WINDHAVEN
SURGERY CENTER

6160 Windhaven Pkwy. Suite 220
Plano, TX 75093
Phone # 972-212-7463

STATE REQUIRED ETHNICITY AND RACE QUESTIONNAIRE BACKGROUND INFORMATION

Texas law requires the department of State Health Services to collect information on the race and ethnic backgrounds of hospital, ambulatory surgery center, and freestanding emergency medical care facility patients. The rules states "In order to obtain this data, the facility staff retrieves the patient's response from or asks the patient, or the person speaking for the patient to classify the patient. If the patient, or person speaking for the patient, declines to answer, the facility staff is to use its best judgment to make the correct classification based on available date".

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.

If patients fail to identify their own race and ethnic backgrounds, hospital staff will use its best judgment in making the identification.

Question #1: **Ethnic Background**
(Mark the box that the patient believes most accurately identifies his/her ethnic background)

Is the patient…?

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Question #2: **Race**
(Mark the box that the patient believes most accurately identifies his/her race)

Is the patient…?

☐ (1) American Indian/Eskimo/Aleut (10025)

☐ (2) Asian or Pacific Islander (20289)

☐ (3) Black (20545)

☐ (4) White (21063)

☐ (5) other includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category

PAYMENT WAIVER

By signing below, I (print name) _____ acknowledge and agree if my insurance carrier sends me a check payment for services that were rendered by one or more of our rendering providers and or facility, I will immediately endorse the check to the rendering provider and mail the check payment to:

6160 Windhaven Pkwy. Suite 210
Plano, TX 75093

Or bring the check personally directly to our office at the address above

Please see provider list below:

Neurospine Surgical Consultants
Advanced Musculoskeletal Institute
Advanced Institute for Joint and Spine Disorders
Windhaven Ambulatory Surgery Center
Medical Providers International
Windhaven Medical Imaging
CS Surgical

Thank you for your cooperation in this matter.

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

WINDHAVEN
SURGERY CENTER

COVID-19 EXPOSURE SCREENING

Patient name: _____ **Date:** _____

Signature: _____

STAFF INITIALS	_____
TIME:	_____
DATE:	_____
TEMP:	_____

Please circle the physician caring for you today:

Luis A. Mignucci, MD **Dr. Lee Brock, MD**

Dr. Omar Colon, MD **Dr. Jeffrey Buch, MD**

	YES	NO
In the past 24hrs have you had temperature of 100F or more?		
In the past 24hrs have been coughing or had a cold?		
In the past 24hrs have been shortness of breath or had difficulty breathing?		
Have you lost your sense of smell/taste?		
Are you experiencing flu-like symptoms (shills, fatigue, body aches)		
In the last 14 days have you been tested for COVID-19? - What was the result? _____ And when was it? _____		
In the last 14 days have you been in contact with someone with symptoms or under investigation for COVID-19, or are ill with respiratory illness?		
Have you been tested for COVID-19 antibody? - If yes, please write the date of the last test _____ and its result._____		
Have you received the COVID-19 Vaccine?		

If you are planning on receiving the COVID-19, we strongly suggest to be vaccinated 3 days after the surgery/procedure. But not within three days after procedure/surgery

_____ _____ _____

Print name of Person reviewing **Signature** **Date**

WINDHAVEN
SURGERY CENTER

Windhaven Surgery Center COVID-19 Risk Informed Consent

I, _____ understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19 has been declared a worldwide pandemic by the World Health Organization. I further understand the COVID-19 is extremely contagious and is believed to spread by person-to-person contact; as a result, federal and state health agencies recommend social distancing. I recognize that all the healthcare staff at Windhaven Surgery Center are closely monitoring this situation and have put in place reasonable preventive measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my informed consent for the performing physician, anesthesia, and all the healthcare staff at Windhaven Surgery Center precede in my care.

I understand that even if I have been tested for COVID and received a negative test result; the tests in some cases may fail to detect the virus or may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure and/or surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVIID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND CONSENT TO THE PROCEDURE.

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

WINDHAVEN
SURGERY CENTER

HIPPA PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or on untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your expressed authorization. You may revoke your permission to release confidential healthcare information at any time.
- You may restrict the disclosure of your protected health information for any services provided whereby you or somebody else pays “out of pocket”, in full, for the services.
- You may be contacted by the organization to remind you of any appointments.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization’s operations. It is your express right to opt out of any fund-raising communications.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any or all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.

