LibertyDayton
REGIONAL MEDICAL CENTER

1353 N Travis St
Liberty, TX 77575
P: (936) 336-7316
F: (936) 336-2280

PATIENT INFORMATION

Name _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

County _____ SS# _____ Marital Status : M S D W

Sex _____ Race _____ Primary Language Spoken _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Responsible Party (if a minor) _____ Relationship_____ Phone _____

Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY

Emergency Contact _____ Relationship _____ Phone _____

****For your convenience, we now have a patient portal that will provide you with access to your record electronically. Having this electronic access through your personal, secured email will allow you to review your medical history with our facility. A current email address must be on file with our facility to access this portal. ****

Email: _____

INSURANCE INFORMATION

Primary Policy _____ Secondary Policy _____

Insured's Name _____ Insured's Name _____

Insured's Date of Birth _____ Insured's Date of Birth _____

Insured's SS# _____ Insured's SS #_____

Member ID/Group # _____ Member ID/Group # _____

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Medical History / Historial Médico

Please take the time to thoroughly complete this form. Por Favor Complete el Formulario.

Name/Nombre_____ Date of Birth/Fecha de Nacimiento_____

Referring Physician/Médico de Referencia _____ Physician Phone/Teléfono Médico _____

Date of Injury/Fecha de Herida _____ **Date of Surgery/Fecha de la Cirugía**_____

Have you been treated for this condition prior to today?/ ¿Ha sido tratado por esta condición antes de hoy? ____ Yes/Si ____ No

If so, what type of treatment(s) have you received?/ Si es así, ¿qué tipo de tratamientos has recicido? _____

Please list all medications you are currently taking/ Por favor liste los medicamentos: _____

_____

If more space needed, please use back of this form / Si se necesita más espacio, use la parte posterior de la forma

Are you allergic to latex? / ¿Eres alérgico al látex? □ Yes/Si □ No

Are you currently receiving any type of home health services? / ¿Está recibiendo servicios de salud en el hogar? □ Yes/Si □ No

Do you have a history of any of the following/ ¿Tienes un historial de lo siguente?:

□ Bone disorder/trastorno osteo	□ Back pain/Dolor de espalda	□ Neck pain/Dolor de cuello	□ Short of Breath/Falto de aliento
□ Hypertension/hipertension	□ Seizures/Convulsiones	□ Diabetes/Diabetes	□ Asthma/Asma
□ Heart problems/problemas del corazon	□ Dizziness/Mareo	□ Cancer/Cáncer	□ Headache/Delores de cabeza
□ Bladder problems/problemas de vejiga	□ Arthritis/Artritis	□ Pacemaker/Marcapasos	□ Anemia
□ Bowel problems/problemas instestinales	□ Stress/Estrés	□ Depression/Depresión	□ Parkinson's

Other/Otro _____

Are you pregnant or nursing a child? / ¿Estás embarazada o amamantando a un niño? □ YES/SI □ NO

Recent surgeries/ Cirugías recientes:_____

_____

Are you currently working?/ ¿Actualmente trabajando? □ YES/SI □ NO

□ Full time/tiempo completo □ Part time/Medio tiempo

□ Retired/Retirado □ Student/Estudiante

Occupation/Ocupación: _____

Hours/day worked/ Horas/día trabajadas: _____

Días/Semana: _____

Are you on activity restrictions? / ¿Estás en restricciones de actividad?

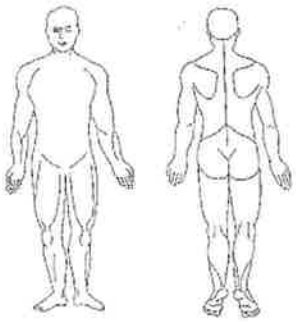
___ YES/SI ____ NO

If yes, please describe / En caso afirmativo, describa:

_____

_____

Draw on diagram where you are experiencing pain / Dibuja en el diagrama donde estás teniendo dolor



Rate your pain / Califica tu dolor:

0	1	2	3	4	5	6	7	8	9	10
NONE										WORST
NINGUNO										PEOR

I have completed the form to the best of my knowledge. I understand that providing false information can impact my care.

Cumplimenté el formulario a lo major de mi conocimiento. Entiendo que proporcionar información falsa puede afectar mi cuidado.

