SIGN-IN SHEET

Thank you for choosing our emergency center at this critical time for you.
Please complete the information below. All information is confidential.

Last Name__________________________________ First Name__________________ Date________________

Birth Date________________ **Social Security #** _________________________ Gender: ( ) Male ( ) Female

Address___________________________Apt#________City____________ State________ Zip Code_______________

Home Phone_____________________ Work Phone ______________________Cell Phone____________________

Email Address____

Emergency Contact________________________________ Relation _______________ Phone________________

Primary Physician____ Phone________________

Ethic Background (circle one) Hispanic/Latino Asian Black White Other _______________

WHAT IS THE NATURE OF YOUR EMERGENCY OR SYMPTOMS?

Insurance Information

Primary Insurance____

ID Number___________________________ Group Number___________________________________

Subscriber's Name ___________________________________ Subscriber's DOB_____________________

Relationship to Patient______________________ Employer____________________________________

Is this an auto accident Injury?	YES	NO
Insurance Company_________Claim Number____________________		
Is this a Work Related Injury?	YES	NO

____ _____________________________

Signature Date

This Village Emergency Centers location is a free-standing emergency room. Texas insurance law provides that all fully-funded insurance plans should pay all emergency claims at "in-network" rates. At the time of your visit, the emergency room co-pay will be collected and your insurance carrier will be billed for your policy's emergency room benefits.

PLEASE ANSWER ALL THE QUESTIONS AS BEST YOU COULD.

1. Have you been here before? Yes ☐ No ☐

2. How did you find us? ZIP CODE_______

Sports Physical ☐

Yelp ☐

Received a Flyer or Mailer ☐

Facebook ☐

Google Search ☐

Referral (Recommended) ☐

Driving by ☐

Community event, which one?________________

Other? (Specify) ____________________________

Thank you for Choosing Village Emergency Centers!

VILLAGE EMERGENCY CENTERS

CONDITION OF SERVICES

1. **Patient initials:___PHYSICIANS ARE NOT EMPLOYEES OR AGENTS OF THE CENTER**. All physician, surgeons, and various allied healthcare professionals furnishing services to the patient, including but not limited to all physicians and other independent practitioners who are consulted or otherwise participate in the care of the patient, are independent contractors with the patient and not employees or agents of the center. The patient is under the care and supervision of his/her attending physicians and it is the responsibility of the center and its nursing staff to carry out the instructions of all physicians. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or center services rendered for the patient under the general and special instructions of the physician.
2. Patient Initials ____FINANCIAL OBLIGATIONS: Notwithstanding paragraph 1, I agree to promptly pay all center bills in accordance with the regular rates and terms of Village Emergency Centers. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law. I understand the center may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt.
3. Patient Initials_____ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO THE CENTER: I assign and herby authorize direct payment to the center of all insurance and plan benefits payable for services rendered. I authorize the center and/or center-based physicians to appeal any denial under my appeal rights provision. I agree that the insurance company's or health plan's payment to the center pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to the assignment.
4. Patient initials____MEDICARE PAITIENT'S RELEASE OF INFORMATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance. Medicare patients may sign a release and be treated as self-pay patients.
5. Patient Initials___RELEASE OF INFORMATION: I hereby authorize Village Emergency Centers to release any information necessary to insurance carriers regarding my illness and treatments; process insurance claims generated in the course of examination or treatment; allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. I also authorize a release to my physician and I will notify the facility.
6. Patient Initials___ACCIDENTAL EXPOSURE OF HEALTHCARE WORKERS: I understand that state law proves and I agree, that if any healthcare worker is exposed to my blood or other bodily fluids to allow Village Emergency Centers to perform tests on my blood or other bodily fluids to determine the presence of any communicable diseases. I understand that the results of tests taken under these circumstances do not become part of my medical record.

7. FINANCIAL RESPONSIBILTY AGREEMENT BY PERSON *OTHER THEN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE*: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (Paragraph 2) and Assignment of Insurance or Health Plan Benefits (Paragraph

Date	Time	Financially Responsible Party	Witness

VILLAGE EMERGENCY CENTERS

CONSENT TO TREATMENT

Consent to Treatment

I understand that an independently contracted physician at my request will order all tests and treatment at Village Emergency Centers. I understand that medicine and surgery are not an exact science and that there is no guarantee that the outcome of my treatment will be what I want it to be. Knowing this and agreeing to this, I request to be a patient at Village Emergency Centers. I consent to all necessary testing and treatment while I am a patient at Village Emergency Centers. I authorize Village Emergency Centers to retain and dispose of any specimen or tissue taken from the below named patient.

Consent to Photograph

I permit the center to photograph as a part of the documentation of my/the patient's medical/surgical condition. These photographs will be maintained as part of my/the patient's permanent medical record. I understand and acknowledge that the center is permitted to use cameras to monitor all patients.

