AllianceHealth
MADILL

ADVANCE DIRECTIVE (Y/N)	ACCOUNT NO.	MEDICAL RECORDS NO.
	5151172	0000821306

PATIENT

ADMIT DATE / TIME	ROOM NO.	PT	FC	AGE	DATE OF BIRTH	SEX	RA	MS	LOCATION	PROGRAM
04/26/2022 17:41	0	E	D	020	07/25/2001	F	1	S	MER	

PATIENT NAME & ADDRESS	SS NUMBER	PATIENT EMPLOYER	EMPLOYER PHONE NO.
BLUE, TATUM 7899 S WILLIARD TISHOMINGO OK 73460 US	***-**-****	UNEMPLOYED	
	PHONE NUMBER		COUNTY
	(580)257-9201		40JOHNSTON 069

GUAR

RESPONSIBLE PARTY & ADDRESS	SS NUMBER	RESPONSIBLE PARTY EMPLOYER	EMPLOYER PHONE
BLUE, TATUM PO BOX 194 MILBURN OK 73450 US	***-**-****	CANNALINK	
	PHONE NUMBER		RELATIONSHIP TO PATIENT
	(580)371-6882		PAT ENT IS GUARANTOR

EMERGENCY CONTACT NAME not in household	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATIONSHIP TO PATIENT
BLUE, AMANDA	(580)371-8719	MOTHER

COMMENTS	MSP	PL ETH REL	PRIVACY	NPP	ADMIT. BY
	☐Y ☒N	ENG N			MAS

PRIVACY	EMAIL	PPI	ACCIDENT	ACCIDENT DATE
		O		

INSURANCE

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
1	856		03839818	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
HEALTHCHOICE PO BOX 99011 LUBBOCK TX 794909011 (800)323-4314	BLUE, TATUM			

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
2	550	OK1	031209623	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
MEDICAID OKLAHOMA PO BOX 18430 OKLAHOMA CITY OK 731540430 (800)522-0114	BLUE, TATUM			

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
3				

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION

MISC

DR. ADMITTING / ATTENDING	DR. FAMILY / PRIMARY CARE
GEORGE, KYLE M. /	NO, PCP PROVIDER
CHIEF COMPLAINT	**ADMITTING DIAGNOSIS**
SINUS PAIN/PRESSURE	

PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).	DISCHARGE DATE/TIME
DISCHARGED TO HOME	04/26/2022 18:18

FACE

5151172

0000821306

AllianceHealth MADILL

901 S. 5th Avenue
MADILL • OK • 73446
PHONE: (580)795-3384

ADVANCE DIRECTIVE (Y/N)	ACCOUNT NO.	MEDICAL RECORDS NO.
	5151172	0000821306

PATIENT

ADMIT DATE / TIME	ROOM NO.	PT	FC	AGE	DATE OF BIRTH	SEX	RA	MS	LOCATION	PROGRAM
04/26/2022 17:41	0000	E	D	20	07/25/2001	F	1	S	MER	N

PATIENT NAME & ADDRESS: BLUE, TATUM
7899 S WILLIARD
TISHOMINGO OK 73460
US

SS NUMBER: ***-**-4463
PHONE NUMBER: (580)257-9201
PATIENT EMPLOYER: UNEMPLOYED
EMPLOYER PHONE NO.:
COUNTY: 40JOHNSTON

GUAR

RESPONSIBLE PARTY & ADDRESS: BLUE, TATUM
PO BOX 194
MILBURN OK 73450
US

SS NUMBER: ***-**-4463
PHONE NUMBER: (580)371-6882
RESPONSIBLE PARTY EMPLOYER: CANNALINK
EMPLOYER PHONE:
RELATIONSHIP TO PATIENT: PATIENT IS G

EMERGENCY CONTACT NAME not in household	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATIONSHIP TO PATIENT
BLUE, AMANDA	(580)371-8719	MOTHER

COMMENTS	MSP	PL ETH REL	PRIVACY	NPP	ADMIT. BY
	☐Y ☒N	ENG N		Y	MAS

PRIVACY	EMAIL	PPI	ACCIDENT	ACCIDENT DATE
		O		

INSURANCE

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
1	856		03839818	07/25/2001

INSURANCE CO. NAME & ADDRESS: HEALTHCHOICE
PO BOX 99011
LUBBOCK TX 79490
(800)323-4314
co ins 20%
co pay $30
OOP: 8700/5352.59
1/1/16 DED 2000/1184.32

INSURED'S NAME: BLUE, TATUM
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
2	550	OK1	031209623	07/25/2001

INSURANCE CO. NAME & ADDRESS: MEDICAID OKLAHOMA
PO BOX 18430
OKLAHOMA CITY OK 73154
(800)522-0114
12/14/21 T-19

INSURED'S NAME: BLUE, TATUM
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
3				/ /

INSURANCE CO. NAME & ADDRESS:

INSURED'S NAME:
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

MISC

DR. ADMITTING / ATTENDING: GEORGE, KYLE M. /
DR. FAMILY / PRIMARY CARE: NO, PCP PROVIDER
CHIEF COMPLAINT: SINUS PAIN/PRESSURE
ADMITTING DIAGNOSIS:

PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).

DISCHARGE DATE/TIME:

	Yes	No	N/A
Consent Signed?	✓		
Insurance Card Copied?		✓	
Copy of ID Secured?		✓	
Passport Reviewed?	✓		
Any Open Balances?		✓	
P/P AFR Administered?		✓	
Dar Notes Entered?	✓		

Deposit Requested $ _____

Deposit Paid $ Ø

YM Smith

Admit Clerk Signature

FACE

5151172

BUSINESS OFFICE COPY

Nurse's Notes
AllianceHealth Madill
Emergency Department
Name: Blue, Tatum
Age: 20 yrs
Sex: Female
DOB: 07/25/2001
MRN: 0000821306
Arrival Date: 04/26/2022
Time: 17:41
Account#: 5151172
Bed 1
Private MD:
Presentation:

04/26
17:50 Presenting complaint: Patient states: patient c/o sinus pressure and headache starting 4 days ago. Transition of care: patient was not received from another setting of care. mjf

04/26
17:50 Method Of Arrival: Walk-in mjf

04/26
17:50 Acuity: ESI Level 5 mjf

Triage Assessment:

04/26
17:51 General: Appears in no apparent distress, well developed, well nourished, well groomed, Behavior is appropriate for age, cooperative, quiet. Pain: Complains of pain in forehead Pain began 4 days ago Current management - is no interventions. Recent Travel History: No recent travel within the last 14 days. mjf

Historical:
- Allergies: No known Allergies;
- PSHx: None;
- History obtained from: patient.
- Immunization history: Last tetanus immunization: unknown Pneumococcal vaccine is not up to date, Patient has never been vaccinated, Flu vaccine is not up to date, Patient has never been vaccinated.
- Social history: : The patient/guardian denies using tobacco, street drugs, No barriers to communication noted. The patient speaks fluent English. Speaks appropriately for age. Smoking Status: patient/guardian denies using tobacco.

Screening:

04/26
17:53 Sepsis Protocol: Suspicion of infection Suspect Infection - No. COVID-19 Risk Screening revealed: Signs and Symptoms of: Headache, Recent Travel History to; No recent travel, Vaccine Status; No. Columbia Suicide Risk Assessment: 1.) Have you wished you were dead or wished you could go to sleep and never wake up? Patient response is "No" (low risk). 2.) Have you actually had any thoughts of killing yourself? Patient answer was "No". 6. Have you ever done anything, started to do anything, or prepared to do anything to your life? Patient's response was "No" Highest Assessed Suicide Risk Level: Low suicide risk. Tuberculosis screening: Never had TB. Exposure/Syndromic None identified. Fall Risk Assessment: History of Fall in Last 3 Months, including since Admission = No (0 Points); Mobility Assist Device Used = No (0 Points); Impaired Gait mjf

= No (0 Points) Disorientation = No (0 Points); Intoxicated or Sedated = No (0 Points); Altered Elimination = No (0 Points); Fall Risk Score = 0. Abuse assessment: No assessment findings of abuse, such as: unexplained injuries or bruising, suspicious burns, signs of withdrawal, depression, or fear of others. Patient states they feel safe at home. Assessment for neglect: No signs or indications of neglect noted, such as: exploitation, malnutrition, or poor hygiene. Smoking history: Patient denies using tobacco products.

