Patient Name:_____

MRN:_____ CSN:_____

D.O.B:_____ Admit Date:_____

University Health

CONSENT FOR TREATMENT AND CONDITIONS FOR ADMISSION

CONSENT FOR TREATMENT

I understand that my health condition requires medical and/or hospital care, and I authorize and consent to any and all diagnostic procedures, tests, medical treatment, and hospital care required in the diagnosis of my illness and course of treatment by the physician and/or physician designee, including advanced nurse practitioners and physician assistants, medical staff, and/or employees of University Health ("UH"),University Medicine Associates ("UMA"), UT Health San Antonio ("UT Health") and/or other healthcare providers.

I further authorize and consent to such diagnostic and special needs testing, communicable disease testing, including HIV, Hepatitis B, and HepatitisC testing, as allowed by law, medical treatment and hospital care as my physician(s), and/or other healthcare providers who may be involved in my care consider to be necessary, and I understand that the results of these tests are confidential.

I authorize University Health nurses, employees, and others as necessary, to carry out the instructions of my doctors regarding the procedures and treatment they order.

I recognize that University Health is a teaching and research facility and that my treatment and care will be observed and, in some instances, aided by residents, medical students, nursing students, and other health care personnel in the course of education and training. I consent to their presence and participation in my care and to the use of my records and specimens for instructional purposes. I understand that: (1) absent an emergency, no substantial procedures will be performed on me unless and until I have had an opportunity to discuss the risks and benefits with the doctor to my satisfaction; (2) I have the right to consent, or to refuse to consent, to any proposed procedure or therapeutic treatment regimen; (3) I will not be involved in any research or experimental procedure without my full knowledge and consent; and (4) any tissue, fluids, or body parts removed from my body while receiving medical and/or hospital care at University Health may be retained, disposed of, or used for other purposes.

If I receive services that are contracted and funded by the Texas Department of State Health Services ("TDSHS"), I consent and authorize participation in any TDSHS integrated database system with respect to the collection and processing of my health data for purposes of financial billing, clinical integration, collaboration, and other health care operations.

I understand that there are certain medical treatments and surgical procedures that require detailed explanation of risks and hazards involved. If it is determined that I require such specific treatments and/or procedures, I will be asked to give a separate consent.

I understand that University Health is required by law to screen a newborn or infant born at University Health for hearing loss; however, the parents may decline such screening should they choose to do so.

NO GUARANTEE

I understand that the practice of medicine and surgery is not an exact science and further acknowledge that no guarantee has been made or can be made as to the results of the tests, examinations, treatments, procedures, or any other service rendered at any University Health facility and/or rendered by any physician or non-physician providers of University Health or Other Providers.

INDEPENDENT CONTRACTORS

I understand that physicians, physician assistants, advanced nurse practitioners, and/or other healthcare providers who may be involved in my care include, without limitation, providers who are credentialed and privileged in accordance with the Bylaws of University Health and/or University Medicine Associates (UMA), but are not employees or agents of University Medicine Associates, University Health, or its facilities. Healthcare staff members of other entities may include my attending physician, physicians who provide consultation services, as well as other members of the healthcare team. I further understand that the referenced staff members from outside entities who are not employees or agents of University Medicine Associates, University Health, or its facilities, serve as independent contractors who exercise their own professional judgment without control by University Health or University Medicine Associates, and have been granted the privilege of utilizing University Health facilities for the care and treatment of their patients.

PATIENT'S RIGHTS

General rights/complaint procedure I have been provided information regarding my rights, which include but are not limited to, the right to make medical decisions, such as the right to accept or refuse medical treatment; to participate in my care plan; and to receive care in a safe environment free of verbal or physical abuse or harassment. I hereby acknowledge receipt of information regarding the process for filing complaints.

Right to Itemized Bill and Charge information I hereby acknowledge that I have been informed of my right to receive an itemized bill within 10 days from the date of the request by calling University Health Patient Account Customer Service at (210) 358-9500, or email questions to uh.customerservice@uhtx.com, and I understand that I may also receive information about my University Health hospital charges for which I will be responsible for through the "My Chart" patient portal or by calling the same Patient Account Customer Service number.

