



CONSENT TO INPATIENT AND/OR OUTPATIENT
ADMISSION AND TREATMENT

- Methodist Dallas Medical Center
Methodist Charlton Medical Center
Methodist Mansfield Medical Center
Methodist Richardson Medical Center
Other

- 1. Consent for Admission or Treatment: I, (Patient's Name), voluntarily consent to be treated by and, if necessary, admitted to Methodist Health System. The medical condition which requires my admission and/or treatment by Methodist Health System has been explained to my satisfaction by my attending physician. I grant permission to the physicians and their assistants, physicians in post-graduate medical education training, medical, nursing and other clinical students, and employees affiliated with Methodist Health System to perform such medical treatment(s) and/or diagnostic procedure(s) during my hospitalization as are prescribed by my attending physician or his/her associate(s) or designee(s).
2. I (we) do do not consent to HIV test.
Initials I confirm that there are two options for testing and that (1) if tested my HIV Test result will be confidential but not anonymous, and (2) an anonymous test is available from other organizations. Declination of an HIV test does not represent refusal of #4 below.
3. I (we) confirm that printed materials regarding HIV, Hepatitis B, and Syphilis have been provided.
Initials
4. Healthcare Worker Exposure/Blood Testing: I understand that Texas law provides and I agree, that if any healthcare worker is exposed to my blood or other bodily fluids, to allow the Hospital to perform test(s) on my blood or other body 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 any test result obtained under these circumstances does not become part of my hospital medical record.
5. Physicians Not Agents of Hospital: I understand that the physicians or physician assistants who treat or otherwise provide professional services to me either directly or indirectly through such services as, but not limited to, emergency medicine, radiology, pathology/laboratory medicine, anesthesiology and perinatology, are (with the exception of physicians in post-graduate medical education training) not employees or agents of Methodist Health System. Rather these physicians are independent practitioners, and are solely responsible for their own judgment and conduct. I also understand that for emergency or unscheduled services, the Hospital may aid my selection of physicians by an established "on-call" roster provided through departments of the Hospital. I agree the hospital is not responsible for the independent judgment or conduct of any of the physicians identified above.
6. Disposal of Removed Tissue: I authorize the Hospital to use its discretion to retain or dispose of any tissue removed during any treatment or diagnostic procedure(s).
7. Risks of Treatment; No Warranty/Guarantee of Result or Cure: I understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to surgical, medical, and/or diagnostic procedure(s) planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death.
8. Responsibility for Personal Property: I understand that Methodist Health System does not assume responsibility for safekeeping any personal property, including but not limited to, jewelry and currency unless specifically deposited in the Admitting Office Safe or in designated units registration safety deposit box.
9. Certification - Understanding of Consent Form: I assert that I have read, or had read to me, and fully understand the above Consent to Admission and Treatment and that any blanks requiring completion were filled in before this Consent was signed.

I hereby voluntarily and knowingly affix my signature.

A.M / P.M

\_\_\_\_\_  
Patient Signature Date Time

\_\_\_\_\_  
Signature of Witness Printed Name of Witness Date / Time

If NOT an employee of MHS, please complete the following:

Witness Address ( Street or P.O. Box): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**MHS Employee's please check appropriate box below for Witness address:**

- METHODIST DALLAS MEDICAL CENTER 1441 N. Beckley Ave. Dallas, Texas 75203
- METHODIST CHARLTON MEDICAL CENTER 3500W. Wheatland Rd. Dallas, Texas 75237
- METHODIST MANSFIELD MEDICAL CENTER 2700 E. Broad St. Mansfield, Texas 76063
- METHODIST RICHARDSON MEDICAL CENTER 401W. Campbell Rd. Richardson, Texas 75080

**IF PATIENT IS AN EMANCIPATED MINOR, COMPLETE DECLARATION OF A MINOR ESTABLISHING CAPACITY TO CONSENT. Policy MHS 212, Form 03732.**

**IF PATIENT IS AN UNEMANCIPATED MINOR, OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:\***

Patient is unable to sign because \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent(s), if known Name of Parent(s), if known

\_\_\_\_\_  
Signature of Legal Guardian, If Appointed Name of Managing Conservator or Guardian, if Appointed

\_\_\_\_\_  
Other Person and Relationship to Minor Parent Signature or Legal Guardian, or managing Conservator, or Guardian, or Other Person if Appointed

\_\_\_\_\_  
Signature of Witness Printed Name of Witness Date/ Time A.M. / P.M.

**If NOT an employee of MHS, please complete the following:**

Witness Address (Street or P.O. Box): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**MHS Employee's please check appropriate box below for Witness address:**

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\_\_\_\_\_  
Telephone Consent Date Time A.M./P.M. Verified By Date Time A.M./P.M.

**\*PERSON OTHER THAN PARENT OR GUARDIAN, AUTHORIZED BY LAW TO SIGN FOR A MINOR (in order listed) if the parent or guardian cannot be contacted and has not given actual notice to the contrary:**

1. Possessory conservator.
2. Grandparent.
3. Brother or Sister 18 years of age or over.
4. Aunt or Uncle 18 years of age or older.
5. Any court having jurisdiction over a suit affecting the parent- child relationship of which the minor is the subject.
6. Any adult who has care and control of the minor and has written authorization to consent from a person authorized to consent.
7. An educational institution in which minor is enrolled that has received written authorization to consent from person authorized to consent.
8. An adult responsible for the care, control and possession of a minor under the jurisdiction of a juvenile court or committed by such court to the care of an agency of the state or county.
9. A peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.
10. The Texas Youth Commission may consent to the medical treatment of any minor committed to it when the person having the power to consent has been contacted and actual notice to the contrary has not been received.

