. _____

_____

Legal

Do you have any current or past legal problems? ☐ No ☐ Yes

If yes, please explain _____

_____

_____ _____

Patient / Parent / Guardian Signature Date

REV 6/13

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PATIENT IDENTIFICATION

PATIENT HISTORY

BAS

Consent for Use and Release of Information

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, _____ or employer's designee when
(Name of Employer)
the services delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

Date	**1, hereby certify I have read, and fully and completely understand this Authorization for Release of** Information/Healthcare Information, and that I have signed this Authorization for Release of Information/Healthcare Information knowingly, freely, and voluntarily.
Time ☐ a.m. ☐ p.m.	☐ Patient is medically unable to sign the Consent for Use and Release of Information. ☐ Patient Refused to Sign

Pat lent/Parent/Gua rd lan	If other than patient, indicate relationship
Spouse (if Married/Available)	Witness (to Signature only)

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CONSENT FOR USE AND RELEASE OF INFORMATION

PATIENT IDENTIFICATION

-ADMIN-

Handwashing

Handwashing is the single most important means of preventing the spread of infections diseases such as colds and flu. Direct contact is the primary way to spread these germs. Wash your hands often! Wash your hands when they are dirty, before and after eating, after coughing or sneezing, after blowing or wiping your nose, after wiping a blood or mucous drainage on the body, and before leaving the restroom.

How to Wash Your Hands:

1. **Wet and apply soap to hands.**
2. **Lather for 15 seconds.**
3. **Rinse hands under running water.**
4. **Dry hands thoroughly with paper towel and discard.**
5. **Turn faucet off with another paper towel and discard.**

Pneumococcal Disease

Pneumococcal disease is a serious disease that causes much sickness and death. In fact, pneumococcal disease kills more people in the United States each year than all other vaccine-preventable diseases combined. Anyone can get pneumococcal disease. However, some people are at greater risk from the disease. These include people 65 and older, the very young, and people with special health problems such as alcoholism, heart or lung disease, kidney failure, diabetes, HIV infection, or certain types of cancer. Vaccines are available at public health departments, physician's offices, and select pharmacies.

Influenza "Flu" and Vaccines

Influenza ("flu") is a very contagious disease. It is caused by the influenza virus, which spreads from infected persons to the nose or throat of others. Other illnesses can have the same symptoms and are often mistaken for influenza. But only an illness caused by the influenza virus is really Influenza. Anyone can get influenza. For most people, it lasts only a few days. It can cause fever, sore throat, chills, fatigue, cough, headache, and muscle aches. Some people get much sicker. Influenza can lead to pneumonia and can be dangerous for for people with heart or breathing conditions. It can cause high fever and seizures in children. Influenza kills about 36,000 people each year in the United States, mostly among the elderly. **Influenza vaccine can prevent influenza.**

Who should get inactivated influenza vaccine? Influenza vaccine can be given to people 6 months of age and older. It is recommended for people who are at risk of serious influenza or its complications, and for people who can spread influenza to those at high risk (including all household members).

People at high risk for complications from, influenza:

- All children 6-23 months *of* age.
- People 65 years of age and older.
- Residents of long-term care facilities,
- People with certain conditions (such as neuromuscular disorders) that can cause breathing problems,
- People with a weakened immune system due to HIV / AIDS or other diseases affecting the immune system , long term treatment with drugs such as steroids, cancer treatment with x-rays or drugs.
- People 6 months to 18 years of age on long-term aspirin treatment (these people could develop Reye Syndrome if they got influenza).
- Women who will be pregnant during influenza season.

Flu vaccines are available at public health departments, physician's offices, and select pharmacies.

OUTPATIENT PATIENT GRIEVANCE PROCEDURE
(DSHS Title 25, Texas Administrative Code (TAC) Ch. 448.702)

Green Oaks Outpatient Clinics shall have a written client grievance procedure. Staff shall give each client and consenter a copy of the grievance procedure within 24 hours of admission and explain it in clear, simple terms that the client understands. Should client feel or believe that they have cause to file a grievance; staff shall tell clients that they can:

1. File a grievance about any violation of client rights or Department rules.

2. Submit a grievance in writing and get staff's help writing it if they are unable to read or write.

3. Request writing materials, postage, and access to a telephone for the purpose of filing a grievance; staff. will provide if necessary.

4. You may submit your complaint directly to the Department at any time to:

Patient Quality Care
Texas Department of State Health Services
MC 1979
P.O. Box 149347
Austin, Texas 78714
(1-800-832-9623)

5. Green Oaks Outpatient Services shall:

   a. Evaluate the grievance thoroughly and objectively obtaining additional information as needed.

   b. Provide a written response to the client within seven days of receiving the grievance;

   c. Take action to resolve all grievances promptly and fairly; and .

   d. Document all grievances, including the final disposition, and keep the documentation in a central file.

6. Green Oaks Outpatient Services shall not:

   a. Retaliate against clients who try to exercise their rights or file a grievance; or

   b. Restrict, discourage, or interfere with client communication with an attorney or with the Department for the purposes of filing a grievance.

If your concerns are unable to be resolved to your satisfaction, you may phone the Joint Commission complaint line: 1-800-994-6610

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PATIENT IDENTIFICATION

GRIEVANCE PROCEDURE
OUTPATIENT SERVICES

PINS

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.

2. You have the right to be treated with dignity and respect.

3. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).

4. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.

5. You have the right to be told about the program's rules and regulations before you are admitted, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusion.

6. You have the right to be told before admission:
   a. The condition to be treated
   b. The proposed treatment
   c. The risks, benefits and side effects of all proposed treatment
   d. The probable health and mental health consequences of refusing treatment and
   e. Other treatments that are available and which ones, if any, may be appropriate for you
   f. The expected length of stay.

7. You have the right to accept or refuse treatment after receiving this explanation.

8. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.

9. You have the right to meet with staff to review and update the plan on a regular basis.

10. You have the right to refuse to take part in research without affecting your regular care.

11. You have the right not to have information about you kept private and to be told about the times when the information can be released without your permission.

12. You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.

13. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.

14. You have the right to make a complaint and receive a fair response from the facility or practice within a reasonable amount of time.

15. You have the right to complain directly to the Texas Department of State Health Services at any time.

16. You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Department of State Health Services.

17. You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

18. You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others.

19. You have the right to be free from abuse, neglect, and exploitation.

20. You have the right not to receive unnecessary or excessive medication.

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PATIENT IDENTIFICATION

OUTPATIENT SERVICES
PATIENT BILL OF RIGHTS

PINS