TO BE PLACED IN MEDICAL RECORDS

Right to Hospital Charge Estimates Total charges for hospital services or procedures will vary based on many factors, including the type of procedure, medications, supplies, and laboratory tests. University Health offers an online price estimator tool at https://search.hospitalpriceindex.com/hpi2/hospital/UniversityHealth/9382 to get estimates for non-emergent procedures, exams, and hospital charges. If you do not find the procedure you are looking for in our price estimator tool or have questions, you can contact the Financial Clearance Department at 210-644-6132 to request a personalized cost estimate, which will be provided within 10 business days of the request. The information provided on hospital charges are only estimates and does not guarantee your final charges, nor does the estimate include the separate cost of physician services. Patients remain responsible for resolution of all charges associated with care.

PATIENT'S RESPONSIBILITIES

I agree to timely provide complete and accurate information to University Health and its agents, and to cooperate in all respects with the gathering and release of financial or other information that will allow University Health and its agents to seek and obtain payment from any third party, and/or any potential source of recovery or reimbursement, including my automobile insurance to facilitate payment of hospital and medical charges incurred in my care. I further understand that it is my responsibility to apply and cooperate in all alternate funding application processes, which could be potential sources of reimbursement for the charges incurred. I hereby authorize University Health and its agents to take all steps necessary to seek reimbursement and recognize and agree that University Health and its agents are not obligated to do so nor are they liable for failing to do so unless otherwise provided by law. I further recognize and agree that not withstanding the above assignment, it is **not** University Health's or any doctor's responsibility to file insurance claims on my behalf. It is my responsibility to timely seek **all** insurance reimbursement, including all applicable automobile insurance, to obtain all proper pre-authorizations, file any claims against any financially responsible parties, and appeal any denials. I understand that my failure to take these actions may result in a denial of reimbursement or money otherwise due to me, University Health, or to my doctors and/or their agents, and in which case I understand and agree that I will be responsible, to the extent that I am legally liable, to pay University Health and its agents for all charges that are not paid by my insurance, health plan or by a person with a duty to pay. Questions regarding bills should be made directly to the entity who issued the bill. I understand and agree that University Health and its agents may take any action permitted under the law to collect such charges, and that failure to timely pay hospital and/or medical charges may result in the account being reported to a credit bureau or referred to collections, in which case I agree to pay reasonable attorney's fees and collection expenses in addition to the balance of the past due account. If I am a member of a health care plan, I understand that I must present my Health Plan identification card at each visit or I may be responsible for all charges billed at the time of the visit. I understand that I am responsible for all co-payments and deductibles under the plan and must pay them at the time of the visit. In the event that I request hospital and/or medical services which are not authorized, covered or deemed medically necessary by my Health Plan, or if I provide inadequate information regarding possible health and/or accident insurance coverage and the charges for my treatment are not reimbursed, I will remain responsible for all charges incurred for my care and will be billed accordingly and agree to pay for the hospital and/or medical services at the rate of customary billed charges for such services. **This is also applicable to patients who receive benefits through the South Texas Veterans Health Care System and for Carelink members.**

ASSIGNMENT OF BENEFITS AND OTHER RIGHTS

Rights and Assignments related to Health Plans.

I assign and transfer to University Health, the Other Providers, and their respective agents, to the extent permitted by law and for myself and my dependents, all right, title and interest in all amounts that may be paid by any payer (to include without limitation any health, automobile, premises, homeowners, liability, umbrella or commercial insurance policy), or under any state, federal, county or agency assistance program, for all medical or hospital care rendered. I specifically direct payment by any such entity or under any such plans, policies and programs to be made directly to University Health, the Other Providers, and their respective agents, respectively and in accordance with services and items provided to me and intend that each entity, and/or its agents, has an independent right of recovery to such payments as a beneficiary under all such plans, policies and programs to the extent permitted by law. I further assign and transfer to University Health, the Other Providers, and their respective agents, all rights, claims and causes of action against any person or entity who may be financially responsible for payment of my hospital charges and against any person or entity who may have caused or contributed to the injury or illness for which I receive treatment, and I consent to University Health, the Other Providers, and their respective agents, independently or jointly with me or others, pursuing recovery against such persons or entities on its own behalf or in my place for the charges incurred in my care. The claims and causes of action that I assign pursuant to this Assignment of Benefits and Rights include, but are not limited to, claims or causes of action that I may have relating to any insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law.

