PATIENT IDENTIFICATION

# TREATMENT AUTHORIZATION AND TERMS OF TREATMENT AGREEMENT



78386 A
REV. 2/19

UTHealth East Texas

A. **Consent for Surgical and/or Medical Treatment:** I hereby grant permission to the physicians in charge of the case of the above-named patient to employ such surgical, x-ray, photographic, and technical procedures as they may deem necessary in the diagnosis and treatment of this case.

B. **Students or Technical Representatives:** I consent to have student(s) or manufacturer's technical representative(s), under direction of the hospital caregiver to observe my care while I am a patient. I further understand that all student(s) or manufacturer"s technical representative(s) have signed confidentiality agreements and that none of my personal health information will be disclosed to anyone other than the caregivers.

C. **Accidental Exposure of Healthcare Worker:** I understand that Texas law provides and I agree, if any healthcare worker is exposed to my blood or other bodily fluid, to allow UT Health East Texas to perform test(s) on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at UT Health East Texas. I understand the results of tests taken under these circumstances do not become a part of my medical record.

D. **Independent Physicians:** UT Health East Texas and any other hospital, or entity operated as a part of the UT Health East Texas (collectively referred to as the "Hospital"), is not responsible for the judgment or conduct or any physician who treats or provides a professional service to me, but rather each physician is an independent contractor who is self-employed and is not the agent, servant, or employee of the Hospital. I further understand that other physicians may be called upon to provide care, either directly (as consultants) or indirectly through professional services (i.e. Radiology, Pathology, EKG interpretations, Anesthesiology). These physicians are also independent contractors who are self-employed and are not the agents, servants, or employees of the Hospital. It is also understood that for emergency services, the Hospital may aid my selection of physicians by an established "on-call" roster provided through each department of the Hospital. These physicians are also independent contractors who are self-employed and are not the agents, servants, or employees of the Hospital. I further agree the Hospital is not responsible for the judgment or conduct of any of the physicians identified above.

E. **Authorization to Release Information:** I hereby authorize any physician or hospital who has attended me to furnish the insurance company, third party payer or its representative, any attending or consulting physician, nursing home or facility or other health care facility to which the patient is transferred or later receives treatment, any medical record, x-ray, test record or result or other information requested. A photo copy of this authorization is to be considered valid. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV and HBV and other diseases, all of which I specifically authorize to be released. **For purposes of treatment, I understand that the hospital may access my medication history through an electronic database.**

F. **Authorization to Disclose Information:** Except as otherwise set forth herein or allowed by law, I **do not** authorize the release of any information to others not acknowledged above. I wish to be a "no information" patient, and I realize that flowers, telephone calls and visitors will be refused on my behalf. (Patient's Initials: _____)

G. **Assignment of Benefits:** In consideration of hospital services rendered, I hereby assign and transfer to UT Health East Texas, all money due or to become due or payable to me under my insurance policy, or third party payment agreement up to the total amount of my account with UT Health East Texas. I appoint UT Health East Texas, and any agent acting on its behalf, as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies on my behalf for collection against any responsible payer of any and all benefits due me for the payment of charges associated with my treatment. I will be responsible for and will pay any amount due to UT Health East Texas not paid by my insurance company or third party payer, and if the insurance company refuses to pay any amount of my claim, I agree to pay my entire bill to UT Health East Texas. I hereby voluntarily grant consent for Service Provider or the Authorized Entities to contact me, my spouse, and where applicable, legal guardian or representative, using an automatic telephone dialing system or an artificial or prerecorded voice, via e-mail or via SMS text messages and any other forms of electronic communication. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. (Patient's Initials: _____)

H. **Physician's Assignment of Benefits:** I direct insurance benefits be paid directly to physicians with UT Health East Texas that provide professional services to me as a result of my hospital stay. I appoint the affiliated physicians, and any agent acting on their behalf, as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies on my behalf for collection against any responsible payer of any and all benefits due me for the payment of charges associated with my treatment. I will be responsible for and will pay any amount due to physicians not paid by my insurance company or third party payer, if the insurance company refuses to pay any amount of my claim associated with those professional services.

I. **Medicare and Champus/Champva Rights (Medicare/Champus Patients Only):** I acknowledge I have received a copy of the Medicare/Champus Rights. (Patient's Initials: _____)

J. **Personal Valuables:** I understand UT Health East Texas maintains a safe for money and valuables, and UT Health East Texas, **will not be responsible** for loss of or damage to any property or money unless deposited with UT Health East Texas for safekeeping and a written safekeeping receipt is issued by UT Health East Texas. (Patient's Initials: _____)

K. **Safety:** I understand, for reasons of safety, personal electrical items are not approved for use in UT Health East Texas. Such items include hair dryers, curling irons, hot rollers, radios, tape players, razors, heating pads and the like.

L. **Advance Directive:** I have been given written materials about my rights to accept or refuse medical treatment and my rights to formulate Advance Directives and have acknowledged whether or not I have executed an Advance Directive. I understand that I am not required to have Advance Directives in order to receive medical treatment at this healthcare facility. (Patient's Initials: _____)

M. **No Warranty:** I understand that no warranty or guarantee has been made to me as to result or cure.

N. **Patient Rights:** I have been given written materials about my rights as a patient. (Patient's Initials: _____)

O. **Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications:** By providing my telephone number (whether landline or wireless) and/or email address to UT Health East Texas, I expressly consent that UT Health East Texas and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to UT Health East Texas or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or UT Health East Texas' services, including, but not limited to the following:

My hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities.

These communications may be transmitted by or on behalf of UT Health East Texas and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing service, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from UT Health East Texas. I understand that I will be able to change my preference at any time.

| _____ | _____ | _____ |
|---|---|---|
| Residential/Landline Telephone Number | Cellular/Wireless Telephone Number | Email Address |

| _____ | _____ | _____ a.m. / p.m. |
|---|---|---|
| Signature of Patient or Legally Authorized Representative | Date | Time |

| _____ | _____ |
|---|---|
| Name & Relationship if not Patient | Reason Patient Unable to Sign |

Witness:_____