CONDITIONS of ADMISSION, AUTHORIZATION for TREATMENT, AND FINANCIAL AGREEMENT

1. **Consent to Treatment:** I voluntarily consent to medical care and treatment by Methodist Medical Group. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), physicians in post-graduate medical education training, and other health care providers or the designees under the direction of a physician, affiliated with Methodist Medical Group to perform such medical treatment(s) and/or diagnostic procedure(s).

   I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

2. **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 surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death.

   I agree and acknowledge that Methodist Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Methodist Medical Group facilities.

   I understand I have the right to discuss the treatment plan with my provider about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my health care provider, I understand I am encouraged to ask questions.

3. **Financial Agreement:** In consideration of Methodist Medical Group furnishing services and supplies to the above named patient, I agree to pay Methodist Medical Group, its agents and assigns, all sums of money which shall become due on the account of the patient receiving services made the subject of this consent in accordance with Methodist Medical Group's regular rates, including costs related to COVID-19 Testing. I understand it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by my insurance at the time of service.

4. **Consent for Wireless Calls, Mail, and Email:** 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 clinic, agents, and independent contractors, including servicers and collection agencies regarding the services rendered, or my related financial obligations. I consent to receive information about Methodist Medical Group events such as: upcoming health fairs, health and wellness updates, new locations and services via email and mail. In addition, I understand Methodist Medical Group patient portal will use my email address in order to access the patient portal, MyChart.

5. **Authorization to release information:** I authorize Methodist Medical Group 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 Medical Group, (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 Medical Group to release information or copies of the patient's medical record to any referring physician.

6. **Assignment of Insurance Benefits:** In consideration of services rendered, I hereby transfer and assign to Methodist Medical Group and to all individuals or groups who perform services for my care and

treatment at Methodist Medical Group 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 until revoked by me in writing. I understand that I am responsible for providing to Methodist Medical Group all insurance information at the time of service to allow for verification prior to my appointment, 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 health plan, responsibility for payment falls solely to me and the patient and/or patients guarantor.

7. **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.

8. **Disclosure of Health Care Information:** The Notice of Privacy Practices provides information about how Methodist Medical Group may use and disclose protected health information about you. Copies of the current Notices 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.

9. **Additional Provision for 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.

10. **Financial Assistance Program:** Methodist Medical Group 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 an Office Manager for more information or to answer any questions.

11. **Welcome Information Packet:** I acknowledge receipt of the welcome information packet on my initial visit at Methodist Medical Group.

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Signature of Patient or Guardian | Patient Date of Birth

_____ _____

Relationship to Patient, if not signed by the Patient | Date