I further assign to University Health, the Other Providers, and their respective agents all rights, claims or causes of action I may have to request and obtain documents from any Health Plan/and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical or hospital care rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that University Health, the Other Providers, and their respective agents can determine if a full and fair review of my claim took place. I assign to University Health, the Other Providers, and their respective agents my rights and any claims or causes of action I may have to collect any penalties for Health Plan's failure to timely produce this required information. This assignment of benefit and right to appeal is irrevocable and as such: (i) University Health's right to seek payment, file an appeal, and/or balance bill the patient cannot be revoked or limited by me or by any third party agreement; and (ii) I will not allow a TPA or Health Plan to block direct communication with me.

Rights and Assignments related to third-party recovery. I assign to University Health, the Other Providers, and their respective agents all rights, claims and causes of action I may have against any third party who caused me legal injury (such as through an auto accident) where University Health, the Other Providers, and their respective agents provided me services as a result of the legal injury. I agree that University Health, the Other Providers, and their respective agents are entitled to full payment for all of their charges from any third party that caused me legal injury for which University Health, the Other Providers, and their respective agents provided me services, notwithstanding any benefits payable or paid by a Health Plan on my behalf. I agree to endorse and turn over to University Health, the Other Providers, and their respective agents any checks made payable to me by any third party for damages related to the services University Health, the Other Providers, and their respective agents have provided. I will not object to University Health, the Other Providers, and their respective agents placing a lien on any recovery from a third party. I will inform any lawyer I retain and the third party that I have incurred charges from Hospital and Hospital's agents, and that such bill should be paid from any settlement.

Authorization to Provide Information I authorize any Health Plan and any of its affiliated entities or its agents to release information to University Health, the Other Providers, and their respective agents that they have about me, which is or may be related to the claims assigned by this Agreement.

My Responsibilities. I understand that complying with all Health Plan's requirements (such as pre-certification, pre-authorization, appeal procedures or second opinions) is my sole responsibility. I further understand that failure to pre-certify or obtain pre-authorization or a second opinion could result in reduced or no payments from Health Plan, leaving the undersigned financially responsible for any portion of the amounts charged by Hospital and Hospital's agents that are not paid. I understand that I remain solely responsible for instituting suit within the applicable statute of limitations and that University Health, the Other Providers, and their respective agents are not responsible for instituting suit on my behalf. I further understand that these assignments and that my, University Health, the Other Providers, and their respective agents obtaining of verification of benefits and/or pre-authorization/pre-certification does not excuse my financial responsibility for goods and services provided to me by University Health, the Other Providers, and their respective agents or any of their respective physicians.

Scope of Assignments; agreement regarding other documents the assignments I have made include claims and causes of action that arise at any time. I agree that I will sign any other documents which University Health, the Other Providers, and/or their respective agents reasonably believe are necessary to make this Agreement effective.

University Health has informed me that this Agreement regarding assignment of benefits and other rights is an important legal document. I have read it (or had it read to me) and understand the above Assignment of Benefits and Other Rights.

Medicare Beneficiaries

University Health is willing and able to act at no cost to patients as the representative for Medicare beneficiaries regarding claims for payment of healthcare charges, and /or to appeal adverse decisions of Centers for Medicare & Medicaid Services (CMS). A separate form entitled, "Appointment of Representative", is provided to Medicare beneficiaries. I acknowledge my responsibility to sign the CMS "Appointment of Representative" form so that University Health can initiate its representation of me to obtain needed appeals information and evidence, and receive any notices in connection with my claim, appeal, grievance or request instead of me.

(MEDICARE AND MEDICAID ONLY) Patient's Certification and Authorization to Release Information and Payment Request 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 Hospital to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I further request that payment of my authorized Medicare and/ or Medicaid benefits be made to the University Health, the Other Providers, and their respective agents.

(MEDICAID ONLY) Member Acknowledgment Statement

I understand that the services or supplies that are provided to me by Hospital may not be covered under the Texas Medical Assistance Program ("Medicaid"), and that whether they are covered is determined by the Texas Health and Human Services Commission or its health insuring agent. I understand that I am responsible for payment for the services or supplies if they are not covered by Medicaid.