Assessment:

04/26 17:55	Present on Arrival: Central Line: NO. Foley Catheter: NO. Wound/Pressure Ulcer: NO.	mjf
04/26 18:13	Nursing diagnosis: Alteration in comfort: actual related to increased sinus pressure.	mjf

Vital Signs:

04/26 17:52	BP 119 / 76 LA Sitting (auto/reg); Pulse 85 LA; Resp 16; Temp 98(T); Pulse Ox 100% on R/A; Weight 89.09 kg (M); Height 5 ft. 1 in. (R); Pain 2/10;	mjf
04/26 17:52	Body Mass Index 37.11 (89.09 kg, 154.94 cm)	mjf
04/26 17:52	Pain Scale: Adult	mjf

ED Course:

04/26 17:41	Patient arrived in ED.	ms1
04/26 17:50	Ferrell, Megan is Primary Nurse.	mjf
04/26 17:51	Triage completed.	mjf
04/26 17:52	Dr. Kyle George is Attending Physician.	kg
04/26 17:54	Arm band placed on right wrist. Patient placed in exam room.	mjf
04/26 17:56	Patient has correct armband on for positive identification. Bed in low position. Call light in reach. Adult w/ patient.	mjf
04/26 18:12	ED Rounding: Call light is within patient's reach, and patient has been educated on it's use. Family Update: Family remains at patient's bedside and has been updated on status of patient's condition Patient has been instructed that nurse will re-visit within 30 minutes.	mjf
04/26 18:12	No procedures required assistance by the nurse.	mjf
04/26 18:15	ED Rounding: Pain Reassessment:.	mjf
04/26 18:15	ED Rounding: Pending Items and/or Delays: Patient is not awaiting any further diagnostics and/or procedures at this time.	mjf

Administered Medications:

04/26 18:07	Drug: Dexamethasone Sodium Phosphate 10 mg Route: IM; Site: left ventrogluteal;	mjf
04/26		

18:18 Follow up: Response: No adverse reaction; Pain is decreased mjf

Outcome:
04/26
18:01 Discharge ordered by MD. kg
04/26
18:12 Discharge Assessment: vital signs assessed, Skin Assessment completed. patient awake and alert no apparent distress mjf
18:12 Discharge instructions given to patient, Instructed on discharge instructions, medication usage, Demonstrated understanding of instructions, medications.
18:12 Braden Scale-Adult not applicable, the patient was discharged.
04/26
18:15 Prescriptions transmitted to pharmacy mjf
04/26
18:18 Patient left the ED. mjf

Signatures:

Dr. Kyle George	kg
Smith, Mary	ms1
Ferrell, Megan	mjf

Corrections: (The following items were deleted from the chart)
04/26
17:55 04/26 17:55 PMHx: ORIF right humerus 2020; mjf mjf

****

Physician Documentation
AllianceHealth Madill
Emergency Department
Name: Blue, Tatum
Age: 20 yrs
Sex: Female
DOB: 07/25/2001
MRN: 0000821306
Arrival Date: 04/26/2022
Time: 17:41
Account#: 5151172
Bed 1
Private MD:
ED Physician George, Kyle
Disposition Summary:
04/26/22 18:01
Discharge Ordered
Location: Home/Self Care. MSE Completed kg
Problem: an ongoing problem kg
Symptoms: are unchanged kg
Condition: Stable kg
Diagnosis
- Allergic rhinitis, unspecified kg
Followup: kg
- With: Private Physician
- When: Next available appointment
- Reason: Recheck today's complaints
Discharge Instructions:
- Discharge Summary Sheet kg
- Allergic Rhinitis, Adult kg
Forms:
- Work release form kg
- Medication Reconciliation Form kg
Prescriptions:
- Flonase Allergy Relief 50 mcg/actuation Nasal spray, suspension
- spray 1 spray by INTRANASAL route 2 times per day kg
administer into each nostril; 1 Applicator; Refills: 0, Product Selection Permitted
- Zyrtec 10 mg Oral Tablet
- take 1 tablet by ORAL route once daily As needed; 20 kg
tablet; Refills: 0, Product Selection Permitted
Disposition:
04/26
18:01 Electronically signed by: Dr. Kyle George. kg

HPI:
04/26
17:58 This 20 yrs old Caucasian Female presents to ER via Walk-in with kg
complaints of Sinus Congestion, Sinus Pain.
04/26
17:58 The patient or guardian reports cough, that is intermittent. Onset: kg
The symptoms/episode began/occurred 4 day(s) ago. Severity of symptoms: At their worst the symptoms were mild, in the emergency department the symptoms are unchanged. Modifying factors: The symptoms are alleviated by nothing, the symptoms are aggravated by nothing. Associated signs and symptoms: Pertinent positives: headache, Pertinent negatives: chest pain, diarrhea, ear ache, fever, nausea, rhinorrhea, vomiting. The patient has not experienced similar symptoms in the past. The patient has not recently seen a physician.

Historical:
- Allergies: No known Allergies;
- PSHx: None;
- History obtained from: patient.
- Immunization history: Last tetanus immunization: unknown Pneumococcal vaccine is not up to date, Patient has never been vaccinated, Flu vaccine is not up to date, Patient has never been vaccinated.
- Social history: : The patient/guardian denies using tobacco, street drugs, No barriers to communication noted. The patient speaks fluent English. Speaks appropriately for age. Smoking Status: patient/guardian denies using tobacco.

ROS:

04/26		
17:59	All other systems are reviewed and negative. ENT: Positive for sinus pain, top frontal region. Respiratory: Positive for cough, with no reported sputum.	kg

Exam:

04/26		
17:59	Head/Face: Normocephalic, atraumatic. Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.	kg
17:59	Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated. Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No murmurs. no JVD. No pulse deficits.	
17:59	Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis. MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits.	
17:59	Constitutional: The patient appears in no acute distress, alert, awake, comfortable, non-diaphoretic, non-toxic.	
17:59	ENT: TM's: are normal, no acute changes, Nose: Nasal septum: is midline, Nasal mucosa: erythematous, Turbinates: are swollen bilaterally, bleeding, is not appreciated, Posterior pharynx: is normal, no acute changes.	
17:59	Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, no acute changes, is not noted, Breath sounds: are normal, no acute changes, throughout.	