You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:

Windhaven Surgery Center
6160 Windhaven Pkwy. Suite 220
Plano, Texas 75093
972-212-7463

All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
For further information about this Privacy Notice, please contact:

Loendry Colegial Sidhu, Adm.

This notice is effective as of 9/23/2013. This date must not be earlier than the date on which the notice is printed or published.

PATIENT HIPPA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of practice 's HIPAA Privacy Note

By subscribing my name below, I acknowledge that WINDHAVEN SURGERY CENTER. LLC has provided a copy of the HIPPA privacy notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

_____ _____ _____

Name of Patient **Signature** **Date**

II. Designation of Certain Relatives, Close friends, and other caregivers as my Personal Representative.

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the physician's practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Password or Last 4 digits of his/her SSN: _____

Print Name: _____ Password or Last 4 digits of his/her SSN: _____

Print Name: _____ Password or Last 4 digits of his/her SSN: _____

I, _____, acting on behalf of my minor son/daughter: _____,
Parent/guardian (Print) Name of Patient

As a legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of the courthouse documents must be provided and kept in medical records.

III. Request to Receive Confidential Communication by Alternative Means.

As provided by *Privacy Rule Section 164.522(b)*, I hereby request that the Practice make all communications to me the alternative means that I have listed below.

Home/Cellphone number:_____
_____Ok to leave a message with detailed information.
_____Leave message with call back number.

Work Telephone number:_____
_____Ok to leave a message with detailed information.
_____Leave message with call back number.

Written communication Address:_____
_____Ok to mail to the address listed above.
_____E-mail me to: _____

Fax communication:_____
_____Ok to fax to the number listed above

Other: _____

Patient's Name (Print) _____ Patient's Signature: _____

Witness: _____ Date: _____

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OWNERSHIP STATEMENT

Windhaven Surgery Center is partially Physician Owned. The following is a list of ownership interests:

Luis. A. Mignucci, M.D.
6160 Windhaven Parkway Suite 200
Plano, Texas 75093

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

Updated 01/2023

PATIENT'S RIGHTS AND RESPONSABILITIES

The office of Windhaven Surgery Center presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Our facility also has a responsibility to the patient. It is in recognition of these factors that rights are affirmed.

The patient has the right:

1. To respectful treatment with concern for individual, cultural or educational difference
2. To complete, up-to-date information about the condition, treatment and outlook for recovery.
3. To know who is responsible for the care provided.
4. To personal privacy and confidentiality in communication and medical records.
5. To an explanation of the various types of care to be received.
6. To refuse treatment, except in some cases where lifesaving treatment is mandated.
7. To know of any affiliations your hospital and physician(s) have with other institutions and physicians.
8. To change their provider if other qualified providers are available.
9. Your designated representative or patient surrogate has the right to participate in the consideration of ethical issues that arise during your care.
10. You or a designated representative or patient surrogate will be fully informed on the services and provisions for after-hours and emergency care available at the surgery center.

The patient has the responsibility:

1. To provide accurate and complete information about present complaints, past illnesses, hospitalization, medications and other health related matters.
2. To report any unexpected change in condition to the responsible physician.
3. To say whether a contemplated course of treatment and the patient's obligation in its administration are u understood.
4. To follow the treatment plan recommended by the physician. The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels are necessary.
5. To keep appointments or notify the appropriate person if it is not possible to do so.
6. To accept the consequences of choosing to ignore physician instructions or to refuse treatment.
7. To see that the financial obligations assumed in receiving health care are met as promptly as possible.
8. To inform the provider about any living will, medical power of attorney, or other directive that could affect his/her care.
9. Be Respectful of all health care providers and staff, as well as other patients.