Patient Signature/Firma _____ Date/Fecha _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

KIRK COLE
INTERIM COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx .us

PATIENT NOTIFICATION OF DATA COLLECTION

PURSUANT TO: 84TH TEXAS LEGISLATIVE REGULAR SESSION, HB 764 SECTION- 108.0095. NOTIFICATION OF DATA COLLECTION which states: A provider shall provide to a patient whose data *is* being collected under this chapter written notice on a form prescribed by the department of the collection of the patient's data for health care purposes. The notice provided under this section must include the name of the agency or entity receiving the data and of an individual within the agency or entity whom the patient may contact regarding the collection of data. The department shall include the notice required under this section on an existing department form and make the form available on the department's internet website.

NAME OF FACILITY/PROVIDER LIBERTY DAYTON REGIONAL MEDICAL CENTER

This document shall provide notice to patients that the Texas Department of State Health Services, Texas Healthcare Information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is held to the highest standard and your information is not subject to public release. THCIC follows strict internal and external guidelines as outlined in Chapter 108 of the Texas Health and Safety Code and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For further information regarding the data being collected, please send all inquiries to:

Chris Aker
THCIC
Dept. of State Health Services
Center for Health Statistics, MC 1898
PO Box 149347
Austin, Texas 78714-9347

Location
Moreton Building, M-660
1100 West 49th Street
Austin, TX 78756
Phone: 512-776-7261 Fax:
512-776-7740
Email: thcichelp@dshs.state.tx.us

PATIENT SIGNATURE OF RECEIPT_____DATE_____

(Relation if not patient)_____

An Equal Opportunity Employer and Provider

Liberty Dayton Regional Medical Center
1353 N Travis
Liberty, TX 77575

HEALTH CARE CONSENT

1. I (we) consent to hospital services, emergency services, outpatient services, treatment and diagnostic procedures by the Liberty Dayton Regional Medical Center as ordered by my doctor and consultants selected by my doctor(s) which is fully described in paragraph 2 of the Conditions of Healthcare (the "Conditions of Health Care") listed below and on the back of this form.
2. The Conditions of Health Care listed below and on the back of this form control the type of care I will receive, release of medical records and other information with respect to AIDS or HIV testing, financial responsibility, consent to disposition of tissue, and other important matters.
3. _____ (Please Initial) If this paragraph is initialed by me, I agree to the following:

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT

I certify that the information given by me in applying for payment 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 and the Health Care Financing Administration and the intermediaries and carriers any information needed to pay this or a related Medicare claim. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by me or in the hospital. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

I further understand that Medicare does not pay for private room difference, unless properly certified as medical necessity, therefore, I will be financially responsible for such differences should I occupy a private room.

My signature acknowledges that I have been given the opportunity to satisfy myself by asking questions about this consent form and the Conditions of Health Care. This authorization is valid for 90 days from the date of discharge. A photocopy of the authorization shall be considered as effective and valid as the original.

Witness:_____ Signature_____

Date:_____Time_____ a.m. Patient; (parent or Legal Guardian):

p.m. ( ) Other (Specify in space below)

_____

(Minor patient and parent/guardian to sign)

( ) Assumption of Financial Responsibility: The undersigned hereby consents to and agrees to the Financial Agreement, Assignment of Benefits, and Health Care Service Plan, as stated in the Conditions of Healthcare, and agrees to pay all sums required to be paid thereunder for care of provided to the above named patient. (This paragraph to be checked and signed by anyone assuming financial responsibility for health care services provided to the patient other than the patient or his parent or legal guardian.)

_____ _____

Patient Name (PLEASE PRINT) Signature of Patient/Legally Authorized Representative

_____ _____

Address (Street or P.O. Box) (Relation if not patient)

_____

City, State, Zip Code

For Hospital Use Only

_____ _____

CONDITONS OF HEALTH CARE

1. CARE

The above named patient (herin sometimes referred to as the "patient") is under the care and supervision of the patient's attending doctor(s) and consultants selected by the patient's doctor(s). It is the responsibility of the hospital and its staff to carryout out the instructions of these doctors.

All doctors furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, emergency room physicians and others, are independent contractors for the patient and are not employees or agents, of the hospital and may bill directly for these services. The hospital does not render or provide physician services. All physician services are provided by private, independent doctors who practice at the hospital.

The hospital provides only general duty nursing care unless the patient's doctor(s) orders that the patient be provided more intensive nursing care. If the patient's condition requires the service of a special duty nurse or sitter, this service must be arranged by the patient or the patient's parent, legal guardian, or other authorized representative, since the hospital does not provide this special care. When protective rails are placed on the patient's bed and raised for patient protection or when protective restraints are ordered, the patient assumes all risks of injury or damage if the patient refuses to permit raised side rails or restraints.

I understand that among those who attend patients at this facility are medical, nursing and other health care personnel in training who, unless requested otherwise may be present during patient care as part of their education.

2. SERVICES AND/OR SURGICAL PROCEDURE CONSENT

The consent to hospital care includes permission for x-ray examinations, laboratory procedures, local anesthesia, HIV, or Acquired Immune Deficiency Syndrome ("AIDS") tests, injections, medication and hospital services rendered to the patient under the general and special instructions of the patient's doctor(s) for treatment for the medical conditions for which the patient has been admitted to the hospital. It is hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor beforehand. The hospital encourages you to discuss this with your doctor(s) the risks and benefits of any proposed procedure and the availability of alternative procedures and the relative risks and benefits of alternative procedures with those proposed.

The patient has the right to consent or refuse consent to surgery and other medical procedures. Except in emergencies or other unusual circumstances, the hospital does not all its facilities to be used without this discussion and the patient's consent. A special consent, separate from this, will be completed for all invasive/special procedures.

The patient understands that no warranty or guarantee has been made to the patient as to result or cure with respect to the patient's examination or treatment at the hospital.

3. RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, the hospital, and the patient's doctor(s) may disclose the patient's records, including HIV or AIDS information, to any person, the Social Security Administration, any insurance or benefit payer, any health care service plan, or any worker's compensation carrier which is, or may be liable for all or any portion of the hospital's or treating doctor's charges.

The hospital may obtain from any source and examine, discuss and disclose the patient's records, including medical history, examinations, diagnoses, treatment and HIV or AIDS information, to treating doctors, hospital personnel and agents, other health care providers, medical researchers, audit committees, care evaluators, and state and federal agencies.

Upon receiving an inquiry as to the presence or general condition of the patient, the hospital may (unless otherwise requested by the patient, next of kin or doctor) release the patient's name and address, age and sex, general nature of injuries, or the general condition of the patient.

If the patient is receiving care in an alcohol or drug abuse treatment program, special written authorization may be requested before releasing information.

4. PERSONAL VALUABLES

For your protection, you are encouraged not to bring personal valuables to the hospital. The hospital is not responsible for the loss of or damage to any money, jewelry, documents, garments, dentures, eye wear, prosthetic devices or other articles or personal property. The hospital maintains a safe for the protection of money and valuables.

_____(Initial)

5. FINANCIAL AGREEMENT

In consideration of the services to be rendered to the patient, the patient of any person signing this Health Care Consent as the parent or legal guardian of a patient and any other person signing the Assumption of Responsibility above authorizes credit investigation and individually obligates himself/herself to pay the patient's account in accordance with the regular rates and terms of the hospital, and, if the account is referred to an attorney or collection agency.

6. ASSIGNMENT OF BENEFITS

Each person signing this Health Care Consent assigns all rights, title, and interest and authorizes direct payment to the hospital of any insurance benefits payable under any insurance policy or policies paying benefits for health care services provided by the hospital to the patient and under the Social Security Act or any other insurance benefits otherwise payable to the patient for the hospitalization authorized hereunder at a rate not to exceed the hospitals regular charges. Payment to the hospital by an insurance company according to this authorization shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. The patient further authorizes payment directly to anesthesiologists, pathologists, radiologists, and other treating physicians rendering professional services. Each person signing this Health Care Consent as the patient or as the legal representative of the patient or under the Assumption of Financial Responsibility set out above is financially responsible for charges not collected by this assignment to the extent not prohibited by all applicable law, rules, and regulations for Medicare and Medicaid payments under the Social Security Act.

7. HEALTH CARE SERVICE PLANS

The hospital maintains a list of the health care service plans with which it has contracted. This list is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. Each person signing the Health Care Consent as patient or as parent or legal guardian of the patient or under the Assumption of Financial Responsibility set out above is individual obligate to pay the full cost of all services rendered to the patient by the hospital if the patient belongs to a plan which does not appear on the list or to the extent that the patient is responsible for hospital charges on any plan which does not appear on the list.

