UT★Physicians

Consent for Medical Treatment, Disclosures, and Waivers

CONSENT FOR MEDICAL CARE AND TREATMENT

Knowing that I or the individual for which I am a legal guardian (the Patient) have (has) a condition requiring medical care, I hereby voluntarily consent to such care encompassing examinations, diagnostic procedures and medical treatment by the Patient's physician, his/her assistants and consignees as may be necessary in their judgment. I acknowledge that no guarantees have been made as to the result of diagnostic procedures, medical treatments or examinations by UT Physicians clinicians.

The Patient is under the care and supervision of the Patient's attending physician and consultants selected by this physician. It is the responsibility of UTP and its staff to carry out the instructions of these physicians. Some physicians furnishing services to the Patient, including radiologists, pathologists, anesthesiologists, emergency room physicians and others are independent contractors, are not employees or agents of UTP, and may directly bill the Patient or other legally responsible person (Guarantor) signing this consent for services rendered.

FINANCIAL RESPONSIBILITY

In consideration for the services to be rendered to the Patient, the Patient and/or Guarantor signing this consent authorizes credit investigation and individually assumes full financial responsibility for the payment of the Patient's account in accordance with the regular rate and terms of UTP. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS

In consideration for services rendered, I hereby irrevocably assign and transfer to UTP for myself, my dependents and those for which I am financially responsible all rights, title and interest in the benefits payable for services rendered by UTP provided in any insurance policy(ies) under which I, any of my dependents or those for which I am financially responsible are insured. Said irrevocable assignment and transfer shall be for the purpose of granting UTP an independent right of recovery in any policy(ies) of insurance to which benefits may be payable for services rendered, but shall not be construed to be an obligation of UTP to pursue any such rights or recovery. I herby authorize and direct all insurance company(ies) under which I, any of my dependents or those for which I am financially responsible are insured to pay directly to UTP all benefits due under said policy(ies) by reason of services rendered therein. I will pay UTP for all charges incurred. or alternately, for all charges in excess of the sums actually paid by said policy(ies). I also irrevocably assign to UTP all rights, title and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which the Patient may be entitled to recover.

PATIENT RESPONSIBILITIES

In order to receive proper care, Patients must accept certain responsibilities. Patients and/or their legal guardians are responsible for providing accurate and complete information about matters relating to the Patient's health and for reporting changes in the Patient's condition. Patients and/or their legal guardians are responsible for following the treatment plan recommended for the Patient and reporting any side effects to the Patient's physician(s) and/or nurse(s). If treatment is refused or the directions of Patient's physician(s) are not followed, Patients and/or their legal guardians are responsible for their actions and the consequences of those actions. Patients and/or their legal guardians are responsible for the Patient's financial obligations. Patients and/or their legal guardians and their visitors are responsible for following the physician office guidelines and for being considerate of the rights of others while in the physician office (for example, assisting in the control of noise, not smoking, limiting the number of visitors, etc.).

PATIENT CONCERNS

Our entire staff strives to provide excellent care and service, and we hold ourselves to high personal and professional standards. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never adversely affect the care and service we provide. If there is a problem, we sincerely want to correct it. Usually, a word to your nurse is all that is needed, but if you prefer, call Patient Relations to speak confidentially with a patient representative. Your question or concern will be promptly addressed. We appreciate the opportunity to assist you and to make your visit as pleasant as possible. You also have the right to register a complaint with Health Care Financing Administration, Texas Medical Board and/or Texas Department of Insurance.

AUTHORIZAITION FOR USE OF EMAIL ADDRESS

You are requested to provide your email address to UT Physicians. The provision of your email address is entirely voluntary. Your email address may be used by UT Physicians, its affiliated entities, and business associates for the following purposes: appointment reminders, to inform you of benefits and services related to your health, through the use of online surveys emailed to you by UT Physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received, as required by law and for certain law enforcement activities, as otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) UT Physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation. As the patient email addresses UT Physicians collects will be assembled into a mailing list, group mailings will not be sent in a manner in which recipients are visible to one another.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize UTP and the Patient's physician(s) to disclose the Patient's health care information to any person, Social Security Administration, insurance or benefit payer, health benefit plan, worker's compensation carrier or other entity specified in UTP's Joint Notice of Privacy Practices, and to the extent specified in said Notice, which is or may be liable for all or a portion of the treating physician's charges, and to complete claim forms on behalf of the Patient.

I understand that special written authorization from me (the Patient or legal guardian of the Patient) will be requested by UTP prior to releasing health care information if the Patient is receiving mental health services or care in an alcohol or drug treatment program or facility.

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

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PATIENT/LEGAL GUARDIAN SIGNATURE
(Patients over 18 years of age)

____

DATE

____

PRINT NAME
(If Legal Guardian, state relationship to patient)

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PATIENT/LEGAL GUARDIAN EMAIL ADDRESS

____

GUARANTOR/INSURED SIGNATURE

____

DATE

____

PRINT NAME

____

RELATIONSHIP TO PATIENT

____

WITNESS SIGNATURE

____

DATE

____

PRINT NAME

Place Label Here or Enter Info:
Patient Name:__________
____
MRN or DOB:__________

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received a copy of the Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. UTHealth and UTP have given me the opportunity to ask questions about this notice and all of my questions have been answered.

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Patient or Guardian Signature

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If Guardian, Relationship to Patient

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Date Signed

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth
X	X

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, X ______________________ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: X ______________________ Date: X ______________________

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________

Relationship to Individual: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only: