CONDITIONS OF ADMISSION, CONSENT TO TREATMENT, AND FINANCIAL AGREEMENT

Patient: ______________________ Date: __________ Time: __________ a.m. / p.m.

CONSENT TO TREATMENT

I am presenting myself for admission to this health care facility for care and treatment during this hospitalization or on an outpatient basis, and I voluntarily request and consent to the rendering of such care by the health care facility's employees, medical staff, or others holding clinical privileges, including routine hospital services, diagnostic procedures, intravenous therapy, medications, anesthesia, injections and blood transfusions, and other services or procedures that may be administered to or performed on me under the general or special instruction of my physician or his or her designees, as they may deem necessary or beneficial for my care. I understand that testing for infectious conditions such as Human Immunodeficiency Virus (HIV) may be included. This consent is valid during the course of my admission or outpatient treatment unless revoked by me. I understand that my consent may be revoked verbally or in writing.

I understand that I have the right to discuss proposed procedures or treatments with my physician, and to consent to, or refuse such procedures or treatments. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result or effectiveness of treatment or services rendered in this health care facility.

I further understand that it is my physician who has the medical knowledge and pertinent information on my condition and who is or will be recommending proposed treatment after adequately informing me of such, together with any risks and alternative treatment; and that it is the responsibility of my physician to obtain my informed consent to any proposed treatment, operation, or procedure.

INDEPENDENT PRACTITIONERS

I understand my care in this health care facility is under the control and direction of my physician, sometimes called the attending or primary physician, who must exercise independent professional judgment in rendering and directing medical care. I understand that my physician and any other physicians, including emergency room physicians, radiologists, pathologists, and anesthesiologists, are independent contractors, **not** employees or agents of the health care facility, and are not under the direction or control of the health care facility in making medical decisions. Further, I understand that such practitioners may bill separately for their services and may not accept the same insurance coverage as is accepted for this health care facility's services.

FACILITY OWNERSHIP

This health care facility may be physician-owned. A list of the physician owners, if any, is immediately available upon request. These physicians become owners to provide absolute quality patient care in this healthcare environment. Physician ownership in this facility helps facilitate control over quality of care. I understand that if I have any questions or concerns about this notice, I will contact my attending physician.

FINANCIAL AGREEMENT

I assume full financial responsibility for and agree to pay all charges of the health care facility and of physicians rendering services. All charges are due and payable upon presentment. No extensions, forbearances, or delays in enforcing any rights of collection of charges shall in any manner release or affect my responsibility for charges.

If it becomes necessary to refer an account to a collection agency or an attorney to collect unpaid amounts due, I agree to pay all costs of collection, including reasonable attorneys' fees, in addition to the unpaid amount due.

DOB: AGE: HSV: SEX:
ADMIT: RM/BED: /
ATT: #:
MR #: PAT #:

ASSIGNMENT OF BENEFITS

I hereby assign all of my rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the health care facility and authorize direct payment to the health care facility of any insurance benefits otherwise payable to me for the hospitalization or for outpatient services, including emergency services, if rendered, goods, and facilities provided. I understand there is no guarantee of reimbursement or payment from any insurance company or other third-party payor and that I am financially responsible for all charges not paid for any reason by my health insurance or other third-party payor within a time period the health care facility deems reasonable. Any exception to these terms must be agreed to by the health care facility before services are rendered.

ASSIGNMENT OF CLAIMS

I hereby assign to the health care facility any and all claims and causes of action of any kind whatsoever against an insurance company or other third-party payor or against any other person or entity (each a "Responsible Party") for payment or reimbursement for services, goods, or facilities provided by the health care facility, and I hereby irrevocably appoint the health care facility as my authorized representative to pursue such claims and causes of action on my behalf. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal or administrative claims. I understand and agree that this assignment takes effect upon notice to me by the health care facility that it intends to exercise these rights. I also understand that this assignment is given to permit the health care facility to pursue these claims on my behalf as a courtesy to me and that the health care facility is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation and agreement to pay the health care facility's charges.

I agree to take all actions necessary to assist the health care facility in collecting payment from any such Responsible Party should the health care facility elect to collect such payment, including allowing the health care facility to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment, I acknowledge that it is my duty and responsibility to immediately pay any such payments to the health care facility.

I also irrevocably assign to the health care facility all rights, title and interest in benefits payable out of any third-party action against any other person, entity, or insurance policy(s) under which I may be entitled to recover. I hereby request that payment of authorized benefits be made on my behalf to the health care facility.

Additional Terms: I hereby authorize the health care facility to obtain a credit bureau report on me if it deems necessary. Such credit report may include investigations of person credit history, employment, and other financial situations.

PREAUTHORIZATION REQUIREMENTS

I understand that it is my sole responsibility to comply with all requirements of any insurance or medical/hospital coverage plan under that I am relying for coverage of the health care facility's and physicians' charges.