Nursing Care I understand and acknowledge that this center will provide nursing care to meet my/the patient's needs in accordance with accepted standards of nursing practices. I understand and acknowledge that the center may use cameras or other devices for patient monitoring.

AUTHORIZATION FOR DISCLOSURE OF COVID-19 TEST RESULTSI hereby voluntarily authorize the disclosure of my COVID-19 test results, provided by Village Emergency Centers, to:

Me via email even though email is not a completely secure means of communication.

- Me via SMS , even though SMS is not a completely secure means of communication.

I confirm that I have read and/or verbalized, understand, and accept the terms of this document, and am the patient,
patient's legal representative, or duly authorized by the patient as the patient's general agent to execute the above and accept its terms. The undersigned certifies that I have read the foregoing, and I am the patient, the patient's legal representative, or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date ________________ Patient/Patient's Authorized Signature ________________

If other than patient, indicate relationship ________________ Witness ________________

PATIENT RIGHTS AND RESPONSIBILTIES

This is a guide to help you understand how Village Emergency Centers care for patients and how you can assist in your own recovery. Our staff will strive to provide you with excellent medical and nursing care, to be considerate of your wishes, to respect your privacy and preserve your dignity. We work to ensure your independence in making health care decisions and encourage you to express your views and concerns openly with your doctor and other healthcare professionals. At Village Emergency Center, we consider you a partner in your own health care and hope you will take an active role in your treatment and recovery. The following information will explain the hospital's policy on patient rights and responsibilities.

PATIENT RIGHTS

EVERY PATIENT ADMITTED TO OR TREATED AT VILLAGE EMERGENCY CENTERS, TO INCLUDE THE PATIENT'S LEGAL REPRESENTATIVE OR PATIENT/GUARDIAN OF MINORS, SHALL HAVE THE FOLLOWING RIGHTS:

1. The right of the patient to considerate and respectful care.
   - (a) The care of the patient includes consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness. To receive appropriate control of pain and interventions to promote comfort, understanding pain management as an important part of care;
   - (b) To receive care in a safe setting;
   - (c) To be free from all forms of abuse or harassment;
   - (d) To the confidentiality of his/her clinical records;
   - (e) To have a family member or representative of his/her *own* choice and his/her own physician notified promptly of his/her admission to the hospital;
   - (f) (*For acute medical or surgical care*) To be free from restraints, of any form, that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

2. The right of the patient, in collaboration with his/her physician, to make decisions involving his/her health care including:
   - (a) The right of the patient to accept medical care or to refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. (b) The right of the patient to formulate advance directives and appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law.
   - (c) In formulating an advance directive, a hospital shall have in place a mechanism to ascertain the existence of and assist in of advance directives at the time of the patient's admission.
   - (d) The provision of care shall not be conditioned on the existence of an advance directive.
   - (e) An advance directive(s) shall be in the patient's medical record and shall be reviewed periodically with the patient or surrogate maker.
   - (f) The right of the patient to the information necessary to enable him/her to make treatment decisions that reflect his/her wishes; a policy on informed decision making shall be developed by the medical staff and governing body and shall be consistent with any legal requirements.
   - (g) The right of the patient to receive, at the time of admission, information about the hospital's patient rights policy(ies) and the mechanism for the initiation, review, and when possible, resolution of patient complaints concerning the quality of care.
   - (h) The right of the patient or the patient's designated representative to participate in the consideration of ethical issues that patients and to provide education to caregivers and patients on ethical issues in health care.
   - (i) The right of the patient to be informed of any human experimentation or other research or educational projects affecting his/her cares to treatment. (j) The right of the patient, within the limits of law, to personal privacy and confidentiality of information. (k) The right of the patient and/or the patient's legally designated representative access to the information contained in the patient's medical records, within a reasonable time frame.
   - (l) The right of the patient's guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient:
     - (1) Has been adjudicated incompetent in accordance with the law.
     - (2) Is found by his/her physician to be medically incapable of understanding the proposed treatment or procedure.
     - (3) Is unable to communicate his/her wishes regarding treatment.
     - (4) Is a minor.

YOUR RESPOSIBILITIES

You have responsibilities as a patient. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medication. You are responsible for asking questions when you do not understand information or instructions. If you feel you can not follow through with your treatment, you are responsible for telling your doctor. Village Emergency Centers work to provide care efficiently and fairly to all patients and the community. You and your visitors are responsible for being considerate of the needs of the patients, staff and the hospital. You are responsible for providing information for insurance and for working with Village Emergency Centers to arrange payment when needed. Your health depends not just on your care but, in the long term, on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal health.

Patient or Legal Guardian Signature ______________________ Date ______ Witness ______________________ Date ______

I understand that I may follow the Center's procedure for voicing a complaint or grievance. I may voice my complaint directly to any staff member. I may voice my grievance to the manager/director of the area in which I am located. Notwithstanding the Center's policy and procedure, I may also submit my grievance to:

Texas Department of Health 1100 W. 49