Methodist HEALTH SYSTEM

CONDITIONS of ADMISSION, AUTHORIZATION for TREATMENT, AND FINANCIAL AGREEMENT

1. **Consent to Treatment:** I 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). I understand in the case of HIV testing ordered **by my physician** 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. I confirm that, as applicable, printed materials regarding HIV, Hepatitis B, and Syphilis have been provided to me.

   _____ (initial) I do consent to Physician ordered HIV testing.

   _____ (initial) I do not consent to Physician ordered HIV testing.

2. **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 fluids 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.

3. **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 (with the exception of physicians in post-graduate medical education training) **are not** employees or agents of Methodist Health System. 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.

4. **Risks of Treatment:** 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 procedures 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.

5. **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).

6. **Financial Agreement:** In consideration of Methodist Health System furnishing services and supplies to the above named patient, I agree to pay Methodist Health System, its agents and assigns, all sums of money which shall become due on the account of the above named patient with Methodist Health System in accordance with its regular rates and terms. I understand that insurance **will not** pay for the total cost of a suite and I agree to pay any charges toward the cost of a suite that insurance does not pay.

I understand and agree that the account is due upon discharge with allowances made for insurance coverage approved and verified prior to discharge. Methodist Health System will not extend credit. I understand that although the patient and others may also be responsible for paying this account by virtue of an express or implied agreement, or otherwise, I shall be responsible to pay the entire account, and I further understand that this agreement in no way relieves any such other party of any obligation to pay this account. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I as the designated responsible party shall pay the reasonable attorney fees or collection expenses. All accounts are due and payable in Dallas, Dallas County, Texas.

7. **Consent for Wireless Telephone Calls:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, agents, and independent contractors, including servicers and collection agencies regarding the hospitalization, the services rendered, or my related financial obligations.
8. **Authorization to release information:** I authorize Methodist Health System to furnish requested information from the patient's medical and other records to (1) any insurance company or third party payor for the purpose of obtaining payment on the account of Methodist Health System, (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, and federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's record for purposes of conducting any medical audits, utilization reviews, or quality assurance reviews. I authorize Methodist Health System to release information or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which the patient may be transferred.
9. **Assignment of insurance Benefits:** In consideration of services rendered, I hereby transfer and assign to Methodist Health System and to Pathologist, Radiologist, Anesthesiologist, and other licensed physicians, individuals or groups who perform services for my care and treatment at Methodist Health System all right title and interest in any payment due me for services described herein as provided in any health insurance or similar policy or employee benefit plan.

   I understand that I am responsible for providing to Methodist Health System all insurance information at the time of admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and items supplied. In the event a procedure, service or item provided is deemed experimental or investigational or for any other reason is deemed not covered by my Managed Care Insurance Plan, responsibility for payment falls solely to me and the patient and/or patients guarantor.

   Based on the Insurance or Third Party Coverage Information you provided at the time of service, Methodist Health System will inform the patient and/or patient's guarantor whether Methodist Health System is a participating provider under your third party payor coverage. The information is based on good faith of our understanding of the information you have provided us. Even though you have insurance, having coverage does not mean that every procedure is covered by your plan.

_____ (initial) I acknowledge my plan is out of network.

_____ (initial) I acknowledge my plan is in network.

10. **Medicare/Medicaid Assignment of Benefits:** I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare/Medicaid.

Medicaid

I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, initial duration, and/or scope of the Texas Medicaid Program, as determined by the Medicaid department or its health insuring agency. All payments for non-covered services are due and payable at time of discharge.

11. **Outpatient Medicare Patients Only:** There are Federal rules that apply to outpatients who are Medicare recipients. One of these rules involves what Medicare calls "Self-Administered" medications. Outpatient self-administered therapeutic medications are excluded from Medicare coverage under Title XVIII of the Social Security Act. **Medicare will not pay for them.** In addition, Medicare will only pay for observation room services up to 48 hours. We will order self-administered medications or observation room services beyond 48 hours only when medically necessary. We are required to collect payment for these services from you or your secondary insurance company. If you have any questions about these rules or charges, please ask your utilization review nurse or contact the Patient Accounts office at 214-947-6300.

12. **Understanding Physician Billing:** I understand that services provided to me at Methodist Health System facilities are provided by doctors and their physician assistants who are not employees or agents of Methodist Health System. I further understand that these medical providers will bill me separately for their services, such as emergency care, administration of anesthesia, interpretation of x-rays and laboratory tests, and neonatologist services (care of newborn babies). Certain physician services may be provided by medical residents, who are participants in the Methodist Health System postgraduate medical education program and consequently will not bill me separately.

_____(initial) I acknowledge that a physician or other health care provider who provides services to the patient during their hospital admission may not be participating in the same plans as the hospital. I will be responsible for paying these health care providers separately subject to the terms of my health insurance plan, if any. I may request a listing of facility based physicians who have been granted medical staff privileges to provide medical services at this facility. I may also request information from a physician on whether the physician has a contract with my health plan.