Vital Signs:

04/26		
17:52	BP 119 / 76 LA Sitting (auto/reg); Pulse 85 LA; Resp 16; Temp 98(T); Pulse Ox 100% on R/A; Weight 89.09 kg (M); Height 5 ft. 1 in. (R); Pain 2/10;	mjf
04/26		
17:52	Body Mass Index 37.11 (89.09 kg, 154.94 cm)	mjf
04/26		
17:52	Pain Scale: Adult	mjf

Procedures:

04/26		
18:00	No procedures were performed on this patient.	kg

MDM:

04/26 17:52	Patient medically screened.	kg
04/26 18:00	No hypotension present. Antibiotic administration: Not indicated, the patient has a suspected viral illness. Data reviewed: vital signs, nurses notes. Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit/observation diagnosis, the need for outpatient follow up, for definitive care, a family practitioner, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. Special discussion: I discussed with the patient/guardian in detail that at this point there is no indication for admission to the hospital. It is understood, however, that if the symptoms persist or worsen the patient needs to return immediately for re-evaluation.	kg

Dispensed Medications:

04/26 18:07	Drug: Dexamethasone Sodium Phosphate 10 mg Route: IM; Site: left ventrogluteal;	mjf
04/26 18:18	Follow up: Response: No adverse reaction; Pain is decreased	mjf

Signatures:

Dr. Kyle George	kg
Ferrell, Megan	mjf

Corrections: (The following items were deleted from the chart)

04/26 17:55	04/26 17:55 PMHx: ORIF right humerus 2020; mjf	mjf

****

Discharge Summary
AllianceHealth Madill
Name:Tatum Blue
Emergency Department
Age:20 yrs
Sex:Female
DOB:07/25/2001
MRN:0000821306
Arrival:04/26/2022
17:41
Account#:5151172
Departure Date04/26/2022
Departure Time18:18
Private MD:
Outcome: Discharge
Location: Home/Self Care. MSE Completed
Condition: Stable
Chief Complaint: Sinus Congestion, Sinus Pain
Diagnosis: Allergic rhinitis, unspecified
Prescriptions: Flonase Allergy Relief 50 mcg/actuation Nasal spray, suspension - spray 1 spray by INTRANASAL route 2 times per day administer into each nostril; 1 Applicator, Zyrtec 10 mg Oral Tablet - take 1 tablet by ORAL route once daily As needed; 20 tablet
Custom Notes:
Attending Physician: Dr. Kyle George
Private MD:
Mid Level Provider:
Orders: Dexamethasone Sodium Phosphate
Discharge Instruction: Discharge Summary Sheet, Allergic Rhinitis, Adult, Work release form, Medication Reconciliation Form
****

Order Summary
Emergency Department
Name: Blue, Tatum
MRN: 0000821306
20 yrs
/ Caucasian
/ Female
Arrival: 04/26/2022
17:41
Chief Complaint: Sinus Congestion, Sinus Pain
Departure Date 04/26/2022
Departure Time 18:18
Orders:
Medication
Order: Dexamethasone Sodium Phosphate 10 mg IM once; Ordered: 04/26 17:58; By: kg; For: kg;Administered: 04/26 18:07 By: mjf; Frequency: once; Order Method: Electronic Administration: Dexamethasone Sodium Phosphate 10 mg IM in left ventrogluteal Follow Up: 04/26 18:18 Response: No adverse reaction; Pain is decreased

Order Signatures:
Dr. Kyle George, kg;
****

AllianceHealth Madill

901 S. 5th Ave.
Madill, OK 73446
580-795-3384

Discharge Instructions for: **Blue, Tatum**

Arrival Date: **Tuesday, April 26, 2022**

Thank you for choosing **AllianceHealth Madill** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: George, Kyle

Diagnosis: Allergic rhinitis, unspecified

DISCHARGE INSTRUCTIONS	**FORMS**
Allergic Rhinitis, Adult	Medication Reconciliation Form Work release form
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When: Next available appointment; Reason: Recheck today's complaints	Flonase Allergy Relief Zyrtec
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).

Tatum Blue _____ _____

Tatum Blue **ED Physician or Nurse**

MRN # 0000821306

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

PIN

FOLLOW UP INSTRUCTIONS

Private Physician
When: Next available appointment
Reason: Recheck today's complaints

PRESCRIPTIONS

Pharmacy:
Tishomingo Express Pharmacy (140 E Main , Tishomingo, OK 73460, Phone: 580-371-2355)

Flonase Allergy Relief 50 mcg/actuation Nasal spray, suspension — Electronic
Spray 1 spray by INTRANASAL route 2 times per day administer into each nostril; Quantity: 1 Applicator

Zyrtec 10 mg Oral Tablet — Electronic
Take 1 tablet by ORAL route once daily As needed; Quantity: 20 tablet

TESTS AND PROCEDURES

Labs
None

Rad
None

Procedures
None

Other
None

AllianceHealth Madill

901 S 5th Ave
Madill OK 73446
580 795-3384

Discharge Instructions for **Blue, Tatum**

Arrival Date **Tuesday, April 26, 2022**

Thank you for choosing **AllianceHealth Madill** for your care today The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care You should contact your follow up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit

Care provided by George Kyle

Diagnosis Allergic rhinitis unspecified

DISCHARGE INSTRUCTIONS	FORMS
Allergic Rhinitis Adult	Medication Reconciliation Form Work release form
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When Next available appointment Reason Recheck today's complaints	Flonase Allergy Relief Zyrtec
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any)

Tatum Blue **ED Physician or Nurse**

MRN # 0000821306

X RAYS and LAB TESTS
If you had x rays today they were read by the emergency physician Your x rays will also be read by a radiologist within 24 hours If you had a culture done it will take 24 to 72 hours to get the results If there is a change in the x ray diagnosis or a positive culture we will contact you Please verify your current phone number prior to discharge at the check out desk

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PIN

FOLLOW UP INSTRUCTIONS

Private Physician
When Next available appointment
Reason Recheck today's complaints

PRESCRIPTIONS

Pharmacy
Tishomingo Express Pharmacy (140 E Main Tishomingo OK 73460 Phone 580 371 2355)

Flonase Allergy Relief 50 mcg/actuation Nasal spray suspension — Electronic
Spray 1 spray by INTRANASAL route 2 times per day administer into each nostril Quantity 1 Applicator

Zyrtec 10 mg Oral Tablet — Electronic
Take 1 tablet by ORAL route once daily As needed Quantity 20 tablet

TESTS AND PROCEDURES

Labs
None

Rad
None

Procedures
None

Other
None

AllianceHealth MADILL

901 S. 5th Avenue
MADILL • OK • 73446
PHONE: (580)795-3384

ADVANCE DIRECTIVE (Y/N)	ACCOUNT NO.	MEDICAL RECORDS NO.
	5151172	0000821306

PATIENT

ADMIT DATE / TIME	ROOM NO.	PT	FC	AGE	DATE OF BIRTH	SEX	RA	MS	LOCATION	PROGRAM
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PATIENT NAME & ADDRESS	SS NUMBER	PATIENT EMPLOYER	EMPLOYER PHONE NO.
BLUE, TATUM 7899 S WILLIARD TISHOMINGO OK 73460 US	***-**-4463 PHONE NUMBER (580)257-9201	UNEMPLOYED	COUNTY 40JOHNSTON

GUAR

RESPONSIBLE PARTY & ADDRESS	SS NUMBER	RESPONSIBLE PARTY EMPLOYER	EMPLOYER PHONE
BLUE, TATUM PO BOX 194 MILBURN OK 73450 US	***-**-4463 PHONE NUMBER (580)371-6882	CANNALINK	RELATIONSHIP TO PATIENT PATIENT IS G

EMERGENCY CONTACT NAME not in household	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATIONSHIP TO PATIENT
BLUE, AMANDA	(580)371-8719	MOTHER

COMMENTS	MSP	PL ETH REL	PRIVACY	NPP	ADMIT. BY
	☐Y ☒N	ENG N		Y	MAS

PRIVACY	EMAIL	PPI	ACCIDENT	ACCIDENT DATE
		O		

INSURANCE

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
1	856		03839818	07/25/2001

INSURANCE CO. NAME & ADDRESS: HEALTHCHOICE, PO BOX 99011, LUBBOCK TX 79490, (800)323-4314
INSURED'S NAME: BLUE, TATUM
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
2	550	OK1	031209623	07/25/2001

INSURANCE CO. NAME & ADDRESS: MEDICAID OKLAHOMA, PO BOX 18430, OKLAHOMA CITY OK 73154, (800)522-0114
INSURED'S NAME: BLUE, TATUM
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
3				/ /

INSURANCE CO. NAME & ADDRESS:
INSURED'S NAME:
GROUP NUMBER:
GROUP NAME:
AUTHORIZATION:

MISC

DR. ADMITTING / ATTENDING	DR. FAMILY / PRIMARY CARE
GEORGE, KYLE M. /	NO, PCP PROVIDER

CHIEF COMPLAINT	ADMITTING DIAGNOSIS
SINUS PAIN/PRESSURE	

PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).

