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: /
#:
PAT #: