HOUSTON PHYSICIANS' HOSPITAL

HOSPITAL CONSENT - TEXAS

CONDITIONS OF TREATMENT AND AUTHORIZATION FOR OUTPATIENT ANCILLARY PROCEDURES (LABS, RADIOLOGY) AND PHYSICAL THERAPY

The terms "Hospital" includes the Hospital's delivery of certain outpatient ancillary services, in the Hospital or in the Hospital's outpatient clinics, including, but not limited to, laboratory services, radiology/diagnostic imaging, and physical therapy services.

I, the undersigned, consent to the procedures which may be performed during this outpatient encounter, 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 healthcare providers. I understand that my treatment is under the control of my healthcare providers, 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 treatment or 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 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 treatment or 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 treatment or 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 treatment or procedure.

I authorize the Hospital staff or my physician to photograph or videotape my treatment or 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.

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

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

«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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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 be 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

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 Hospital and the physician(s) including, but not limited to, my anesthesiologist(s), radiologist(s), pathologist(s) and emergency room physician(s) and any other healthcare 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 healthcare 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 healthcare professional(s) if, and to the extent, they do not accept assignments of third party payor(s) and/or insurance benefits. In the event such physician(s) and/or healthcare 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 to the extent permitted under state and federal law. I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

DISCLOSURE OF OWNERSHIP
We are required by Federal law to notify you that this Hospital meets the Federal definition of a "physician-owned hospital" as specified in 42 C.F.R. § 489.3. A list of physicians or immediate family members of physicians (as defined in 42 C.F.R. 411.351) who have a financial interest in this Hospital is available for review during normal operating hours upon request at the business office of the Hospital. You are free to choose another Hospital 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.

CONSENT FOR CONTACT BY LANDLINE OR CELLULAR TELEPHONE NUMBER
By signing below, I hereby consent to Hospital, or its agents or representatives, contacting me by the following means (even if the Hospital, or its agents or representatives, initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice): (1) paging system: (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6) facsimile

HIPAA PRIVACY NOTICE
By signing below, I acknowledge that I have received the Hospital's HIPAA Notice of Privacy Practices and have had the opportunity to review its content.

BILL OF RIGHTS
By signing below, I acknowledge that I have been notified and shown the Bill of Rights and understand my rights as a patient.

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

«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»