DISCHARGE DATE/TIME:

COMPLICATIONS

COMORBIDITY(IES)

PRINCIPAL PROCEDURE

FACE

DOCTOR'S COPY

5151172

ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.
All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*	**YES**	**NO**
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.* I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Primary Spoken Language: _____
Patient's preferred language for discussing healthcare: _____
Interpreter services are available 24 hours per day.
Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.
Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.
Call 1-580-795-3384 (TTY: 1-800-722-0353).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-580-795-3384 (TTY: 1-800-722-0353).

Nhà cung cấp này tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-580-795-3384 (TTY: 1-800-722-0353).

Patient/Family Member/Companion Signature: Tatum Blue	Date/Time
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time: 4/26/22
Witness: M Bruth	Date/Time

Patient Label
AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 20 F MER-GEORGE KYLE M.
MR#: 0000821306
DOS: 4/26/2022
Patient Acct #: **5151172**

COA

1. **GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:**

I consent to treatment / admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me. I have a right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when health care personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments given by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or given by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I have been informed of the treatment/procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by a physician or one or more additional physicians, fellows, residents, interns, and employees of the Facility, who may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment. I agree and understand that all individuals involved in my care are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for their acts or omissions. Services may be performed by independent contractors who are not employed by the Facility. I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made for the results of treatments, care or examinations in the Facility.

I consent to the photographing, videotaping and/or video monitoring, of appropriate portions of my body, for medical and medical record documentation purposes, as long as such photographs or videotapes are maintained and released in accordance with protected health information regulations.

I consent to virtual health/telemedicine services as part of my treatment. I understand that "virtual health" or telemedicine services include the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that medical, nursing, and other authorized health care providers in training may be observing and participating actively in my care under the supervision of authorized personnel. I give my consent to such observations and/or participation.

I understand the facility may authorize the disposal of records in accordance with facility retention policies and state retention laws.

2. **ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:**

I assign to the Facility or as necessary to any Facility-based physician (for the purposes of this section, collectively the "Facility") all of my rights and benefits under existing policies of insurance providing coverage and payment for any expenses incurred as a result of services and treatment rendered by the Facility or any independent contractor. I authorize direct payment to the Facility or to any independent contractor of any insurance benefits otherwise payable to or on behalf of myself. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the Facility any and all documents related to my insurance plan, summary benefit description, insurance policy(ies), and/or settlement information upon written request from the Facility.

(continued on page 2)

TB *Initials*

Patient Label
AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 20 F MER-
GEORGE KYLE M.
MR#: 0000821306
DOS: 4/26/2022
Patient Acct #: **5151172**

(continued from page 1)

I irrevocably appoint the Facility 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. I acknowledge that the Facility is not obligated to pursue any such claims.

In addition, I grant the Facility power of attorney to pursue any claims, penalties, and administration and/or legal remedies for collection against any responsible payer, employer sponsored medical benefit plans, third party liability carrier, or any other responsible third party. This power of attorney shall not be affected by subsequent disability or incapacity of me. This is not a power of attorney for health care decisions generally, and the powers granted hereby are expressly limited to those reasonably required to collect any payments or benefits under any policy of life, accident, disability, hospitalization, medical or casualty insurance.

I assign to the Facility all insurance benefits, sick benefits, injury benefits, or proceeds of claims resulting from the liability of a third party unless my account is paid in full when I am discharged or finish my outpatient care.

If I am eligible for Medicare, I request Medicare services and benefits. I agree this assignment will not be withdrawn until my account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.

I understand I am responsible to pay any account balance not covered by my insurance company in accordance with the standard charges that the Facility bills for such services. If I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, coUrt costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me.

3. NURSING CARE:

The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. I release Facility from any and all liability arising from the fact that I am not provided private nursing care.

4. EMTALA:

During the time period that the federal government has invoked 1135 waivers in order to deal with the emergency COVID-19 crisis, if I have a medical emergency or if I am a pregnant woman in labor, I understand that the Hospital will do its best to provide care in the setting most appropriate and within the capabilities of this Hospital's staff and facilities, including an appropriate medical screening exam, stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

5. PERSONAL VALUABLES:

I understand that the Facility is not liable for the loss or damage to any articles of personal valuables unless I have given them to the Facility to be put in the safe and been given a receipt by Facility for their safe return. At no time will the Facility be responsible for more than $500 for my deposited items.

(continued on page 3)

TB _____ *Initials*

(continued from page 2)

6. WEAPON / EXPLOSIVES / DRUGS:

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including giving them to law enforcement.

7. CONSENT TO RELEASE HEALTH INFORMATION:

I understand this Facility uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Facility's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Facility; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Facility). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

8. NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Facility's Notice of Privacy Practices and consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

Please initial one option:

_____ I give the Facility permission to disclose my name, room number, and general condition to anyone who inquires during my stay at the Facility.

_____ I do not give permission to the Facility to disclose information about my presence at the Facility during my stay. I realize that by choosing this options, I will not be able to receive flowers, cards, phone calls, family/visitors or clergy visits.

(continued on page 4)

_____ *Initials*

(continued from page 3)

9. RESEARCH STUDIES: ***Please initial:***

___ Yes ___ No Are you currently a participant in any research study or project: *If yes, please briefly describe what is being studied (drug, medical device or other)* _____

_____

Who can the Facility contact with questions about the study? _____

_____

10. COMMUNICATIONS:

I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

11. EXTERNAL PHARMACY:

I consent to the exchange of prescription information between the facility and my pharmacy(ies).

12. VIDEOTAPING/RECORDING:

I agree not to photograph, video record, audio record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure my visitors comply with this requirement.

13. ED NAVIGATOR PROGRAM:

If this facility offers an ED Navigator Program which provides information and assistance to patients who request help obtaining a referral to a Primary Care Physician, the ED Navigator Program disclosures are attached hereto as Exhibit: "ED Navigator Program Disclosures" and incorporated herein by reference. By signing this consent, Patient affirms that the ED Navigator Program disclosures have been effectively communicated to the Patient and the Patient has had the opportunity to have any questions regarding the ED Navigator Program answered to his/her satisfaction."

14. OUT-OF-NETWORK SERVICES:

I understand that the Facility may not participate in my medical health insurance network or my health insurance carrier may not have any established health insurance networks with hospitals or other provider groups. I understand that even where the Facility participates in my medical health insurance network, some physicians or other healthcare providers who may not be employed by this Facility and who may not participate in my insurance network, such as

(continued on page 5)

TB _____ *Initials*

(continued from page 4)

anesthesiologists, radiologists, emergency room physicians, and pathologists, may be called upon to render healthcare items or services during the course of treatment at the Facility that may be billed separately. The list of such specialists is available on the Facility's website, and that listing is incorporated herein by reference. I understand and acknowledge that, when the Facility or provider or particular specialist does not participate in my medical health insurance network, the Facility or provider or specialist, as applicable, is not bound by the payment provisions that apply to health care items or services rendered by a network provider under my health insurance plan.

I acknowledge that I have the right to verify or confirm and, prior to receiving services, have verified or confirmed or had the opportunity to with my insurance carrier to find out if the Facility or medical care providers involved in my treatment at the Facility are in-network and to obtain a list of network providers that may render the health care items or services I request. I understand if I do not verify places me at risk of higher out-of-network charges due to a possible benefit reduction.

Finally, I acknowledge and understand that, if I am to receive medical care by a healthcare provider not in my insurance network, I will be billed at 100% of the standard charges that the Facility bills for such services, which I can view on the Facility's website or upon request, to the extent permitted under state law. I further acknowledge that I am responsible to pay any account balance not covered by my insurance company, in accordance with the standard charges that the Facility bills for such services to the extent permitted under state law. Under these circumstances, if I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, court costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to any past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me pursuant to the assignment of benefits set forth herein.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above.

