HOUSTON PHYSICIANS' HOSPITAL

FACILITY CONSENT - TEXAS

Place Patient Sticker Here

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT
CONSENT TO MEDICAL AND SURGICAL PROCEDURES

1. I, the undersigned, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations, diagnostic procedures, access to prescription information, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician.

2. Except in cases of emergency, operations or procedures are not performed until I have had the opportunity to receive this information and have given my consent. If there are surgeries or procedures that I do not want performed, I have informed my doctor.

3. I authorize my doctor to use additional associates, assistants, or other healthcare providers to assist with my surgery/medical procedure. My doctor may assign or request additional assistance from anesthesiologists, other anesthesia providers, licensed medical residents in training or others who perform specialized medical care and treatment. My doctor has explained their role and involvement in my care and treatment.

4. I understand the legal relationship between the hospital and physician: and that the persons who perform these specialized medical services, such as anesthesia, surgeons, allied health professionals, radiology or pathology, are independent contractors and, are not agents or employees of the Facility or my doctor. Since they are independent contractors, the Facility is not responsible or liable for their acts or omissions.

5. I understand that the Facility maintains personnel and equipment to assist my doctor with surgical operations and other special diagnostic or therapeutic procedures. I consent to use of this staff and equipment for my care.

6. I authorize the presence of approved observers for my surgery/medical procedure. This includes medical/nursing students; medical school residents/interns; medical company equipment specialists; and other healthcare students. My doctor has discussed this with me and explained their role in my surgery/medical procedure. I understand that I have a right to privacy and that I do not have to agree to their presence during my surgery/medical procedure.

7. I authorize the pathologist to use his/her discretion in disposing of any body parts, organ, or other tissue removed from my body during the surgery/medical procedure.

8. I authorize the Facility staff or my doctor to photograph or videotape my surgery/medical procedure and use the prints, negatives or videotapes for purposes related to my healthcare, professional activities or medical education. My identity will not be shown, and the photos, negatives and videotapes will be the property of the doctor or the Facility.

9. In case of an emergency, I authorize the Facility and my doctor to transfer me to another healthcare facility if medically necessary for my care. I also consent to the release of my medical records to that facility and to other doctors who will continue my care.

10. In the very rare event that a Facility employee or health professional has accidental exposure to my blood or other body fluids (for example, they are stuck by a needle), I authorize the Facility to draw blood for testing for the presence of HIV/AIDS or hepatitis. I know I will not be charged for this testing. Test results will be used, if tests show presence of these illnesses, to offer medical care to the employees or healthcare professionals and to protect my health and the health of my family. All results will be forwarded to my personal physician for confidential medical follow-up and treatment if needed.

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ADVANCE DIRECTIVES:

11. I understand that advance directives may include living wills or other probate arrangements, durable powers of attorney or appointment of a "healthcare surrogate".

Please **read** and **initial** all applicable statements and circle the words **[DO] or [DO NOT]:**

Advance Directive (please select one):	_____I **DO** have an executed Advance Directive and as requested, have supplied a copy to the hospital. _____I **DO** have an executed Advance Directive and although requested, have **NOT** supplied a copy to the hospital.
	_____ I **DO NOT** have an executed Advance Directive. The hospital has offered me information on Advance Directive which I [DO or DO NOT] wish to receive
Durable Power of Attorney (please select one):	_____ I **DO** have an executed Durable Power of Attorney for Healthcare Decisions and have supplied a copy to the hospital. _____ I **DO** have an executed Durable Power of Attorney for Healthcare Decisions but have **NOT** supplied a copy to the hospital
	_____I **DO NOT** have an executed Durable Power of Attorney for Healthcare Decisions. The hospital has offered me information on Durable Power of Healthcare Decisions which I [DO or DO NOT] wish to receive.

12. **PERSONAL VALUABLES:**
I understand that the Facility maintains a safe for the safekeeping of money and personal valuables, and that the hospital shall not be liable for the loss or damage to any money or personal valuables, unless placed therein and shall not be liable for loss or damage to any other personal property, unless deposited with the Facility for safekeeping.

13. **WEAPONS/EXPLOSIVES/DRUGS**:
I understand and agree that if the Facility at any time believes that there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate including delivery of any item to law enforcement authorities.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

RELEASE OF INFORMATION: I agree that the Facility may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer when legally appropriate. This includes appropriate release of and disclosure of my medical records in compliance with Privacy provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to designated family members, friends or designated caregivers who may be

present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL AGREEMENT: I agree to pay Houston Physicians' Hospital, Webster, Harris County Texas (the Facility) for all services and products administered to the patient. I understand and acknowledge that any monies collected by the Facility prior to the date services are rendered or products are administered by the Facility will be applied as a deposit towards total charges assessed for the patient's care. The deposit shall not be considered payment in full for services rendered or products administered by the Facility. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services rendered or products administered to the patient that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the Facility and any out of network charges.