13. Disclosure of Health Care Information: Methodist Health System Notice of Privacy Practices and Methodist Health System Medical Staff Practitioners Notice of Privacy Practices provide information about how Methodist Health System and Methodist Health System Medical Staff Practitioners may use and disclose protected health information about you. Copies of the current Notices will distributed to you during the Registration process and are available through our website, methodisthealthsystem.org. The notices contain on the first page, in the top right corner, the effective date. As provided in the Notices, the terms of the Notices may change. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

14. Facility Directory: My presence and Condition: I understand if I request to be classified as a "No Information Patient", no information pertaining to my medical visits will be disclosed to anyone for purposes outside of normal treatment, payment, and clinic/hospital operations. I understand that I will be responsible for informing those individuals that I wish to be aware of reasons for my medical visits to the clinic or hospitalization. Further, I understand that Methodist Health System and the clinics are not responsible for any disclosures regarding visits that are made by individuals that I inform. I understand that if Methodist Health System agrees to classify me as a "No Information Patient", this restriction will have no impact on Methodist Health System's right to disclose and use my protected health information for purposes of treatment, payment and health care operations. Under some conditions, Methodist Health System may find it necessary to impose the "No Information" status on patients because the law demands it or for patient safety and the safety of hospital staff. If this status is deemed necessary, this status places a special responsibility to maintain confidentiality on you, the patient, your family or others who may be aware of the hospitalization. Failure to cooperate may require the hospital to revoke the status.

_____ A copy of the Methodist Notice of Privacy
(initial) Practices has been provided.

_____ A copy of the Methodist Staff Practitioners
(initial) Notice of Privacy Practices has been provided.

_____ I **do not** request to be classified as a
(initial) "No Information Patient".

_____ I **do** request to be classified as a
(initial) "No Information Patient".

15. Patient Visitation Rights: I understand that I have the right to receive the visitors whom I or my support person designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions on my visitors to protect my health and safety in addition to the health and safety of other patients. The hospital will clearly explain the reason for my restrictions if imposed. If I believe my visitation rights have been violated, I or my representative has the right to utilize Methodist Health System's complaint resolution system.

_____ I wish to designate a support person
(initial) for visitation

_____ I do not wish to designate a support
(initial) person for visitation

Name of
Support Person _____

Telephone Number _____

Relationship of
Support Person _____

16. Other Acknowledgements:

a. **Responsibility for Personal Property:** I understand that Methodist Health System does not assume responsibility for safekeeping of any personal property, including but not limited to, jewelry and currency unless specifically deposited in the Admitting Office Safe or in designated unit's registration safety deposit box.

b. **Methodist Health System is a Tobacco-Smoke Free Environment:** It is the policy of Methodist Health System (MHS) to provide a Tobacco-Smoke Free environment on all campuses and buildings. This includes hospitals, clinics, and professional office buildings, imaging centers, Family Health Centers, grounds, sidewalks, and parking areas.

c. **Additional Provision for Admission of Minors:** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient and have legal authority to consent to the treatment to be provided to said patient and understand, acknowledge and agree to be responsible for the cost of all care provided to said patient.

d. **Financial Assistance Program:** Methodist Health System maintains an established policy to provide health care services to those unable to pay. Information and application forms are available upon request. Please ask to speak with a Financial Counselor for more information or to answer any questions.

e. **Community Benefit Plan:** Methodist Health System files an annual report of its Community Benefit Plan with the Bureau of State Health Data and Policy Analysis of the Texas Department of Health (TDH). The report is public information and is available upon request from TDH, 100 West 49th Street, Austin, Texas 78756

17. Patient Self Determination Act

I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to **any** of the following applicable statements:

_____ (initial) a. I executed an Advance Directive and have been requested to supply a copy to the hospital.

_____ (initial) b. I have not executed an Advance Directive, wish to execute one and have received an Advance Directive form along with information on how to execute an Advance Directive and have been requested to supply a copy of the signed Advance Directive once I sign same.

_____ (initial) c. I have not executed an Advance Directive and do not wish to execute one at this time.

_____ (initial) a. I do not wish to designate a representative for medical decisions at this time.

_____ (initial) b. I do wish to designate a representative for for medical decisions at this time.

Name of Representative _____

Telephone Number _____

Relationship of Representative _____

I, the undersigned, as the patient or legal agent of and responsible for the patient, hereby certify I have read, and fully and completely understand this Conditions of Admission, Authorization for Treatment and Financial Agreement, and that I have signed this Conditions of Admission, Authorization for Treatment and Financial Agreement knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services provided or to be provided. If insurance coverage is insufficient, denied altogether or otherwise unavailable, I agree to pay all charges not paid by the insurer.

Patient/Authorized Representative Signature:

Date:_____Time: _____

If you are not the patient, please identify your Relationship to the patient by **circling or marking** the appropriate relationship below.

❑ Healthcare Power of Attorney

❑ Representative appointed by Patient for this Visit

*If not one of the above, I am the person **in the following priority sequence** who has been determined to be readily available and willing to consent on behalf of an incapacitated patient.*

❑ 1) Spouse
❑ 2) Adult Child
❑ 3) Parent
❑ 4) Legal Guardian
❑ 5) Sibling
❑ 6) Other _____ (please specify)

Witness Signature and Title

Additional Witness Signature and Title
(Required for patients unable to sign without a representative or patients who refuse to sign)