RELEASE OF INFORMATION

I authorize the health care facility and my physicians to release information from my medical records for treatment, payment and health care operational purposes as described in the health care facility's Notice of Privacy Practices, including to any health care provider involved in any way in my care and to any person or entity which is or may be liable for all or part of the charges for services, goods or facilities provided to me. I also authorize the release of information needed for discharge planning, transfer and follow-up purposes. I understand that following release of this information, the health care facility cannot control its confidentiality.

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the health care facility staff or my physician to speak freely about my condition, diagnosis, prognosis, or test results with the individuals listed below.

Name	Relationship	Contact Information

Additionally, I would like to have, as designated below, restrictions from release of my protected personal health information.

Entity that you do not want information released to:	Specify the information you do not want released. This may include restriction of disclosures of PHI to the individual's health plan/payor where you have paid for the items or services out of pocket and in full.

Either of these requests, listed above, may be changed verbally or in writing at any time, by letting your health care provider (nurse or physician) know that you wish to make a change.

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I acknowledge the following:

1. I have been given written materials on this health care facility's policies regarding the implementation of advance directives and about my right to accept or refuse medical treatment.
2. I have been informed of my rights to formulate advance directives.
3. I understand that am not required to have an advance directive in order to receive medical treatment.
4. I understand that the terms of any advance directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. However, I understand it is my responsibility to provide the health care facility with a copy of my advance directive, and I understand that until I provide this document, the health care facility may not be able to honor my wishes.

☐ Yes ☐ No I have executed an advance directive.
☐ Yes ☐ No A copy of the advance directive was obtained at admission.
If no copy, name patient's agent or surrogate: ______________________________
☐ Yes ☐ No I would like assistance regarding advance directives.

If no copy of the patient's advance directive is available, what is the patient's intent (use the patient's or healthcare surrogate's own words.)

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ACKNOWLEDGEMENT TO MAIL OR EMAIL

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a representative of the health care facility or my physician to mail, call, or email me with communications regarding my health care, including but not limited to such things as appointment reminders, referral arrangements, laboratory results and my financial account Notices. I understand that I have the right to rescind this authorization at any time by notifying the health care facility in writing.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

I agree that, in order for the health care facility, or its billing service providers or collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your billing service providers and collection agents may contact me by telephone at any telephone number I have provided or you or your billing service providers and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization or outpatient visit, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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RM/BED: /
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PAT #:

PERSONAL VALUABLES

It is understood and agreed that the health care facility is not responsible for the safekeeping of money and valuables. I have been encouraged to send all money and valuables home with family or trusted friends. The health care facility shall not be liable for the loss or damage including but not limited to any money, jewelry, garments, or other articles of value.

FIRE ARMS NOTICE

Pursuant to Texas law, a person licensed to carry a concealed handgun may not enter this property with a concealed handgun. Pursuant to Texas law, a person licensed to openly carry a handgun may not enter this property with a handgun that is carried openly.

NON-SMOKING NOTICE

It is the policy of the health care facility to provide a healthy and smoke-free environment for all who enter the facility. Therefore, smoking is not permitted in any facility structure and only at exterior locations marked as smoking area. "NO SMOKING" signs are posted in all buildings and areas controlled by the health care facility where patients are seen or housed. Patients who are non-compliant will be warned and their smoking materials removed until time of discharge. Visitors who are non-compliant may be asked to leave the facility.

PHOTOGRAPHY AND AUDIO-VIDEO RECORDINGS

I understand that photographs, videotapes, digital or other images may be recorded to document my care or for internal staff education and the facility's health care operations purposes, and I consent to this internal use only and for the health care facility to retain ownership rights to these images. I understand that these images will be stored and destroyed in a secure manner that will be consistent with protecting my privacy as it applies to the purpose of the use of these images. I understand that after these images have been created, stored, and used, I cannot revoke this authorization. My specific consent will be separately obtained for any release of photographs, video, audio, or other electronic recordings to external parties.

I ACKNOWLEDGE I HAVE READ THIS CONDITIONS OF ADMISSION, CONSENT TO TREATMENT, AND FINANCIAL AGREEMENT, UNDERSTAND ITS CONTENTS, AND HAVE RECEIVED A COPY OF IT. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT OR A PERSON AUTHORIZED BY THE PATIENT OR OTHERWISE TO SIGN AND ACCEPT THIS CONDITIONS OF ADMISSION, CONSENT TO TREATMENT, AND FINANCIAL AGREEMENT ON BEHALF OF THE PATIENT.

I further acknowledge that I have received a copy of the health care facility's Notice of Privacy Practices and Patient's Rights and Responsibilities on the date written below.

____ ____________________
Signature of Patient or Authorized Representative | Date

____ ____________________
Signature of Witness | Date

____ ____________________
Signature of Second Witness *(required on verbal authorization)* | Date

If signed by an Authorized Representative:

Print or Type Name: ______________________________

Explain How Authorized: ____

DOB:
ADMIT:
ATT:
MR #:

HSV:
AGE: SEX:
RM/BED: /
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PAT #: