JEFFERSON COUNTY MEMORIAL HOSPITAL, dba FW HUSTON MEDICAL CENTER
Includes the Hospital, Clinics, Pharmacy, Senior Living Center and Assisted Living Facility

Patient/Resident Name _____ Date of Birth _____

TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Jefferson County Memorial Hospital, including its acute care, swingbed unit, long term care unit, emergency department, outpatient clinics and outpatient departments is hereinafter referred to as "Hospital".

1. CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians/providers. I understand and consent that sometimes the provider may be utilizing telemedicine or other electronic technologies to communicate between healthcare providers and patients receiving care. I understand that my treatment is under the control of my attending physicians/providers, their assistants or designees. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by myself or my family and the Hospital shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the Hospital determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

3. CONSENT TO DISPOSAL OF TISSUE/FLUID/SPECIMENS: I agree that the Hospital may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

4. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as the patient/resident, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms and its Financial Policy. I acknowledge I have received a copy of the Financial Policy. However, I am aware that any patient/resident arriving at the facility will have a medical screening examination performed regardless of the ability to pay.

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Hospital. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

6. MEDICARE/MEDICAID BENEFITS: I authorize the Hospital to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related 6furnished to me, and to the physicians involved for their services, including those physicians/specialists/providers doing their own billing, while I was a patient in the Hospital.

7. PERSONAL VALUABLES/BELONGINGS: I have elected/refused (circle one) to place valuables (i.e., money, jewelry, credit cards, or other articles of unusual value, etc.) into the Hospital's safekeeping during my period of hospitalization. Dentures, glasses, hearing aids, my garments, cell phones, electronic devices, and other essential daily necessities are considered personal belongings. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Hospital CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced.

8. NOTIFICATION TO PATIENTS/ RESIDENTS: Certain diseases and conditions, including cancer, are required by law to be reported. I understand that the Hospital will comply with this by submitting the necessary information on my condition and myself to a centralized registration point.

9. CONTRABAND WEAPONS/ DRUGS: I agree that should the Hospital find contraband weapons and/or nonprescription drugs not sold over-the-counter within my possession, these items will be confiscated, and the police will be contacted.

10. USE OF APPLIANCES: I hereby agree that in using any and all electrical appliance in my room, not owned by or under the control of the Hospital while a patient/ resident in the Hospital, I do so at my own risk and hereby absolve the Hospital from any and all responsibility for injuries or property damage which may result from any use of said appliance.

11. PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution. There is not discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

12. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

13. DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS:

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER OR NURSE MAY DISCUSS YOUR MEDICAL CONDITION? ☐ YES ☐ NO IF YES, PLEASE LIST THEIR NAMES BELOW.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

I understand that I may revoke this authorization and its names at any time in writing.

14. ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES. I hereby acknowledge I have been offered a copy of the Hospital's Notice of Privacy Practices and have received a copy if requested. This Notice provides information about how the Hospital may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law.

X_____
(Patient/ Personal Representative Signature or Initial)

15. I certify that I have read and fully understand this entire document and that I have received a copy of it if requested. I, as the patient/resident/personal representative, sign this document indicating that I agree with all of its terms and statements.

X_____ _____ _____
(Patient/Resident/Personal Representative) (Relationship to patient) DATE

_____ _____
Signature of witness DATE

Complete Sections 16 – 17 for patients admitted to the hospital (acute/observation/swing bed/respite care) or the emergency department.

16. CONSENT TO DISCLOSE GENERAL INFORMATION. If I am admitted to the hospital as a patient, I understand that my name and location in hospital may be provided to any person asking about me by name, and to members of the clergy, my family, individuals involved in my health care. ☐ I do ☐ I do not give consent for this information to be disclosed.

X_____
(Patient/ Personal Representative Signature or Initial)

17. ADVANCE DIRECTIVE INFORMATION:

	YES	NO
Do you have a DNR (Do Not Resuscitate) Order?		
Do you have a living will or advance directive?		
Do you have a Durable Power of Attorney for Healthcare (DPOA-HC)?		
If yes, is the living will or DPOA on file with us?		
If no to the above, would you like information on Advance Directives?		