Endoscopy Center

MEDICATION RECONCILIATION

( ) Copy to Patient

ALLERGIES: ☐ No Known Drug Allergies

(Please include reactions with allergy)

REVEIWED BY RN DATE/TIME	MEDICATION, DOSAGE and FREQUENCY	LAST DOSE	START AFTER THIS VISIT	STOP	RESUME
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

RN SIGNATURE:_____DATE:_____

PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT. PLEASE INCLUDE ANY OVER THE COUNTER OR HERBAL MEDICATIONS. PLEASE DO NOT WRITE IN SHADED AREA.

MEDICARE SECONDARY PAYER QUESTIONNAIRE (MSPQ)

Question	Additional Information (if applicable)
1. Are YOU currently employed? (**Check one**) ☐No – Currently not employed ☐No – Never employed ☐No – Retired (*Enter retirement date) ☐Yes – Currently employed (*Enter employer info)	*Retirement Date: / / *Employer Name: *Employer Phone: *Employer Address (Street): *(City): *(State): *(Zip): -
1a Do you have Group Health Plan based on YOUR own current employment? ☐No / ☐ Yes (*Enter additional info)	*Group Health Plan Name: * If over age 65, does the employer sponsoring this Group Health Plan employ 20 or more employees? **or…** * If under age 65, does the employer sponsoring this Group Health Plan employ 100 or more employees?
2. Is your SPOUSE currently employed? (**Check one**) ☐No – Currently not employed or no spouse ☐No – Never Employed ☐No – Retired (*Enter retirement date) ☐Yes – Currently employed (*Enter Employer Info)	*Retirement Date: / / *Employer Name: *Employer Phone: - - *Employer Address (Street): *(City): *(State): *(Zip): -
2a Do you have Group Health Plan coverage based on your SPOUSES current employment? ☐No / ☐ Yes (*Enter additional info)	*Group Health Plan Name: * If over age 65, does the employer sponsoring this Group Health Plan employ 20 or more employees? **or…** * If under age 65, does the employer sponsoring this GROUP HEALTH PLAN employ 100 or more employees?
3. Is this visit associated with a work injury/illness? ☐No / ☐ Yes (*Enter additional info)	*Date of Injury/Illness: / /
4. Is this visit associated with a non-work related accident? ☐No / ☐Yes (*Enter additional info)	*Date of Injury/Illness: / / *Is "**No-Fault**" insurance available? *Is "**Liability**" insurance available?
5. Are you receiving Black Lung Benefits? ☐No / ☐Yes (*Enter date benefits began)	*Date Benefits Began: / /
6. Are the services to be paid by a Government Program, such as a Research Grant? ☐No / ☐Yes	
7. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? ☐No / ☐ Yes	

MEDICARE SECONDARY PAYER QUESTIONNAIRE (MSPQ) – *Continued*

Question	Additional Information (if applicable)
8. Are you eligible for Medicare because of a Disability? ☐No / ☐ Yes	
9. Are you eligible for Medicare because of End Stage Renal Disease (ESRD)? ☐No / ☐ Yes (*Enter additional info)	*** Have you received a kidney transplant?** **If Yes, enter date of transplant: / /** ***Have you received maintenance dialysis treatments?** **If Yes, enter date dialysis began: / /** **Do you participate in a self-dialysis training program?** **If Yes, enter date training started: / /** *** Are you within the 30-month coordination period?** *** Was your initial entitlement to Medicare based on ESRD?** *** Are you entitled to Medicare on the basis of either of the following?** **ESRD and Age: or ESRD and Disability:** ***Does the working aged or disability MSPQ provision apply? (i.e. is the Group Health Plan already primary based on age or disability entitlement)?**
10. Have you been an inpatient in a hospital or Skilled Nursing Facility in the last 60 days? ☐No / ☐ Yes (*Enter additional info)	*** Enter facility name:** *** Enter dates of stay: From : / /** **To: / /** *** Length of stay (# days):**

Information provided by (name): _____

Relationship: This person is the _____to the patient.

16D Consent

St. Vincent

Patient Sticker

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING

CONSENT AND CONDITIONS OF ADMISSION

I request and authorize _____, its agents and employees ("Hospital") and my physicians, their associates and assistants ("Physicians") who may attend to me during hospitalization, emergency service, or outpatient visit to provide and perform such medical and surgical care, tests, procedures, drugs and other services and supplies as are considered advisable by my Physician for my health and well being. I understand this may include, but is not necessarily limited to anesthesia, pathology, radiology services and other special services and tests, including tests for communicable diseases, ordered by my Physician.

CONSENT FOR BODY FLUID-BORNE INFECTIOUS DISEASE TESTING

I authorize the Hospital to test for body fluid-borne infectious diseases including, but not limited to, hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV") if a Physician orders such test(s) or if ordered by protocol. The results of these tests will become part of my confidential medical record and reported to my provider, and other providers as permitted or required by law. I understand I have the right to refuse testing and failure to consent to these test will not result in denial of admission to the Hospital.

☐ YES. I authorize the Hospital to conduct body fluid-borne infectious disease testing and have been offered written information regarding testing that may be conducted.

☐ NO. I do not authorize the Hospital to conduct body fluid-borne infectious disease testing.

SEARCH OF ITEMS BROUGHT ONTO HOSPITAL PREMISES AND PERSONAL VALUABLES

In order to maintain the safety of its premises, Hospital reserves the right to search all items brought onto its premises including purses, wallets and other personal effects. If Hospital determines, within its sole discretion, that an item poses a potential safety threat, Hospital will: (1) dispose of the item; (2) place the item in Hospital's safe until the time of discharge; or (3) turn over the item to law enforcement. If you do not wish for your belongings to be searched and possibly removed from your possession, please refrain from bringing such items onto Hospital premises or send such items home with a friend or relative.
The Hospital will not be liable for any personal articles that are lost, stolen or damaged. The Hospital encourages patients to send personal items and valuables home with a relative or friend. If this is impossible, the Hospital will place valuables in the Hospital's safe upon request.

TOBACCO CESSATION

Smoking has been identified as the No. 1 cause of preventable disease. Smoking accounts for one out of every five deaths in the United States. If you are currently smoking or using tobacco please discuss with your physician the best way for you to quit. For more information about tobacco cessation programs in your area or to ask about St. Vincent Bridges telephone counseling program, call the St. Vincent CARE Line at 317-338-2273 or 1-888-338-2273. You may also call the State of Indiana's quit line at 1-800-QUIT NOW.

RELEASE OF INFORMATION

If admitted, unless you tell the Hospital otherwise, the Hospital will list in the patient directory your name, location in the Hospital, and your general condition (good, fair, etc.) to anyone who asks for you by your name. Your religious affiliation may be disclosed to members of the clergy only. (See Notice of Privacy Practices for more information on disclosures and uses of your protected health information).

☐ NO. The Hospital may not release the foregoing information to those requesting it.
Note: A choice of "No" means the Hospital information desk will not acknowledge your presence as a patient, without exception, to anyone wishing to visit or call.

PHOTOGRAPHY/VIDEO/RECORDINGS

I acknowledge the use of video monitoring throughout the facility and that video monitoring images may be recorded for security purposes. I understand that if I object to the production of such recordings created for security purposes, I may discuss my objections and concerns with facility personnel and, as appropriate, may request discharge or transfer to another facility. I further acknowledge Hospital may take moving pictures, television images, or other pictures or videotapes during the procedure(s). I understand that these images will be used for internal purposes only (i.e., education or performance improvement) unless I consent in writing to another use.

YOUR RIGHTS AND OTHER ACKNOWLEDGEMENTS

- ☐ YES ☐ NO I have been offered and/or received a written copy of my patient rights and responsibilities.
- ☐ YES ☐ NO Any email address I provide is my personal email and authorize the Hospital or its agents to contact me via that email address.
- ☐ YES ☐ NO I understand that the Hospital will provide interpretation services at no cost to me in my preferred language of communication.
- ☐ YES ☐ NO I have received and/or been offered a copy of the Hospital's Notice of Privacy Practices.
- In the event I am admitted to the Hospital, information regarding advance directives will be provided to me.
  (Medicare Patients Only) In the event I am admitted to the Hospital, I will be provided with a copy of the "Important Message From Medicare."

16D Consent

St. Vincent

Patient Sticker

ASSIGNMENT OF PAYMENT / ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY / RELEASE OF INFORMATION

I hereby assign any payment otherwise payable to me from Medicare, Medicaid, insurance carriers, employee health benefit plans and/or other third-party payers (collectively referred to as "Plans") to Hospital and other health care providers who provide services, care or treatment to me at Hospital.

I acknowledge that I am responsible for knowing the limitations of my Plan benefits and agree to be personally responsible for paying the charges billed for services, care or treatment that my Plan deems to be: (i) not a covered benefit; or (ii) in excess of the Plan's benefit limitation.

I authorize Hospital and my treating health care providers to release a copy of my medical records and to release any other information necessary for them to obtain the assigned payment from any Plan(s) under which I am eligible to receive covered benefits and/or any settlement(s) or award of damages arising from an incident that caused the injuries for which I am receiving treatment.