Patient's Signature or Legal Representative: Tatum Blue		Date/Time
Relationship to Patient	Interpreter, if Utilized	Date/Time: 4/26/22
Witness Signature		Date/Time

Inpatient/Outpatient Conditions of Admission and Consent to Medical Treatment
ADM-1703GHMS Page 5 of 5
(Rev. 01/16, 06/16, 01/17, 11/17, 02/18, 05/19, 03/20, 11/20, 04/21)
ORIGINAL – Medical Record COPY – Recipient

Patient Label
AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 20 F MER-
GEORGE KYLE M.
Patient Acct #: **5151172**
MR#: 0000821306
DOS: 4/26/2022

eAbstract Summary
MARC- Marshall 735

Medical Record #	0000821306	**Encounter #**	5151172	**Name**	BLUE, TATUM

Admission Date	04/26/2022	**Encounter Type**	ED-Emergency
Discharge Date	04/26/2022	**Race**	NON HISPANIC
Birthdate	07/25/2001	**Primary Payor**	D-PPO
		Sex	Female
Admission Type	Emergency	**LOS**	1
Admission Source	Physician Referral	**Admission Service**	EMR
Discharge Disposition	Home	**Discharge Service**	EMR

Discharge MD	4104	GEORGE, KYLE

RVDX	R0981	Nasal congestion
Princ Diag	J309	Allergic rhinitis, unspecified

CPT Proc	96372	THER/PROPH/DIAG INJ, SC/IM	4/26/2022	4104	GEORGE, KYLE
CPT Proc	99283	EMERGENCY DEPT VISIT	4/26/2022	4104	GEORGE, KYLE
CPT Proc	J1100	Dexamethasone sodium phos	4/26/2022	4104	GEORGE, KYLE

Coded	04/29/2022	SBrimble
Bill Submitted	04/29/2022	SBrimble
Abstracted		
Abstract Status:	Complete	

AllianceHealth
MADILL

ADVANCE DIRECTIVE (Y/N)	ACCOUNT NO.	MEDICAL RECORDS NO.
	5132289	0000821306

PATIENT

ADMIT DATE / TIME	ROOM NO.	PT	FC	AGE	DATE OF BIRTH	SEX	RA	MS	LOCATION	PROGRAM
07/15/2021 12:19	0	E	D	019	07/25/2001	F	1	S	MER	

PATIENT NAME & ADDRESS	SS NUMBER	PATIENT EMPLOYER	EMPLOYER PHONE NO.
BLUE, TATUM 7899 S WILLIARD TISHOMINGO OK 73460 US	***-**-****	CANNALINK	
	PHONE NUMBER		COUNTY
	(580)371-6882		40JOHNSTON 069

GUAR

RESPONSIBLE PARTY & ADDRESS	SS NUMBER	RESPONSIBLE PARTY EMPLOYER	EMPLOYER PHONE
BLUE, TATUM PO BOX 194 MILBURN OK 73450 US	***-**-****	CANNALINK	
	PHONE NUMBER		RELATIONSHIP TO PATIENT
	(580)371-6882		PAT ENT IS GUARANTOR

EMERGENCY CONTACT NAME not in household	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATIONSHIP TO PATIENT

COMMENTS	MSP	PL ETH REL	PRIVACY	NPP	ADMIT. BY
	☐Y ☒N	ENG N		Y	NB

PRIVACY	EMAIL	PPI	ACCIDENT	ACCIDENT DATE
		O		

INSURANCE

	1	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
		856		03839818	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
HEALTHCHOICE PO BOX 99011 LUBBOCK TX 794909011 (800)323-4314	BLUE, TATUM			

	2	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
		550	OK1	031209623	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
MEDICAID OKLAHOMA PO BOX 18430 OKLAHOMA CITY OK 731540430 (800)522-0114	BLUE, TATUM			

	3	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION

MISC

DR. ADMITTING / ATTENDING	DR. FAMILY / PRIMARY CARE
GEORGE, KYLE M. /	*NOT FOUND*
CHIEF COMPLAINT	ADMITTING DIAGNOSIS
EAR PAION	

PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).	DISCHARGE DATE/TIME
DISCHARGED TO HOME	07/15/2021 13:08

FACE

5132289

0000821306

Nurse's Notes
AllianceHealth Madill
Emergency Department
Name: Blue, Tatum
Age: 19 yrs
Sex: Female
DOB: 07/25/2001
MRN: 0000821306
Arrival Date: 07/15/2021
Time: 12:19
Account#: 5132289
Bed 1
Private MD:
Presentation:

07/15
12:24 Presenting complaint: Patient states: left ear pain. Transition of care: patient was not received from another setting of care. sw

07/15
12:24 Method Of Arrival: Walk-in sw

07/15
12:24 Acuity: ESI Level 5 sw

Triage Assessment:

07/15
12:26 General: Appears well developed, well nourished, well groomed, Behavior is appropriate for age, pleasant. Pain: Complains of pain in left ear Pain currently is 7 out of 10 on a pain scale. Quality of pain is described as throbbing, Pain began this am. Recent Travel History: No recent travel within the last 14 days. EENT: Reports pain in left ear. sw

OB/GYN:

07/15
12:27 Gravida 1, Full Term 0, Premature 0, Abortion 0, Living 0, LMP 4/29/2021, Pregnancy Verified, EDC 2/3/2022, Gestational age from LMP: 11 weeks 0 days sw

Historical:
- Allergies: No known Allergies;
- Home Meds:
  1. Prenatal Vitamin Oral tab 1 tab once daily
- PMHx: ORIF right humerus 2020;
- History obtained from: patient.
- Immunization history: Last tetanus immunization: unknown Pneumococcal vaccine is not up to date, Patient has never been vaccinated, Flu vaccine is not up to date, It has been more than one year since last vaccine..
- Social history: : Smoking Status: patient/guardian denies using tobacco. the patient stated never smoked. No barriers to communication noted. Speaks appropriately for age.
- Family history: No immediate family members are acutely ill.
- Social history: Smoking Status: patient/guardian denies using tobacco.

Screening:

07/15
12:30 Sepsis Protocol: Patient presentation is not suspicious for sepsis; screening is stopped. COVID-19 Risk Screening revealed: Signs and Symptoms of: No Symptoms, Recent Travel History to; No recent sw

travel, Received Testing with results of: Yes, Negative, Vaccine Status; No, Meets COVID Criteria Not Met. Columbia Suicide Risk Assessment: 1.) Have you wished you were dead or wished you could go to sleep and never wake up? Patient response is "No" (low risk). 2.) Have you actually had any thoughts of killing yourself? Patient answer was "No". 6. Have you ever done anything, started to do anything, or prepared to do anything to your life? Patient's response was "No" Highest Assessed Suicide Risk Level: Low suicide risk. Tuberculosis screening: Never had TB. Exposure/Syndromic None identified. Fall Risk Assessment: History of Fall in Last 3 Months, including since Admission = No (0 Points); Mobility Assist Device Used = No (0 Points); Impaired Gait = No (0 Points) Disorientation = No (0 Points); Intoxicated or Sedated = No (0 Points); Altered Elimination = No (0 Points); Fall Risk Score = 0 Fall Risk Interventions No Bundle = 0 points: = None. Abuse assessment: No assessment findings of abuse, such as: unexplained injuries or bruising, suspicious burns, signs of withdrawal, depression, or fear of others. Assessment for neglect: No signs or indications of neglect noted, such as: exploitation, malnutrition, or poor hygiene. Smoking history: Patient denies using tobacco products.

