ADMISSION ACKNOWLEDGEMENTS AND GENERAL CONSENT FOR TREATMENT

1. **General consent**. I understand that my health condition requires inpatient or outpatient admission. I consent to and authorize testing, treatment and hospital care at this hospital ("Hospital"), a Texas Health Resources hospital, by Hospital nurses, employees, and others as ordered by my physician and his/her consultants, associates, and assistants, or as directed pursuant to standing medical orders or protocols. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand that persons in professional training programs may be among the persons who provide care to me. I understand that in connection with my treatment, photos or videos may be taken. Any tissue or body parts removed from my body may be retained or disposed of by the Hospital at its sole discretion.

2. **Independent physicians**. I acknowledge that the physicians taking part in my care or providing a professional service to me do not work for the Hospital and that the Hospital is not responsible for their judgment or conduct. They practice independently and are not employees or agents of the Hospital. The exception to this is that some physicians may be medical residents in a graduate medical education program of the Hospital under the supervision of more experienced physicians. In addition to my attending physician, other physicians who may take part in my care may include radiologists, pathologists, anesthesiologists, hospitalists, neonatologists, cardiologists, emergency physicians, psychiatrists, and other specialists.

3. **No guarantee** I acknowledge that no guarantees or warranties have been made to me with the respect to treatment or services to be provided at this Hospital. I understand that all supplies, medical devices and other goods provided or billed to me by the Hospital are provided by the Hospital on an "AS IS" basis, and the Hospital disclaims any expressed or implied warranties with respect to them. With respect to specific supplies and devices, manufacturers' warranties may apply, and I may request manufacturer's warranty information concerning such supplies and/or devices.

4. **My valuables**: I understand that the Hospital does not assume responsibility for personal property I keep with me during my treatment/hospital stay. I understand that unnecessary items should be sent home and that a safe is available for my valuables.

5. **Assignment of benefits**: I hereby irrevocably assign to the Hospital and any practitioner providing care and treatment to me, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from any other payer providing benefits on my behalf, for and to the extent of the services and goods provided to me during this admission. Under this assignment, the Hospital shall have an independent, non-exclusive right to appeal or pursue any denied or delayed claims on behalf of the insured or beneficiary. This assignment is not and shall not be construed as an obligation of the Hospital and/or Hospital-based physician to pursue such interest and rights. In signing this form, I (as the patient or patient's agent) am directing any applicable health insurer, health benefit plan, indemnity plan, reinsurer, third-party liability insurer or other payer providing benefits on my behalf to pay the Hospital and/or Hospital-based physicians directly for the services and goods the Hospital and/or Hospital-based physicians provide to me.

6. **Financial agreement:** I hereby promise to pay the Hospital its full billed charges for all services and goods provided to me. I understand that the Hospital, as a courtesy to me, may bill my insurance company, health benefit plan, or other non-governmental payer concerning the services and goods provided by the Hospital to me but that the Hospital is under no obligation to do so. Except as prohibited by law or by written agreement of the Hospital, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and/or health benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and/or plan limitations, exclusions, and/or failure to comply with insurance and/or plan requirements. I further understand that the Hospital, by mutual agreement with me or a person and/or entity making payments on my behalf, may agree to accept a discounted amount of its charges in full payment of the charges; however, to the extent the Hospital has not agreed to accept less than the charges, I agree to be responsible for payment of the full amount of the charges less any amounts already paid by me or on my behalf. If I am entitled to benefits under a governmental plan, such as Medicare or Medicaid, I further understand the Hospital may bill such plan and may accept as payment in full a discounted payment for the services and goods provided to me. Charity care may be available if Hospital eligibility criteria are met.
An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of my treatment, intensity of care, physician practices, and the necessity of providing additional services and goods.

   I hereby consent to credit bureau inquiries and to receiving auto-dialed and/or artificial or pre-recorded message calls to my cellular telephone and to any telephone number provided during my registration process from Texas Health Resources or its affiliates and their agents including, without limitation, any account management companies and independent contractors including any collection agents.

7. **Medicaid patients only**: I understand that the services or goods that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or goods I request and receive if these services or goods are determined not to be reasonable and medically necessary for my care. If I am a Medicaid Star patient, these provisions may not apply.

8. **Medicare patients only:** I acknowledge receipt of the written material entitled, "*Important message from Medicare*".

9. **Communicable disease testing**. I acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, the Hospital may perform tests, without my consent, on my blood or other bodily fluid to look for the presence of hepatitis B and C and HIV. I understand that such testing is needed to protect those who will be caring for me while I am a patient at the Hospital. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my Hospital patient record.

10. **Obstetrics patients only:** This *Admission Acknowledgement and General Consent for Treatment* also applies to any child(ren) born to me during this hospitalization.

11. **Outpatients only:** If I am registering as an outpatient, I understand this form shall be valid during my present visit and future outpatient visits at the Hospital until revoked by me or I sign a new *Admission Acknowledgements and General Consent for Treatment* form.

Acknowledgement:

I, the undersigned, certify that I have read and fully understand the information in this form and agree to be bound by its terms.

Signature of patient or authorized representative	Relationship to patient	Date	Time

Witness	Title	Date	Time

If the person signing this form is not the patient, please give full name, phone number and address:

Name

Phone number Address

HOSPITAL NAME MUST BE FILLED IN BLANK BELOW

PATIENT IDENTIFICATION

9051

Texas Health Resources®

Admission Acknowledgements and General Consent for Treatment