I acknowledge that a health care provider who does not contract with my Plan or participate in my Plan's network (an "Out of Network Provider") may be called upon to render items or services during the course of my treatment, or I may receive a referral to obtain items and services from an Out of Network Provider. I understand that my Plan may apply different coverage and payment limitations to items and services rendered by Out of Network Providers, and that I may contact my Plan for assistance, including identification of health care providers currently in my Plan's network, prior to obtaining such items and services.

Hospital will make a reasonable effort to verify my Plan's coverage for the services, care and treatment I am expected to receive at Hospital and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and treatment provided to me by Hospital and its health care providers, I am responsible for paying the billed charges for such items, consistent with any applicable, written, contractual discounts and Hospital's patient financial assistance policies.

I agree to promptly pay, when requested by Hospital, the difference between Hospital's billed charges for the services, care and treatment I received and the amount covered by my Plan benefits, other than those amounts excluded by a written contractual agreement and/or Hospital's patient financial assistance policies. Upon request, an authorized patient representative will be made available to explain eligibility for financial assistance under such policies.

If Hospital refers my account for collection, I will be responsible for paying the cost of collection, including reasonable attorney fees, expenses and interest as allowed by Indiana law. I authorize Hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone, which could result in charges to me, and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication to discuss any past, future or current services, including the collection of any past due amounts. I acknowledge that it is my responsibility to present any questions I may have regarding charges for services provided to me by the Hospital within 60 days of receiving my first bill for such services and/or procedures.

INDEPENDENT PHYSICIANS AND OTHER PROVIDERS

READ CAREFULLY:

I recognize that many of the physicians who provide services to me at Hospital are independent contractors and are not agents or employees of the Hospital. This includes but is not limited to: emergency department physicians and physician assistants, the anesthesiologists, the radiologists, the pathologists, and the physicians who are on-call to the emergency department to render specialty services. I understand and agree that each of the above referenced physicians is not subject to the control and supervision of the Hospital. Should I have any questions regarding the relationship between the physician providing services to me and the Hospital, I have the right to ask further questions.

I have read and understand this paragraph Initials_____

The undersigned certifies that he/she has read and understands both page 1 and page 2 of this consent form.

_____ _____

[Date/Time signed] [Signature of Patient or Patient's legal representative if Patient unable to sign]

Relationship to Patient if Patient unable to sign: _____

If signed by person other than the Patient, please check the appropriate box indicating why the Patient cannot give own consent:

☐ Patient's Age (Minor) ☐ Medical Condition

_____ _____

[Date/Time signed] [Signature of witness]

_____ _____

[Date/Time signed] [Signature of second witness]

CARMEL AMBULATORY SURGERY CENTER
ENDOSCOPY CENTER

Registration Information

Patient Sticker

PATIENT EMAIL: _____
REQUIRED BY INDIANA STATE DEPT OF HEALTH

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER: _____
PHONE: ( ) _____

EMERGENCY CONTACT #2: _____
REQUIRED FOR ALL PATIENTS UNDER 18 YEARS OF AGE

RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER: _____
PHONE: ( ) _____

INSURANCE INFORMATION

NAME OF PERSON CARRYING INSURANCE (POLICY HOLDER): _____
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER: _____
POLICYHOLDER'S DATE OF BIRTH: ____/____/____
POLICY HOLDER'S EMPLOYER: _____
EMPLOYER ADDRESS: _____
(STREET ADDRESS) (CITY) (STATE)

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ NO ☐ YES: DATE OF INJURY: ____/____/____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been verbally informed and have the right to receive a paper copy of the Carmel Ambulatory Surgery Center and Endoscopy Center Notice of Privacy Practices, Patient Right and Responsibilities, Advance Directives and Physician Ownership information prior to the procedure. You may request that we give you a copy of this information at any time. Even if you have agreed to receive this information, electronically, you are still entitled to receive a paper copy.

I acknowledge on this date, I received and/or was offered a copy of the Carmel Ambulatory Surgery Center and Endoscopy Center Notice of Privacy Practices which describes the uses and disclosures of my protected health information that may be made by Carmel Ambulatory Surgery Center, and my rights and Carmel Ambulatory Surgery Center and Endoscopy Center legal duties with respect to my protected health information.

ADVANCE DIRECTIVES

"Advance Directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. Examples include, but are not limited to, living will declaration, power of attorney and health care representative.

MARK ONLY ONE:

☐ I do not have an Advance Directive. ☐ I do have an Advance Directive

_____ _____
PATIENT/PATIENT REPRESENTATIVE DATE SIGNED