Assessment:

07/15		
12:33	Present on Arrival: Central Line: NO. Foley Catheter: NO. Wound/Pressure Ulcer: NO. Nursing diagnosis: Alteration in comfort: actual Alteration in coping mechanism: actual Deficient knowledge (learning need) regarding condition, treatment plan, self-care, discharge needs.	sw

Vital Signs:

07/15		
12:27	BP 126 / 77 LA Sitting (auto/reg); Pulse 97 RA; Resp 18 S; Temp 97.7(T); Pulse Ox 99% on R/A; Weight 88.45 kg (M); Height 5 ft. 1 in. (154.94 cm) (R); Pain 7/10;	sw
07/15		
12:27	Body Mass Index 36.84 (88.45 kg, 154.94 cm)	sw

ED Course:

07/15		
12:20	Patient arrived in ED.	nb2
07/15		
12:22	Wegner, Susanne, RN is Primary Nurse.	sw
07/15		
12:24	Triage completed.	sw
07/15		
12:31	Arm band placed on right wrist. Patient placed in exam room.	sw
07/15		
12:33	Dr. Kyle George is Attending Physician.	kg
07/15		
12:35	ED Rounding: Pain Reassessment: remains unchanged at this time Call light is within patient's reach, and patient has been educated on it's use. Family Update: Patient does not have any family members to update Pending Items and/or Delays: Patient awaiting physician at this time Patient has been instructed that nurse will re-visit within 30 minutes.	sw
07/15		
12:35	Patient has correct armband on for positive identification. Bed in low position. Call light in reach. Door closed. Noise minimized. Verbal reassurance given.	sw
07/15		

12:35 No procedures required assistance by the nurse. sw
07/15
13:00 ED Rounding: Pain Reassessment: remains unchanged at this time Call light is within patient's reach, and patient has been educated on it's use. Family Update: Patient's family has been updated over the phone Pending Items and/or Delays: Patient is not awaiting any further diagnostics and/or procedures at this time Patient has been instructed that nurse will re-visit within 30 minutes Pt laying on right side following administration of ear drops to left ear. sw

Administered Medications:
07/15
12:59 Drug: Augmentin 875 mg Route: PO; sw
07/15
13:08 Follow up: Response: No adverse reaction sw
07/15
12:59 Drug: Ciprofloxacin Drops 0.3 % 2 drops {Note: drops placed in left ear per order.} Route: Ophthalmic; Site: left eye; sw
07/15
13:08 Follow up: Response: No adverse reaction sw

Outcome:
07/15
12:44 Discharge ordered by MD. kg
07/15
13:01 Discharge Assessment: patient awake and alert no apparent distress sw
13:01 Discharge instructions given to patient, Instructed on Antibiotic Use and Resistance discharge instructions, follow up and referral plans. medication usage, Demonstrated understanding of instructions, medications, Prescriptions given X 1
13:01 Discharged to home ambulatory.
13:01 Braden Scale-Adult not applicable, the patient was discharged.
07/15
13:08 Patient left the ED. sw

Signatures:

Wegner, Susanne, RN	RN	sw
Bryant, Nettie		nb2
Dr. Kyle George		kg

Corrections: (The following items were deleted from the chart)
07/15
12:26 07/15 12:24 PMHx: None; sw sw

****

Physician Documentation
AllianceHealth Madill
Emergency Department
Name: Blue, Tatum
Age: 19 yrs
Sex: Female
DOB: 07/25/2001
MRN: 0000821306
Arrival Date: 07/15/2021
Time: 12:19
Account#: 5132289
Bed 1
Private MD:
ED Physician George, Kyle
Disposition Summary:
07/15/21 12:44
Discharge Ordered

Location: Home/Self Care. MSE Completed	kg
Problem: new	kg
Symptoms: are unchanged	kg
Condition: Stable	kg
Diagnosis	
- Acute serous otitis media, left ear	kg
Followup:	kg
- With: Private Physician	
- When: Next available appointment	
- Reason: Recheck today's complaints	
Discharge Instructions:	
- Discharge Summary Sheet	kg
- Otitis Media, Adult	kg
Forms:	
- Medication Reconciliation Form	kg
Prescriptions:	
- Augmentin 875-125 mg Oral Tablet	
- take 1 tablet by ORAL route every 12 hours for 7 days; 14 tablet; Refills: 0, Product Selection Permitted	kg

Disposition:
07/15
13:02 Electronically signed by: Dr. Kyle George. kg

HPI:
07/15
12:58 This 19 yrs old Caucasian Female presents to ER via Walk-in with complaints of Ear Pain. kg
07/15
12:58 The patient presents with pain, moderate. The complaints affect the left ear. Onset: The symptoms/episode began/occurred last week. Modifying factors: The symptoms are alleviated by nothing, the symptoms are aggravated by nothing. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were mild in the emergency department the symptoms are unchanged. The patient has not experienced similar symptoms in the past. The patient has been recently seen by a physician: Dr. Tishomingo family. kg

OB/GYN:
07/15
12:27 Gravida 1, Full Term 0, Premature 0, Abortion 0, Living 0, LMP 4/29/2021, Pregnancy Verified, EDC 2/3/2022, Gestational age from LMP: 11 weeks 0 days sw

Historical:
- Allergies: No known Allergies;
- Home Meds:
  1. Prenatal Vitamin Oral tab 1 tab once daily
- PMHx: ORIF right humerus 2020;
- History obtained from: patient.
- Immunization history: Last tetanus immunization: unknown Pneumococcal vaccine is not up to date, Patient has never been vaccinated, Flu vaccine is not up to date, It has been more than one year since last vaccine..
- Social history: : Smoking Status: patient/guardian denies using tobacco. the patient stated never smoked. No barriers to communication noted. Speaks appropriately for age.
- Family history: No immediate family members are acutely ill.
- Social history: Smoking Status: patient/guardian denies using tobacco.

ROS:

07/15 12:59	All other systems are reviewed and negative. ENT: Positive for ear pain.	kg

Exam:

07/15 12:59	Head/Face: Normocephalic, atraumatic. Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.	kg
12:59	Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated. Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis. MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits.	
12:59	Constitutional: The patient appears in no acute distress, alert, awake, non-diaphoretic, non-toxic.	
12:59	ENT: External ear(s): are unremarkable, Ear canal(s): erythema, that is moderate, of the left canal, swelling, that is minimal, of the left canal, TM's: erythema, that is moderate, on the left, rupture, is not appreciated, Nose: is normal, no acute changes, Mouth: is normal, no acute changes, Posterior pharynx: is normal, no acute changes.	

Vital Signs:

07/15 12:27	BP 126 / 77 LA Sitting (auto/reg); Pulse 97 RA; Resp 18 S; Temp 97.7(T); Pulse Ox 99% on R/A; Weight 88.45 kg (M); Height 5 ft. 1 in. (154.94 cm) (R); Pain 7/10;	sw
07/15 12:27	Body Mass Index 36.84 (88.45 kg, 154.94 cm)	sw

Procedures:

07/15 13:00	No procedures were performed on this patient.	kg

MDM:

07/15
12:33 Patient medically screened. kg
07/15
13:00 Differential diagnosis: otitis media, otitis externa, ruptured TM, foreign body, cerumen impaction, barotrauma . Data reviewed: vital signs, nurses notes. Sepsis Protocol: The hospital sepsis protocol was not initiated because the patient did not meet appropriate scoring criteria. No hypotension present. Data interpreted: Pulse oximetry: on room air is 99 %. Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, the need for outpatient follow up, for definitive care, a family practitioner, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. kg

Dispensed Medications:
07/15
12:59 Drug: Augmentin 875 mg Route: PO; sw
07/15
13:08 Follow up: Response: No adverse reaction sw
07/15
12:59 Drug: Ciprofloxacin Drops 0.3 % 2 drops {Note: drops placed in left ear per order.} Route: Ophthalmic; Site: left eye; sw
07/15
13:08 Follow up: Response: No adverse reaction sw

Signatures:
Wegner, Susanne, RN RN sw
Dr. Kyle George kg

Corrections: (The following items were deleted from the chart)
07/15
12:26 07/15 12:24 PMHx: None; sw sw