8. DISPOSTION

The patient consents to and the hospital may preserve tissue or other body parts of the patient for scientific purposes, for teaching purposed, for grafts, or it may otherwise dispose of tissue or other parts resulting from procedures in the hospital to the extent allowed by applicable law. In the event of fetal or ther death without proper disposition arrangement by or on behalf of the patient within twenty-four hours after death, the hospital is authorized to make disposition arrangement as allowed by law and hospital policies.

9. ABSENCE/TRANSPORTATION

If the patient's doctor authorizes temporary absence from the hospital or if the patient leaves the hospital against medical advice, the hospital is not responsible for the patient' welfare. Pass days are not covered by Medicare, Medicaid, and other insurance companies, and patient assumes all responsibility for payment of the days on which the patient is absent from the hospital. If the hospital assists in arranging private ambulance services, the responsibility of the hospital is limited to reservation assistance.

Liberty Dayton Regional Medical Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information,
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and. to provide you with a copy of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

_____
Patient's Printed Name

_____ _____
Signature of Patient/Legally Authorized Representative (Relation if not patient)

_____
Date

For Hospital Use Only

_____ _____
(Witness and date) (Witness and date)

Liberty Dayton Regional Medical Center
Your Rights As A Hospital Patient

It is a privilege to serve your medical care needs at Liberty-Dayton Regional Medical Center. It is our goal to assure that you are well informed, participate in the medical treatment decisions, receive fair and equal medical treatment, and communicate with the physicians and nursing staff. While you are a patient in the hospital, your rights include the following:

- **You have the right** to appropriate pain assessment and management.
- **You have the right** to considerate and respectful care from all hospital caregivers.
- **You have to right** to information about your illness, possible treatments, and likely outcomes. Additionally you have the right to discuss this information with your doctors and other caregivers.
- **You have the right** to consent or refuse medical treatment, as permitted by law. Other care opportunities will be discussed with you before making and informal final decision.
- **You have to right** to an advanced directive, such as a living will or health care proxy. These documents express your choice about your future care or name someone to decide if you cannot speak for yourself. If you have a written advanced directive, you should provide a copy to the hospital, your family, and your doctor.
- **You have the right** to privacy. The hospital, your physician and others caring for you will protect your privacy, as much as possible.
- **You have the right** to review your medical records and have the information explained, unless when restricted by law.
- **You have the right** to expect that the hospital will give you necessary health services to the best of its ability. Treatment referral or transfer may be recommended or requested. Risks, benefits, and alternatives will be discussed with you and your family.
- **You have the right** to know if this hospital has relationships with outside parties that may influence your treatment and care. These relationships may be with education institutions, and other care providers, and/or insures.
- **You have the right** to know about hospital rules that affect you and your treatment. You have the right to know about hospital resources, such as patient advocates of the ethics committee. This can help you resolve problems and questions about your stay.
- **You have the right** to express your concerns regarding the care and treatment that you have received at the hospital. The hospital's grievance process is handled through its Quality Management Department at 936-336-7316 ext 132. You also have the right to contact Health Facility Compliance Group (MC 1979) Texas Department of State Health Services P.O. Box 149347 Austin, TX 78714-9347; or by phone **888-973-0022**.
- **You have the right** receive treatment that is equitable, humane, and respectful to your individuality and dignity. No person is denied impartial access to professional care and treatment on the basis of race, sex, color, age disability, sexual orientation, financial status, or natural origin.
- **You have the right** to have conflicts regarding admission, treatment, and/or discharge resolved that arise between the hospital and neonate, child, adolescent, or geriatric patient and their family or guardian. Such conflicts shall be resolved by appropriate communication between patient, family member, attending physician, and other members of the healthcare team to include, but not necessarily limited to representatives of the nursing department, and administration. Unresolved conflicts can be referred to the Ethics Committee.
- **You have the right** to be free from restraints or confinement of any form that is not medically necessary or is used as a means of coercion, discipline, convenience or retaliation by staff.
- **You have the right** to expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. When the hospital releases records to others, such as insurers, it emphasizes that the records are confidential.
- **You have the right** to be told of realistic care alternatives when hospital care is no longer appropriate.
- **You have the right** to be free from all forms of abuse or harassment.
- **You have the right** to choose a person to be your healthcare representative and/or decision maker. You may also exercise your right to exclude any family members from participating in your healthcare decisions.
- **You have the right** to designate visitors, including but not limited to a spouse, a domestic partner (including same sex), family members, and friends. These visitors will not be restricted or otherwise denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity, gender expression, sexual orientation or disability. All visitors will enjoy full and equal visitation privileges consistent with any clinically necessary or other reasonable restriction or limitation that facilities may need to place on such rights. In addition, you have the right to refuse visitors.
- ***You have these responsibilities as a patient. You are responsible*** for providing information about your health; including past illnesses, hospital stays, and use of any current medication. ***You are responsible*** for asking questions related to your care and treatment.