PHOTOGRAPHY/ TELEMEDICINE

I hereby authorize my physician and/or his/her designee to record our treatment conversation or film my likeness utilizing photographic, video, electronic or audio media for identification, diagnosis, treatment, education and/or training. This authorization includes consent to participate in remote electronic communication, commonly referred to as "telemedicine", with physicians, and/ or other members of the healthcare team, as determined to be medically necessary and appropriate for my care. I understand I have the right to refuse to participate or decide to stop participating in the recording of my conversation or filming of my likeness, and that my refusal will be documented in my medical record. This decision will not affect my right to future care or treatment.

CONSENT TO INFORMATION DISCLOSURE

Disclosure of Information for Payment, Claim, and Other Purposes I hereby authorize University Health, the Other Providers, or any entity following up on claims payment issues to make disclosures of my demographic, medical or financial information in University Health's or Other Providers' possession to facilitate payment of claims on my behalf or in furtherance of other University Health or UMA purposes. This information may be released to insurance companies, managed care organizations, health benefit plans, third party administrators or payers or their affiliates, governmental agencies, or any organization contracting with any of the above entities to obtain payment.

I understand that the information I am authorizing to be disclosed may contain references to psychiatric conditions, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, including an HIV or AIDS diagnosis (collectively, "Sensitive Information"), unless I revoke this authorization with respect to the disclosure of such information. I understand that I may revoke this authorization with respect to the disclosure of any type of Sensitive Information by providing written notice of such revocation to University Health Medical Records Department, including email communication to medical.records@uhtx.com, provided that no such revocation shall be effective until received by University Health. Questions to the Medical Records Department may be directed by phone (210) 358-3532.

Directory Information Unless I request that I be confidential, my name will be added to the University Health Directory, and if a person asks for me by name, University Health may acknowledge my presence, room number, and, if requested, my condition with a one word statement (good, fair, serious, critical). *NOTE: all patients in Foster Care, or in the custody of Child Protective Services (CPS), and patients in custody of a correctional facility will be automatically confidential.*

Request to be Confidential

☐ I wish to be confidential in the University Health Directory. I understand that I may change my status at any time so that I may be listed in the directory by contacting **(210) 743-0114.**

Patient Surveys I hereby authorize University Health to use my information to conduct patient satisfaction surveys, which may include contacting me by phone or email to learn more about my experience with University Health.

FINANCIAL RESPONSIBILITY

Financial Agreement I agree to pay University Health, the Other Providers, and their respective agents and physicians, including their radiologists, pathologists, anesthesiologists, hospitalists, neonatologists, emergency room doctors and consultants) for all charges and expenses incurred. I understand and agree that I am responsible for the total charges for services rendered, regardless of any assignment of benefits provided. I further agree that all amounts charged are due upon request. If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest at the legal rate, reasonable attorney fees, costs and collection expenses. I agree that if I have a credit balance with University Health, the Other Providers, and their respective agents for any reason, the credit will first be applied to any outstanding balance, and then any remaining amounts shall be returned to me. These agreements apply regardless of whether University Health, the Other Providers, and their respective agents and physicians have contracts with my Health Plan. If University Health, the Other Providers, or their respective agents has a contract with my Health Plan, that contract may limit my financial liability.

Health Plan Members' Financial Responsibility If I am a participant in a Health Plan or covered under an insurance policy, I must present a Health Plan identification card at each visit or I agree to pay the charges billed by University Health at the time of the visit. Upon presentation of such Health Plan identification card, University Health will provide confirmation of whether University Health is a participating provider under my Health Plan on the date services are to be rendered based on the information received from me. University Health does not guarantee that Health Plan will pay my claims. I agree to pay all applicable co-payments, co-insurance and deductibles established by my Health Plan at the time of the visit.

In the event that my physician or I request that University Health, the Other Providers, or their respective agents provide services or supplies which are not authorized or covered by my Health Plan, or which are for my convenience, I agree to pay for such services or supplies at the customary billed charge for such services or supplies.

I have been informed that I should contact my Health Plan for accurate information regarding my benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact my liability for payment for services.

Out-of-Network Services University Health does not guarantee that all of the health care providers who provide services to me are in my Health Plan's network or covered by my Health Plan's policies. I understand that if the services of other healthcare providers are not covered by my Health Plan, they are considered to be out-of-network and I remain responsible for payment of non-emergent, out-of-network referral(s)and non- covered services. I have been advised that I may request information concerning which Health Plans a health care provider has a contract with directly from the provider, and I am aware that I have the right to choose a facility or provider in my Health Plan's network.

