CHRISTUS Health

STATE OF TEXAS

HOSPITAL CARE CONSENT

1. **General Consent:** I consent to _____ (the "Facility") giving me medical services and treatment that my doctor or other medical staff have ordered. My consent includes diagnostic testing (such as labs and x-rays), injections, immunizations, medications, and other medical treatment. I have the right to make decisions about my care. I know that I have the right to discuss treatment and procedures with the doctor beforehand. I also have the right to consent or refuse any treatment. Where appropriate, I consent to delivery of care utilizing interactive video conferencing thereby enabling a provider at a distant location to provide treatment to me and/or consult and advise my local healthcare provider in making decisions about the care provided to me. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Facility is under the direction of an independent provider, who is not an employee of the Facility. The Facility is not responsible for the medical care, medical judgment, and plan of care provided by non-employees. I recognize that services rendered in the hospital, including but not limited to, in the emergency department, inpatient, outpatient, SDC, etc. are admissions to the hospital for the purposes of, among other things, the Texas Property Code, Section 55.
2. **Personal Property:** I understand that I am responsible for my personal property while at the Facility. The Facility is not responsible for keeping my property safe.
3. **Financial Assistance:** If I cannot afford my Facility medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Facility's plain language summary of its Financial Assistance Policy. The full policy and more information is available at www.christushealth.org/charitycare.
4. **Release of Information:** I allow the Facility to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Facility's Notice of Privacy Practices. I agree that all records about my treatment are the Facility's property. I understand that medical records and billing information created or maintained by the Facility are available to Facility workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.
5. **Medicare/Medicaid Benefits:** If applicable, I certify that the information given by me in applying for payment under Title XVIII 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 any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.
6. **Communication:** I authorize the Facility (including any billing service, collection agency, agent, or contractor on the Facility's or contractor's behalf) to contact me by phone at any number that I have provided to the Facility at any time. The Facility may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Facility may use pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Facility may send me voicemail messages, text messages, or e-mails. I allow the Facility to contact me using any e-mail address that I have given it or any e-mail addresses that the Facility may obtain for me in the future.
7. **Testing After Accidental Exposure and State Reporting:** If a healthcare worker accidentally touches my blood or other body fluids, state law allows the Facility to test me for certain diseases. These diseases include human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Facility is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or Centers for Disease Control.
8. **Photography:** I consent to the Facility videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for medical education, quality improvement, research, or for other reasons related to treatment or operations. If the recordings or images are used, my identity will not be revealed. I will talk with my doctor if I do not want my recordings used for these purposes.
9. **Ethics:** The Facility is a Catholic health ministry dedicated to helping the sick and injured in compliance with the *Ethical and Religious Directives for Catholic Health Facilities*. The Facility may not be used for procedures that violate the directives.

CHRISTUS Health

STATE OF TEXAS

HOSPITAL CARE CONSENT

10. **Teaching and Observation:** I understand that the Facility may be a teaching facility. I consent to allow medical residents, students, and fellows who have a formal affiliation with the Facility to participate in my care as supervised by the treating physicians and permitted by Facility policy. Students, residents, and fellows from other non-affiliated programs as well as vendors may observe my care consistent with Facility policy and as approved by my treating physician.

11. **Assignment of Benefits:** In consideration of services rendered and to be rendered, the sufficiency of which is hereby acknowledged, I hereby **irrevocably assign and transfer to** CHRISTUS _____ Hospital (hereinafter referred to as the "Hospital") all right, title, and interest in all claims or benefits payable for hospital services rendered in the past or future, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity (hereinafter referred to as "Benefits") from whom my dependents or I may be entitled to recover. I further hereby irrevocably assign and transfer to the Hospital all right, title, and interest in any and all causes of action against all insurance companies, employee benefit plans, liability carriers, third party administrators, tortfeasors, and/or all other persons or entities responsible for payment (hereinafter referred to as "Responsible Parties") of Benefits and I hereby appoint the Hospital as my attorney in fact, with power of substitution, to sue or otherwise obtain payment of Benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of irrevocably granting the Hospital an independent right of recovery of Benefits against any Responsible Parties, at its option, but shall not be construed to be an obligation of the Hospital to pursue any such right of recovery. I hereby direct and irrevocably authorize all Responsible Parties to pay directly to the Hospital all Benefits and amounts due for services rendered by the Hospital without further request or written authorization from me. I further irrevocably authorize and direct that any Responsible Parties furnish copies of any insurance policies, employee benefit plans or any other document requested by the Hospital without further request or written authorization from me. I understand that in the event that the Hospital is not paid in full by proceeds of my insurance policies, this assignment does not release my obligation and liability to the Hospital for payment of the services and items provided to me by the Hospital. I agree to pay the Hospital for all charges incurred by me, or in the alternative, for all charges in excess of the sums actually paid by my insurance policies. We have the right to apply available funds in any or all of your accounts with us and our affiliates otherwise payable to you to any prior existing or future debt that you owe us. When we set-off a debt that you owe us, we reduce the funds in your account(s) by the amount of the debt. We are not required to give you any prior notice to exercise our right of set-off. The effect and consequences of this irrevocable assignment and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement.

12. **Balance Billing Disclosure:** Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually be seen, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services. We encourage you to contact your health plan to determine whether the independent healthcare professionals are participating with your health plan. In order to obtain the most accurate and up-to-date information about in-network and out-of-network independent healthcare professionals, please contact the customer service number of your health plan or visit its website. Your health plan is the primary source of information on its provider network and benefits. To help you determine whether the independent healthcare professionals who provide services at this facility are participating with your health plan, this healthcare facility has provided you with a complete list of the names and contact information for each individual or group.

CHRISTUS Health

STATE OF TEXAS

HOSPITAL CARE CONSENT

13. **Patient Rights and Advance Directives:** The Facility provided me a copy of the Patient Rights and Responsibilities when I arrived to the hospital. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Facility an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order, I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.

    _____ **(Initials) I have declined a copy of the Patient Rights and Responsibilities, and understand I can request a copy at any time.**

14. **Notice of Privacy Practices:** I have received a copy of the Facility's Notice of Privacy Practices at this or an earlier visit. The Facility will give me a copy of the Notice of Privacy Practices any time I ask for one.

    _____ **(Initials) I acknowledge receipt of the CHRISTUS Notice of Privacy Practices**

15. **Facility Directory:** Unless I object, the Facility will include my name, location in the facility (room number), and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to Facility) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Facility Directory.

    (If you object, initial below.)

    _____ I ***DO NOT*** want any information about me to be included in the Facility Directory. I understand that mail, flowers, telephone calls, and visitors will be refused on my behalf because hospital staff cannot acknowledge my presence in the hospital. If I make phone calls from the hospital, caller ID may show call recipients that I am calling from the hospital.

16. **Insurance Information:**

    Primary Insurance:

    Secondary Insurance:

    Tertiary Insurance:

    _____ **(Initials) I acknowledge that I have provided the Facility with complete and correct insurance information in the appropriate filing order listed above.**

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient or I am the patient's legally authorized representative and/or guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

_____ _____

Signature of Patient / Legally Authorized Representative — Date

_____

Patient's Name

_____ _____

Name of Legally Authorized Representative (if not Patient) — Relationship to Patient

_____ _____

Facility Representative — Date

PERMANENT PART OF MEDICAL RECORD