You and our visitors are responsible for being considerate of the needs of other patients, staff, and the hospital property. You are responsible for providing the hospital with your insurance information and for making payment arrangements when required. Your health depends on the decisions you make in your daily life, not on just your hospital care. The staff members and physicians strive to serve and accommodate your health needs in relation to your hospital stay. If you have any questions or comments regarding your rights, please discuss them with a LDRMC healthcare provider.

The Liberty Dayton Regional Medical Center has zero tolerance for verbal or physical intimidation of staff. Such threatening behavior will result in a formal warning or immediate notification of law enforcement and termination of any non-emergency patient care from this facility.

_____ _____

Patient signature Date

_____ (Relation if not patient)

LIBERTY DATYON REGIONAL MEDICAL CENTER

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

PATIENT NAME_____

BIRTHDATE:_____SOCIAL SECURITY_____

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool routing healthcare operations such as assessing care quality and reviewing the competence of health care professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

LIMITED HEALTH CARE INFORMATION

Sharing of Information with Providers: You agree that Liberty Dayton Regional Medical Center's staff and those who care for you will be able to access and share your health information with any physician or hospital that has treated you through CommonWell.

No Health Information Restrictions_____ (please initial)

Partial Restrictions

** Directory Information may be released to: _____

_____

**Health Care Information may be released, but only to: _____

_____

Complete Restrictions

_____(please initial) I do not authorize the disclosure or Directory Information or Healthcare Information to anyone. I understand that this instruction means that any telephone calls, flower/gifts, and visitors will be refused, and that information will not be provided to any family members, clergy, or other third parties.

_____ _____

Signature of Patient/Legally Authorized Representative Date

_____

(Relation if not patient)

*"Health Care Information" means information recorded in any form or medium that identifies that patient and relates to the history, diagnosis, treatment, or prognosis of the patient. It includes your medical record and any communicable disease information such as hepatitis and AIDS/HIV test results that may be reflected in the record.

**"Directory of Information" means (a) the fact that the patient is receiving hospital services, (b) nature of injury, (c) age, sex, and city of residence, (d) general health status (for example: "good," "fair," or "serious.") The only exception is if this information is otherwise protected by state or federal law (for example: HIV status, substance abuse diagnosis/treatment, or mental health information

For Hospital Use only

_____ _____

(Witness and date) (Witness and date)

LIBERTY DAYTON REGIONAL MEDICAL CENTER

PATIENT ACKNOWLEDGEMENT INFORMATION

Section 1

Please read the following statements (place your initials after each statement):

1. I have the right to accept or refuse any medical treatment. _____
2. I have the right to formulate an advanced directive. _____
3. I have received the copy and understand the patient rights form. _____
4. I choose/have chosen to be a participant in Organ Donation. Yes or No
5. I give consent for my photo to be used for identification purposes. Yes or No

---

Section 2

1. I have executed an advance directive _____
   _____Copy
   _____If no, instruct patient to bring or check with medical records for a copy.

2. I have not executed an advance directive _____

Signature_____ Date _____

Witness _____ Date _____

Section 3 (if applicable)

For Hospital Use Only:

The patient is not able to understand and sign above. A patient representative is not present.

Employee Signature _____ Date _____

Witness_____ Date _____

Section 4 (if applicable)
To the Nurse:

If the patient or patient representative has not signed section 2 above, please assure that it is signed as soon as the patient is able to understand/sign or the patient representative is present and can sign.

Check for completion:

_____ Nurse flag chart to obtain signature.

_____ Signature of patient or patient representative obtained.