****

Discharge Summary
AllianceHealth Madill
Name:Tatum Blue
Emergency Department
Age:19 yrs
Sex:Female
DOB:07/25/2001
MRN:0000821306
Arrival:07/15/2021
12:19
Account#:5132289
Departure Date07/15/2021
Departure Time13:08
Private MD:
Outcome: Discharge
Location: Home/Self Care. MSE Completed
Condition: Stable
Chief Complaint: Ear Pain
Diagnosis: Acute serous otitis media, left ear
Prescriptions: Augmentin 875-125 mg Oral Tablet - take 1 tablet by
ORAL route every 12 hours for 7 days; 14 tablet
Custom Notes:
Attending Physician: Dr. Kyle George
Private MD:
Mid Level Provider:
Orders: Augmentin, Ciprofloxacin
Discharge Instruction: Discharge Summary Sheet, Otitis Media,
Adult, Medication Reconciliation Form
****

Order Summary
Emergency Department
Name: Blue, Tatum
MRN: 0000821306
19 yrs
/ Caucasian
/ Female
Arrival: 07/15/2021
12:19
Chief Complaint: Ear Pain
Departure Date 07/15/2021
Departure Time 13:08
Orders:
Medication
Order: Ciprofloxacin Drops 0.3 % 2 drops Ophthalmic once; left ear;
Ordered: 07/15 12:47; By: kg; For: kg;Administered: 07/15 12:59
By: sw; Frequency: once; Order Method: Electronic Administration:
Ciprofloxacin Drops 0.3 % 2 drops Ophthalmic in left eye Follow
Up: 07/15 13:08 Response: No adverse reaction
Order: Augmentin 875 mg PO once; Ordered: 07/15 12:45; By: kg; For:
kg;Administered: 07/15 12:59 By: sw; Frequency: once; Order
Method: Electronic Administration: Augmentin 875 mg PO Follow Up:
07/15 13:08 Response: No adverse reaction

Order Signatures:
Dr. Kyle George, kg;
****

AllianceHealth Madill

901 S 5th Ave
Madill OK 73446
580-795-3384

Discharge Instructions for **Blue, Tatum**

Arrival Date **Thursday, July 15, 2021**

Thank you for choosing **AllianceHealth Madill** for your care today The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit

Care provided by George Kyle

Diagnosis Acute serous otitis media left ear

DISCHARGE INSTRUCTIONS	FORMS
Otitis Media Adult	Medication Reconciliation Form
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When Next available appointment Reason Recheck today's complaints	Augmentin
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any)

Tatum Blue _____ S Wagner RN _____

Tatum Blue **ED Physician or Nurse**

MRN # 0000821306

X RAYS and LAB TESTS
If you had x rays today they were read by the emergency physician Your x rays will also be read by a radiologist within 24 hours If you had a culture done it will take 24 to 72 hours to get the results If there is a change in the x ray diagnosis or a positive culture we will contact you Please verify your current phone number prior to discharge at the check out desk

MEDICATIONS
If you received a prescription for medication(s) today it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have It is also important that you notify your follow up physician of all your medications including the prescriptions you may receive today

Chart Copy

FOLLOW UP INSTRUCTIONS

Private Physician
When Next available appointment
Reason Recheck today's complaints

PRESCRIPTIONS

Pharmacy
Tishomingo Express Pharmacy (140 E Main Tishomingo OK 73460 Phone 580 371 2355)

Augmentin 875 125 mg Oral Tablet — Electronic
Take 1 tablet by ORAL route every 12 hours for 7 days Quantity 14 tablet

TESTS AND PROCEDURES

Labs
None

Rad
None

Procedures
None

Other
None

AllianceHealth MADILL

901 S. 5th Avenue
MADILL • OK • 73446
PHONE: (580)795-3384

ADVANCE DIRECTIVE (Y/N)	ACCOUNT NO.	MEDICAL RECORDS NO.
	5132289	0000821306

PATIENT

ADMIT DATE / TIME	ROOM NO.	PT	FC	AGE	DATE OF BIRTH	SEX	RA	MS	LOCATION	PROGRAM
07/15/2021 12:19	0000	E	D	19	07/25/2001	F	1	S	MER	N

PATIENT NAME & ADDRESS	SS NUMBER	PATIENT EMPLOYER	EMPLOYER PHONE NO.
BLUE, TATUM 7899 S WILLIARD TISHOMINGO OK 73460 US	***-**-4463 PHONE NUMBER (580)371-6882	CANNALINK	COUNTY 40JOHNSTON

GUAR

RESPONSIBLE PARTY & ADDRESS	SS NUMBER	RESPONSIBLE PARTY EMPLOYER	EMPLOYER PHONE
BLUE, TATUM ~~7899 S WILLIARD~~ PO Box 194 ~~TISHOMINGO~~ OK ~~73460~~ US Milburn 73450	***-**-4463 PHONE NUMBER (580)371-6882	CANNALINK	RELATIONSHIP TO PATIENT PATIENT IS G

EMERGENCY CONTACT NAME not in household	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATIONSHIP TO PATIENT

COMMENTS	MSP	PL ETH REL	PRIVACY	NPP	ADMIT. BY
	☐Y ☒N	ENG N			NB

PRIVACY	EMAIL	PPI	ACCIDENT	ACCIDENT DATE
		O		

INSURANCE

1	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
	856		03839818	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
HEALTHCHOICE PO BOX 99011 LUBBOCK TX 79490 (800)323-4314 1-1-2016	BLUE, TATUM			

2	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
	550	OK1	031209623	07/25/2001

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION
MEDICAID OKLAHOMA PO BOX 18430 OKLAHOMA CITY OK 73154 (800)522-0114 6-04-2021	BLUE, TATUM			

3	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
		T-19		/ /

INSURANCE CO. NAME & ADDRESS	INSURED'S NAME	GROUP NUMBER	GROUP NAME	AUTHORIZATION

MISC

DR. ADMITTING / ATTENDING	DR. FAMILY / PRIMARY CARE
GEORGE, KYLE M.	
CHIEF COMPLAINT	**ADMITTING DIAGNOSIS**
EAR PAION	

PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).

	DISCHARGE DATE/TIME

	Yes	No	N/A
Consent Signed?	✓		
Insurance Card Copied?	✓		
Copy of ID Secured?	✓		
Passport Reviewed?	✓		
Any Open Balances?		✓	
P/P AFR Administered?		✓	
Dar Notes Entered?	✓		

Deposit Requested $

Deposit Paid $

NB

Admit Clerk Signature

FACE

5132289

BUSINESS OFFICE COPY

ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.
All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*	YES	NO
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.* I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Primary Spoken Language: _____
Patient's preferred language for discussing healthcare: _____
Interpreter services are available 24 hours per day.
Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.
Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.
Call 1-580-795-3384 (TTY: 1-800-722-0353).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-580-795-3384 (TTY: 1-800-722-0353).

Nhà cung cấp này tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-580-795-3384 (TTY: 1-800-722-0353).

Patient/Family Member/Companion Signature: Tatum Blue	Date/Time: 7-15-2021
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time
Witness: N. Bryant	Date/Time: 7-15-2021

Patient Label
AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 19 F MER-
GEORGE KYLE M.
MR#: 0000821306
DOS: 7/15/2021
Patient Acct #: **5132289**

COA

1. GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:

I consent to treatment / admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me. I have a right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when health care personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments given by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or given by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I have been informed of the treatment/procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by a physician or one or more additional physicians, fellows, residents, interns, and employees of the Facility, who may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment. I agree and understand that all individuals involved in my care are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for their acts or omissions. Services may be performed by independent contractors who are not employed by the Facility. I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made for the results of treatments, care or examinations in the Facility.

I consent to the photographing, videotaping and/or video monitoring, of appropriate portions of my body, for medical and medical record documentation purposes, as long as such photographs or videotapes are maintained and released in accordance with protected health information regulations.