Right to Protection from Surprise Billing/An Unexpected Balance Bill. If I have an emergency medical condition requiring emergency services, and it is determined that my Health Plan is out-of- network at University Health or with any other healthcare providers who provide me services, the most that University Health and/or the other health care providers may bill me is my plan's in- network cost-sharing amount, such as copayments, coinsurance and deductibles. I **cannot** be balance billed for these emergency services. This includes services I may get after I am in stable condition, unless I give written consent and give up my protections not to be balanced billed for these post-stabilization services. However, I am aware that I am not required to give up my protections from balance billing..

Notice of Relationship Between Hospital and Physicians/Other Health Care Providers

The physicians and other health care providers who treat me at a University Health facility are not employees or agents of University Health. They are independent physicians or other health care providers who have staff privileges at such facility. As a result, I understand that I will be separately billed by these physicians or other health care providers for their services. I understand that:

- I may receive a bill for medical services from a hospital-based physician (i.e., a radiologist, an anesthesiologist, a pathologist, an emergency department physician, a hospitalist, or a neonatologist) for the amount unpaid by my Health Plan;
- I may request a listing of facility-based physicians who have been granted medical staff privileges at a University Health facility, or I may access the list on Hospital's web site; and
- I may request information from a facility-based physician or other health care provider on whether they have a contract with my Health Plan and under what circumstances I may be responsible for payment of any amounts not paid by my Health Plan.

EMERGENCY TREATMENT NOT DEPENDENT ON DOCUMENT

I understand that University Health has the duty to perform a medical screening examination and to provide appropriate treatment for an emergency medical condition regardless of whether I sign this document.

RELEASE FOR LOSS OF VALUABLES

I understand and have been informed that University Health maintains a secure place for safekeeping of money, valuables, and personal effects if I have no other alternative for safekeeping of these valuables and that **University Health will not be liable for the loss of or damage to any of my personal property at any time I am hospitalized unless secured with the hospital.**

I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY RIGHTS AND RESPONSIBILITIES AS A PATIENT AND ABOUT THE REPRESENTATIONS IN THIS FORM. BY MY SIGNATURE I CERTIFY THAT THIS CONSENT TO TREATMENT AND CONDITIONS OF ADMISSION FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, AND THAT I UNDERSTAND, ACCEPT AND AGREE TO ALL TERMS AND CONDITIONS. I UNDERSTAND THAT IF I DO NOT TIMELY PROVIDE ALL INSURANCE INFORMATION, INCLUDING MY OWN AUTOMOBILE INSURANCE, I WILL REMAIN RESPONSIBLE FOR PAYMENT OF ALL CHARGES FOR THE HOSPITAL AND MEDICAL CARE PROVIDED TO ME. I FURTHER UNDERSTAND THAT I WILL RECEIVE A BILL FOR SERVICES PROVIDED TO ME AS WELL AS A SEPARATE BILL FOR THE CLINICAL PROFESSIONAL SERVICES OF THE PHYSICIAN(S) OR ALLIED HEALTH PROFESSIONALS WHO PROVIDE MY CARE.

If executing this document on behalf of a patient, I certify that I have the authority to execute this form on behalf of the patient.

EACH ENTRY MUST BE SIGNED, DATED AND TIMED BELOW BY PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

_____ / _____

Signature of Patient OR Patient's Representative **If Representative, Relationship to Patient**

_____ / ____ / ____ ☐AM / ☐PM

If Representative, Printed Name of Representative **Date** **Time**

DECLARATION OF MINOR

I understand the Consent for Treatment and Conditions of Admission document. In addition, I declare: **CHECK ONE**:

☐ I have the capacity to consent to my own medical treatment on the basis that I am 16 years of age or older, reside separate and apart from my parents, managing conservator or guardian, and I manage my own financial affairs. **I agree to pay to the doctor(s) and/or hospital (University Health) all charges not paid by a third party, unless prohibited by law or insurance agreement.**

OR

☐ I am under the age of 18, do not manage my financial affairs, but require diagnosis and treatment of an infectious or contagious disease, or am unmarried and require treatment related to pregnancy, or I require examination and treatment related to drug or chemical use.

_____ _____ _____

Signature of Minor Patient **Date/Time** **Printed Name of Minor Patient**

Interpreter Services:

Was an interpreter used? ☐ YES ☐ NO

Interpreter Name:_____ Interpreter ID#:_____