TERMS: Net 30 days from date of invoice unless otherwise indicated above. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights, title, and interest in and to the basic and major medical benefits specified herein, that would otherwise be payable to me, to my physician(s) including, but not limited to, my anesthesiologist(s), radiologist(s), pathologist(s) and emergency room physician(s) and any other health care professional(s) who is/are providing professional services to me hereunder. Furthermore, I authorize separate payments to be made directly to such physician(s) and/or health care professional(s) if, and to the extent, they agree to accept this assignment of insurance benefits. I understand that I am financially responsible to such physician(s) and/or health care professional(s) if, and to the extent, they do not accept assignments of their party pay(s) and/or insurance benefits. In the event such physician(s) and/or health care professional(s) do accept assignments of the third party payor(s) and or insurance benefits, I understand that I am responsible for any and all charges not covered by this assignment of benefits

I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

DISCLOSURE OF OWNERSHIP: The physician who refers you to our facility may have an ownership interest in this facility. You are free to choose another facility in which to receive services.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

HIPAA PRIVACY NOTICE: I acknowledge that I have received the Facility's HIPAA PRIVACY notice and have had the opportunity to review its content. _____ with the effective date of 9/23/2013. (Please initial)

HOUSTON PHYSICIANS' HOSPITAL

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For Staff Use Only

The above named Patient/Personal Representative was provided with a copy of the "Notice of Privacy Practices." A good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement could not be obtained because:

_ Patient/Personal Representative refused to sign

_ Patient/Personal Representative was unable to sign

_ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

_ Other reason (please specifiy):_____

_____

_____

Signature of Staff Member Completing Form:

_____ _____ _____

Date Time

Original to be maintained in Patient's medical record

BILL OF RIGHTS: I acknowledge that I have been notified and shown the Bill of Rights and understand my rights as a patient. _____(Initial).

I certify that I have read this document, and am the patient, or am duly authorized to execute this form. My signature below certifies that (1) that I have read and understood the information provided in this form; (2) that I have had a chance to ask questions; (3) that the information has been presented in a clear manner, and (4) that I accept its terms.

_____

Patient Signature Date Time

_____

Parent/Guarantor/Conservator Date Time

_____

Witness Date Time

HOUSTON
PHYSICIANS'
HOSPITAL

PATIENT STATEMENT OF RESPONSIBILITIES

1. I will provide accurate information about present and past illnesses, hospitalizations, medications, allergies and "NPO" status.
2. I will make every attempt to understand the implications of my procedure, including risks of refusing treatment, and I will ask for clarification when needed.
3. I will arrive at the scheduled time or notify facility of inability to do so.
4. I will follow all discharge instructions.
5. I will be respectful of the rights of other patients and staff.
6. I will be respectful of others' property.
7. I will immediately inform my physician of change in condition or adverse reaction.
8. I will play an active role in my pain management by notifying the staff of the location and intensity of my pain as well as what interventions if any have worked in the past. I will report how effective interventions for the pain are while at the facility and work with the staff to achieve a comfortable level of pain control.
9. I will be responsible for assuring that the financial obligations of my health care are fulfilled as promptly as possible.

I understand what my responsibilities are at Houston Physicians' Hospital and I will comply.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

HOUSTON PHYSICIANS' HOSPITAL

DIRECTION FOR THE LIMITATIONS, MODIFICATIONS, OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

PART 1

- You may leave messages on my answering machine or voicemail regarding appointment reminders, test results, etc and indicate the office name/physician name.

❑ I give permission to leave a message.

❑ I do NOT give permission to leave a message.

- When I am in the facility under your treatment and care, you have my permission to disclose pertinent information to family members, friends or designated caregivers who may be present with me. (I understand that if I am not present in the facility, you will not disclose my personal health information unless I personally agree to the disclosure)

❑ Yes See Part 2

❑ No See Part 3

PART 2

- If you wish to give permission for such communication, please **complete one of these two options.** If you do not choose an option, we will not disclose any information:

❑ I give permission to discuss my treatment of condition with persons who identify themselves as my family members, friends, or designated caregivers when I am not present to consent.

❑ I give permission to discuss my treatment or condition ONLY with the following person(s) when I am not present to consent.

Name_____Relationship_____ Name_____ Relationship_____

PART 3~ For Surgery, Observation or Inpatients

- I understand that I will be contacted after discharge by a nurse to assess my postoperative progress. Please choose preferred method of contact:

❑ Please only contact me (the patient).
The best number to reach me is _____ The best time is_____

❑ I give permission to leave a message.

❑ I do NOT give permission to leave a message.

❑ Do not contact me (the patient) postoperatively.

OR

I designate _____to receive the call at phone number_____

The best time to call is_____

Signature_____Date/Time_____

HOUSTON PHYSICIANS' HOSPITAL ☐

HOUSTON PHYSICIANS' SURGERY CENTER ☐

Place Patient Label Here

Patient Questionnaire About An Injury

1. Is your procedure due to an injury? No _____ (you may stop here, no other questions to complete)
   Yes _____ (please answer the rest of the questions in as much detail as possible)

2. How did your injury occur? (please describe in as much detail as possible)

_____

_____

_____

_____

3. Where were you when the injury occurred? (for example: gym class; vacation; work; a public pool, on the street or highways, etc.)

_____

4. What activity was being performed when your injury occurred? (for example: exercising; playing football; putting items up on a shelf; driving a vehicle, etc.)

_____

_____

_____

5. Date the injury occurred (please complete one of the answers below)

(please provide month/day/year of injury) _____

I do not know the exact date, but can give an estimated year, month, or season _____

Not known _____

Form completed by: (please print name): _____

Today's Date: _____ Time: _____