Patient Complaints:

If you are dissatisfied with any service you have received, please ask to speak to the administrator. No catalog of rights can guarantee for the patient the kind of treatment he as the right to expect. Within this facility, all activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Grievance Policy Statement:

Every patient has the right to file a grievance with the facility's Director of Nurses. A response to a complaint will be answered in writing within 30 days of filing. If the patient is not satisfied, the process is given to the Medical Director. The patient also has the right to file a complaint with the:

Texas Department of Health
Health Facility Licensing and
Compliance Division
1100 West 49th Street.
Austin, Texas 78756
1-888-973-0022

Center for Medicare Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
1-800-Medicare

AAAHC
5250 Old Orchard Road
Suite 200
Skokie, II 6007
847-853-6060

http://www.cms.gov/center/ombudsman.asp

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

Updated 01/20

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POLICY STATEMENT REGARDING PATIENT RIGHT TO SELF-DETERMINATION

(Texas Health and Safety Code Chapter 166)

1. To the extent allowed by law, it is our policy to follow the directions with respect to medical care at the Windhaven Surgery Center of our patients who have the capacity to make decisions. You will be considered to have capacity to make health care decisions unless unconscious, determined to be incompetent by a court of law or medically determined by your attending physician to be unable to make health care decisions.

2. Before any non-emergency medical treatment is performed, you have a right to receive from your physician whatever information you need to give your informed consent. The information provided to you should answer your questions about the intended procedure or treatment, the potential risks associated with the treatment, alternative treatments and their risks. You will be asked to sign a form verifying you have given your physician your consent to perform the procedure.

3. If you refuse treatment, you will be informed by your physician of significant medical consequences that may result and you may be asked to sign a form about your refusal.

4. If you are unable to make decisions, but have signed a valid advanced directive we would like for you to understand that procedures performed in an Ambulatory Surgery Center are considered elective and by definition should not be performed on a patient considered to be high risk for medical or surgical complications. Therefore, it is our policy to provide life sustaining emergency care for all of our patients and provide emergency transportation to the nearest hospital. A copy of your Advanced Directive, if provided, will be included in the transfer information.

If you have any questions regarding our policies, please talk to your physician or nurse.

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

WINDHAVEN
SURGERY CENTER

TEXAS NOTICE TO PATIENT REQUIED BY THE PATIENT SELF DETERMINATION ACT

This notice is given to you to tell you about rights, under Texas law, to make medical care decisions. After reading this you may still have questions. If so, you should ask your doctors and other caregivers those questions.

1. Who will inform me about my medical care options? Your doctor must talk about medical care options with you, in terms you can understand.

2. Who decides what medical care I will get? As a competent adult, you decide what medical care you will get. You have the right to accept, refuse or stop any medical care, including life-sustaining treatment, which may prolong the dying process.

3. What if I am not able to make my own decisions? If you cannot make decisions about your own medical care, someone must make them for you. An advance directive is the best way to tell people what you want done. You can also name the person, if you can no longer make decisions for yourself.

4. What is an advance directive? An advance directive is a written document you sign while you are still able to make your own decisions. You can use an advance directive to tell people ahead of time what medical care you want. You can also name the person you want to make medical decisions for you if you cannot make them yourself. Texas Law has three kinds of advance directives; 1.Living wills. 2. Health care proxy. 3. Durable power of attorney for health care. You can have one, two or all of these advance directives. Texas's living will and appointment of a health care proxy are combined in a form called Advance Directive for Health Care.

5. What is a living will? A living will is a document that allows you to state your choices about life-sustaining treatment

6. What is a health care proxy? A health care proxy is a person you name to make medical decisions for you, including decisions about life-sustaining treatment. You appoint your health care proxy by naming them in the Advance Directive for Health Care form.

7. What is a durable power of attorney for health care? A durable power of attorney for health care is a document in which you name the person you want to make routine medical care decisions for you when you cannot Texas's durable power of attorney for health care is a separate legal document that required the help of a lawyer. The person you name can also make decisions about life-sustaining treatment if you name that person as your health care proxy using the health care proxy section of the Advance Directive for Health Care form.

8. Do I need all three documents? The Advance Directive for Health Care form can cover most situations.

9. May I refuse tube feeding? You can be sure that you do not receive tube feeding (artificially administered water, food or both) by stating your wishes in writing in a living will. You can also do this by appointing a health care proxy to make such decisions for you. If you fail to give express instructions, tube feeding cannot be withheld from you except in a very limited situation.

10. Should I sign an advance directive? Whether to sign an advance directive is entirely your decision. One reason many people wish to sign an advance directive is to avoid a legal dispute if they become ill and cannot make their wishes known. Signing an advance directive, or at the very least talking about your medical care wishes with your loved one, your doctors and others before a medical crisis, makes good sense.

11. Can I be sure my instructions will be followed: If properly signed, your Advance Directive for Health Care is legally binding on your doctor and other caregivers if they cannot follow your directions, they will make arrangements to transfer your care to others who will.

