

HOSPITAL CONSENT - TEXAS

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

The term "Hospital" includes the Hospital's inpatient department, emergency department, pain management, outpatient surgery, and outpatient departments. This is a comprehensive admission and authorization form that may be utilized for scheduled surgical procedures that contain a surgical package of services to include pre-operative lab work, radiology/diagnostic imaging, surgery, and post-operative care. Only one form is required for the surgical package of services.

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, pain management, 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 healthcare providers. I understand that my treatment is under the control of my attending physicians, their assistants or designees, and that they may utilize telemedicine or other electronic technologies to provide me with care, or communicate and/or consult with other providers involved in my care. I understand that I will be asked to provide informed consent for certain diagnostic studies, surgeries, or other procedures. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

I authorize my physician to use additional associates, assistants, or other healthcare providers to assist with my surgery/medical procedure. My physician 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. I understand that the Hospital maintains personnel and equipment to assist my physician with surgical operations and other special diagnostic or therapeutic procedures. I consent to use of this staff and equipment for my care.

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. 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

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.

I authorize the Hospital staff or my physician to photograph or videotape my surgery/medical procedure and use the prints, negatives or videotapes for purposes related to my healthcare. I understand that these medical images, photographs, audio recordings, digital recordings, or video recordings may be used for treatment and that these images or recordings will become part of my health information subject to uses and discloses as described in the Notice of Privacy Practices. I also understand that these images and recordings may be utilized in professional activities or medical education. In such a case, my identity will not be shown, and the photos, negatives and videotapes will be the property of the physician or the Hospital.

I authorize the Hospital staff or my physician to photograph or videotape my surgery/medical procedure and use the prints, negatives or videotapes for purposes related to my healthcare. I understand that these medical images, photographs, audio recordings, digital recordings, or video recordings may be used for treatment and that these images or recordings will become part of my health information subject to uses and discloses as described in the Notice of Privacy Practices. I also understand that these images and recordings may be utilized in professional activities or medical education. In such a case, my identity will not be shown, and the photos, negatives and videotapes will be the property of the physician or the Hospital.

In case of an emergency, I authorize the Hospital and my physician 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 physicians who will continue my care.

In the very rare event that a Hospital 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 Hospital to draw blood for testing for the presence of HIV/AIDS, hepatitis, or other contagious viruses. 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.

ADVANCE DIRECTIVES

(complete for all inpatients and outpatients in the emergency department, patients who are in observation status, or who are undergoing same-day surgery)

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



2COA
Revised Date: 14 June 2023

«Last_Name», «First_Name»

Age: «Age» «Birth_Date» Sex: «Sex»

DOS: «Admit_Date»

Att: Dr.«Attending_Physician_First_Name»

«Attending_Physician_Last_Name»



VisitID: «Visit_ID»

MRN: «Medical_Record_Number»

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Please **read** and **initial** all applicable statements and check the boxes for DO or DO NOT

Advance Directive (please initial 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 wish to receive information

DO NOT wish to receive information

Durable Power of Attorney (please initial 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 wish to receive information

DO NOT wish to receive information

PERSONAL VALUABLES:

I understand that the Hospital 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 Hospital for safekeeping.

WEAPONS/EXPLOSIVES/DRUGS:

I understand and agree that if the Hospital 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 Hospital 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

CONSENT TO DISCLOSE GENERAL INFORMATION

By signing below, I understand that my name, location in Hospital, and general condition may be provided to any person asking about me by name, and to members of the clergy, my family or other individuals involved in my health care, or for disaster relief purposes.

FINANCIAL AGREEMENT: I agree to pay Houston Physicians' Hospital, Webster, Harris County Texas (the Hospital) for all services and products administered to me or the patient for whom I am signing this authorization. I hereby obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms. I understand and acknowledge that any monies collected by the Hospital prior to the date services are rendered or products are administered by the Hospital 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 Hospital. 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 Hospital and any out of network charges that are permitted under state and federal law. I also understand that services may be provided by individuals who are not employed by the Hospital and they will bill separately for their services.

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



2COA
Revised Date: 14 June 2023

«Last_Name», «First_Name»

Age: «Age» «Birth_Date» Sex: «Sex»

DOS: «Admit_Date»

Att: Dr.«Attending_Physician_First_Name»

«Attending_Physician_Last_Name»



VisitID: «Visit_ID»

MRN: «Medical_Record_Number»