I consent to virtual health/telemedicine services as part of my treatment. I understand that "virtual health" or telemedicine services include the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that medical, nursing, and other authorized health care providers in training may be observing and participating actively in my care under the supervision of authorized personnel. I give my consent to such observations and/or participation.

I understand the facility may authorize the disposal of records in accordance with facility retention policies and state retention laws.

2. ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:

I assign to the Facility or as necessary to any Facility-based physician (for the purposes of this section, collectively the "Facility") all of my rights and benefits under existing policies of insurance providing coverage and payment for any expenses incurred as a result of services and treatment rendered by the Facility or any independent contractor. I authorize direct payment to the Facility or to any independent contractor of any insurance benefits otherwise payable to or on behalf of myself. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the Facility any and all documents related to my insurance plan, summary benefit description, insurance policy(ies), and/or settlement information upon written request from the Facility.

(continued on page 2)

_____ *Initials*

Patient Label

AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 19 F MER-
GEORGE KYLE M.
MR#: 0000821306
DOS: 7/15/2021
Patient Acct #: **5132289**

(continued from page 1)

I irrevocably appoint the Facility 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. I acknowledge that the Facility is not obligated to pursue any such claims.

In addition, I grant the Facility power of attorney to pursue any claims, penalties, and administration and/or legal remedies for collection against any responsible payer, employer sponsored medical benefit plans, third party liability carrier, or any other responsible third party. This power of attorney shall not be affected by subsequent disability or incapacity of me. This is not a power of attorney for health care decisions generally, and the powers granted hereby are expressly limited to those reasonably required to collect any payments or benefits under any policy of life, accident, disability, hospitalization, medical or casualty insurance.

I assign to the Facility all insurance benefits, sick benefits, injury benefits, or proceeds of claims resulting from the liability of a third party unless my account is paid in full when I am discharged or finish my outpatient care.

If I am eligible for Medicare, I request Medicare services and benefits. I agree this assignment will not be withdrawn until my account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.

I understand I am responsible to pay any account balance not covered by my insurance company in accordance with the standard charges that the Facility bills for such services. If I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, coUrt costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me.

3. NURSING CARE:

The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. I release Facility from any and all liability arising from the fact that I am not provided private nursing care.

4. EMTALA:

During the time period that the federal government has invoked 1135 waivers in order to deal with the emergency COVID-19 crisis, if I have a medical emergency or if I am a pregnant woman in labor, I understand that the Hospital will do its best to provide care in the setting most appropriate and within the capabilities of this Hospital's staff and facilities, including an appropriate medical screening exam, stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

5. PERSONAL VALUABLES:

I understand that the Facility is not liable for the loss or damage to any articles of personal valuables unless I have given them to the Facility to be put in the safe and been given a receipt by Facility for their safe return. At no time will the Facility be responsible for more than $500 for my deposited items.

(continued on page 3)

_____ *Initials*

Patient Label

AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 19 F MER-
GEORGE KYLE M.
MR#: 0000821306
DOS: 7/15/2021
Patient Acct #: **5132289**

(continued from page 2)

6. WEAPON / EXPLOSIVES / DRUGS:

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including giving them to law enforcement.

7. CONSENT TO RELEASE HEALTH INFORMATION:

I understand this Facility uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Facility's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Facility; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Facility). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

8. NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Facility's Notice of Privacy Practices and consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

Please initial one option:

_____ I give the Facility permission to disclose my name, room number, and general condition to anyone who inquires during my stay at the Facility.

_____ I do not give permission to the Facility to disclose information about my presence at the Facility during my stay. I realize that by choosing this options, I will not be able to receive flowers, cards, phone calls, family/visitors or clergy visits.

(continued on page 4)

_____ *Initials*

(continued from page 3)

9. RESEARCH STUDIES: ***Please initial:***

___ Yes ✓ No Are you currently a participant in any research study or project: *If yes, please briefly describe what is being studied (drug, medical device or other)* _____

_____

Who can the Facility contact with questions about the study? _____

_____

10. COMMUNICATIONS:

I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

11. EXTERNAL PHARMACY:

I consent to the exchange of prescription information between the facility and my pharmacy(ies).

12. VIDEOTAPING/RECORDING:

I agree not to photograph, video record, audio record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure my visitors comply with this requirement.

13. ED NAVIGATOR PROGRAM:

If this facility offers an ED Navigator Program which provides information and assistance to patients who request help obtaining a referral to a Primary Care Physician, the ED Navigator Program disclosures are attached hereto as Exhibit: "ED Navigator Program Disclosures" and incorporated herein by reference. By signing this consent, Patient affirms that the ED Navigator Program disclosures have been effectively communicated to the Patient and the Patient has had the opportunity to have any questions regarding the ED Navigator Program answered to his/her satisfaction."

14. OUT-OF-NETWORK SERVICES:

I understand that the Facility may not participate in my medical health insurance network or my health insurance carrier may not have any established health insurance networks with hospitals or other provider groups. I understand that even where the Facility participates in my medical health insurance network, some physicians or other healthcare providers who may not be employed by this Facility and who may not participate in my insurance network, such as

(continued on page 5)

_____ *Initials*

(continued from page 4)

anesthesiologists, radiologists, emergency room physicians, and pathologists, may be called upon to render healthcare items or services during the course of treatment at the Facility that may be billed separately. The list of such specialists is available on the Facility's website, and that listing is incorporated herein by reference. I understand and acknowledge that, when the Facility or provider or particular specialist does not participate in my medical health insurance network, the Facility or provider or specialist, as applicable, is not bound by the payment provisions that apply to health care items or services rendered by a network provider under my health insurance plan.

I acknowledge that I have the right to verify or confirm and, prior to receiving services, have verified or confirmed or had the opportunity to with my insurance carrier to find out if the Facility or medical care providers involved in my treatment at the Facility are in-network and to obtain a list of network providers that may render the health care items or services I request. I understand if I do not verify places me at risk of higher out-of-network charges due to a possible benefit reduction.

Finally, I acknowledge and understand that, if I am to receive medical care by a healthcare provider not in my insurance network, I will be billed at 100% of the standard charges that the Facility bills for such services, which I can view on the Facility's website or upon request, to the extent permitted under state law. I further acknowledge that I am responsible to pay any account balance not covered by my insurance company, in accordance with the standard charges that the Facility bills for such services to the extent permitted under state law. Under these circumstances, if I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, court costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to any past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me pursuant to the assignment of benefits set forth herein.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above.

Patient's Signature or Legal Representative: Tatum Blue		Date/Time: 7-15-2021
Relationship to Patient	Interpreter, if Utilized	Date/Time
Witness Signature: N. Bryant		Date/Time: 7-15-2021

Patient Label
AllianceHealth Madill
BLUE TATUM -
DOB: 7/25/2001 19 F MER-
GEORGE KYLE M.
MR#: 0000821306
DOS: 7/15/2021
Patient Acct #: **5132289**

eAbstract Summary
MARC- Marshall 735

Medical Record #	0000821306	**Encounter #**	5132289	**Name**	BLUE, TATUM

Admission Date	07/15/2021	**Encounter Type**	ED-Emergency
Discharge Date	07/15/2021	**Race**	NON HISPANIC
Birthdate	07/25/2001	**Primary Payor**	D-PPO
		Sex	Female
Admission Type	Emergency	**LOS**	1
Admission Source	Physician Referral	**Admission Service**	EMR
Discharge Disposition	Home	**Discharge Service**	EMR

Admit MD	4104	GEORGE, KYLE
Discharge MD	4104	GEORGE, KYLE

RVDX	H9202	Otalgia, left ear
Princ Diag	H6502	Acute serous otitis media, left ear
Other Diag	Z331	Pregnant state, incidental

CPT Proc	99283	EMERGENCY DEPT VISIT	7/15/2021	4104	GEORGE, KYLE

Coded	07/19/2021	sgist
Bill Submitted	07/19/2021	sgist
Abstracted	07/19/2021	sgist
Abstract Status:	Complete	