12. If I sign an advance directive now, can I change my mind? Yes, you can give new instructions by writing them down or telling someone. You can sign a new advance directive at any time you want In fact, you should go over your advance directive at least once a year to be sure it still correctly states your wishes.

13. What if I do not have an advance directive? If you do not have an advance directive and are unable to make your own decisions, medical decisions will be left to a legal guardian, if one has been appointed. Without an advance directive or court appointed legal guardian, Texas Law is not clear about who will make decisions for you. Usually, your family, doctors and hospital can agree about your medical care.

14. What if I signed a "Directive to Physicians" under the old law? If you signed a Directive to Physicians under the old Texas law, it is valid and binding under the new law. You may want to sign a new advance directive, however, because it covers more situations. The new law also allows you to name the person who you want to make your medical decisions. (The new law went into effect on September 1, 1992).

15. What if I signed an advance directive in another state? Advanced directives signed in other states are valid and binding in this state for anything Texas law allows.

16. What if I have other questions? If you have other questions, you should discuss them with your doctors and other caregivers.

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

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PATIENT FINANCIAL RESPONSABILITY AGREEMENT

Payment for Medical Care: In consideration for the medical care I will receive from the Windhaven Surgery Center, its employees, agents, designees, or independent contractors, unless I qualify for Patient Financial Assistance, prompt payment discount(s), or self-pay discount(s), in each case as determined according to Windhaven Surgery Center policies and procedures, I guarantee full payment for all charges by the Windhaven Surgery Center or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payer (for example, an insurance carrier or health maintenance organization (HMO) with which Center has specifically entered into an agreement for payment of medical care provided by the Center or by its employees, agents, designees or independent contractors). I understand that I will be legally responsible for all collections cost, including costs for collection agencies, attorney fees, and all other expenses incurred with collections if I defaults on this agreement.

Assignment Of Benefits: I hereby authorize and assign payment to the Center of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payer, for any and all cost of my medical care provided at the Windhaven Surgery Center or by its agents, designees, or independent medical contractors. Further, I understand that Anesthesiology, Pathology, Physician Services, and Laboratory Services will bill me separately and I also assign my insurance benefits to them if their services are rendered during my treatment. I also authorize for the release of my medical information needed by my insurance carrier to process the claim.

Insurance Precertification: I understand that obtaining insurance precertification for my procedure(s) is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Insurance Precertification: I understand that obtaining a referral for a specialist, if my health care plan has selected Primary Care Physician (PCP), for my procedure(s) is a patient responsibility; I assume all responsibility for notifying my Primary Care Physician (PCP) or health care plan for referral.

Release of Financial Information: I hereby authorize the Windhaven Surgery Center, its employees, agents, designees, or independent contractor for the disclosure of any and all information regarding the medical care I received on the admission to this facility or through its employees, agents, and designees, or independent contractors to any third party payer responsible for paying the costs of my medical care and any part thereof.

"As the patient or responsible party, I hereby consent to receiving auto-dialed and/or artificial or pre-recorded collection or health-care related message calls and text messages to my cellular phone number and any other telephone numbers provided during any interaction, agreement or communication with the facility, its independent contractors, and/or their affiliates, agents and contractors, including any of their billing or account management companies and/or debt collectors."

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

Witness Signature _____ Date _____

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ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to the Windhaven Surgery Center

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this center during this period of treatment.

Release of Information: I authorize the Windhaven Surgery Center to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of, or at the request of my attending physician, or his/her designees, of the Windhaven Surgery Center. I authorize the Windhaven Surgery Center, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. By state law, you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS).

Patient Rights: I acknowledge receipt of information explaining my rights as a patient.

Advanced Directive and Organ Tissue Donor: The patient, or his or her representative, hereby acknowledges having been provided with information regarding patient rights and responsibilities and the patient's right to prepare an advance directive prior to admission.

I have received a copy of the State Notice and this center policy statement regarding Patient Right to Self-Determination.

Personal Property: I have been informed and understand the Center does not assume any responsibility for personal property that I choose to keep with me.

I have reviewed this Admission Agreement and fully understand its contents and implications. I also acknowledge that I have received a copy of the patient's right to self-determination of treatment.

Printed Name: _____

Patient/Parent/Guarantor Signature: _____

Date/Time: _____

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or a parent or legal guardian of a child.