

Location of treatment:

- William P. Clements Jr. University Hospital Outpatient Surgery Center
 Zale Lipshy University Hospital Hospital Outpatient Clinic _____ (clinic name)

1. APPLICATION FOR ADMISSION AND CONSENT FOR TREATMENT:

I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician, and/or his/her assistant or designee. I understand that these procedures and services may include but are not limited to emergency treatment or services, laboratory procedures, imaging services, medical or surgical treatment or procedures, anesthesia or hospital services. I understand that other conditions may be diagnosed which may require additional treatment. I authorize and consent to use of recordings, films, or other images of me (i.e., any photographic, video, electronic or audio media) for purposes of identification, diagnosis or treatment in connection with the care provided to me. 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 any treatment or examinations provided by UT Southwestern. I acknowledge that any supplies, medical devices or other goods sold or given to me are provided "as is", and that UT Southwestern disclaims any express or implied warranties related thereto.

2. AGREEMENTS AND UNDERSTANDINGS:

- a. I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic courses of treatment.
- b. I understand that the physicians participating in my care, including my physician, may be either employees of UT Southwestern or independent contractors who are not employees or agents of UT Southwestern. I understand that the physicians participating in my care have been granted the privilege of using UT Southwestern facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. As a teaching institution, UT Southwestern welcomes medical residents and students in other disciplines, including nursing and University approved observers engaged in an educational purpose, all of whom are under the direct supervision of a privileged provider or staff member.
- c. I understand that regardless of my assigned insurance benefits, **I AM RESPONSIBLE FOR AND DO HEREBY EXPRESSLY ASSUME FINANCIAL RESPONSIBILITY FOR** the total charges for hospital, physician, medical and other services rendered. I will receive separate bills for physician professional fees and services rendered by outside agencies.
- d. I understand that UT Southwestern has the right to pursue full collection efforts including asset credit checks and litigation.
- e. I acknowledge that this consent includes all outpatient care rendered with the same diagnosis and treatment, and that UT Southwestern need not obtain another consent for outpatient care with the same diagnosis or treatment unless I revoke this consent in writing.

3. RELEASE OF INFORMATION:

- a. I understand that as part of my health care, UT Southwestern personnel and my physician create and maintain a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by UT Southwestern to me, as described in the Notice of Privacy Practices.
- b. I understand and acknowledge that UT Southwestern participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from UT Southwestern or Exchange Participants, my health information may be shared electronically between UT Southwestern and Exchange Participants in order to provide care and services to me, and I do hereby authorize UT Southwestern to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychological notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.
- c. I understand and acknowledge that as part of receiving my health care at UT Southwestern, my physician and other personnel engaged in my care may electronically request my prescription medication history from participating pharmacies, pharmacy benefit managers, or payers, and that such prescription medication history may become part of my medical record.

4. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS:

I hereby assign to UT Southwestern, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, Tricare, or any reimbursement from a pre-paid health care plan. This means that UT Southwestern and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to UT Southwestern any interest in any claims I may have to the extent necessary to fully reimburse UT Southwestern for the rendering of services to me. I understand and agree that my account is due in full upon discharge, with allowance made for insurance coverage approved and verified prior to discharge.

5. VALUABLES: I understand that UT Southwestern does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my hospital room during my stay, such as, but not limited to money, jewelry, eyeglasses, dentures or hearing aids.

6. NOTICE OF PRIVACY PRACTICES: I acknowledge that I received a Notice of Privacy Practices as part of this visit/admission or during a previous visit/admission. I understand that a copy of the Notice of Privacy Practice is available to me at any time upon my request.

7. PATIENT RIGHTS AND RESPONSIBILITIES: UT Southwestern acknowledges that I have certain rights as a patient, and I acknowledge I have certain responsibilities as a patient. This information (including how to register complaints I may have) is posted throughout the hospital and a written copy was given to me upon admission.

8. TO BE COMPLETED FOR UT SOUTHWESTERN INPATIENTS AND OUTPATIENTS UNDERGOING INVASIVE PROCEDURES ONLY:

- a. I have a Medical Power of Attorney. _____ Yes _____ No Copy provided? _____ Yes _____ No
 I have a Mental Health Directive. _____ Yes _____ No Copy provided? _____ Yes _____ No
 I have executed an Advance Directive. _____ Yes _____ No Copy provided? _____ Yes _____ No
- b. I have received information about Advance Directives as required by federal law. _____ Yes _____ No
- c. Would you like to discuss Advance Directives with a hospital staff member? _____ Yes _____ No

I understand it is my responsibility to provide a copy of these documents to UT Southwestern.

I have read the above document and understand its contents. I acknowledge that I am the patient or I am the patient's legally authorized representative, and/or guarantor and consent to the above items and make the acknowledgments hereby made.

Signature of Patient/Responsible Party (Relationship to Patient)

Time AM/PM

Date

UT Southwestern Representative

Time AM/PM

Date

Signature and Printed Name of Interpreter or Language Line Interpreter ID#

Time AM/PM

Date



UT Southwestern

Medical Center

PATIENT COMPLAINT PROCEDURE

While we hope every patient's visit goes smoothly, it is important that we are notified of patient concerns so we can take the appropriate steps to address them.

A patient has the right to communicate a verbal or written complaint or concern regarding any aspect of his/her visit (i.e. medical care, service, conditions, billing) and expect a timely response. If you have comments, questions or concerns, we recommend that you or your representative:

- Discuss them with your immediate caregiver, or
- Speak to the manager of the clinic or service in which you are receiving care, or
- If you believe your questions or concerns have not been adequately addressed, you may request a review by contacting the Patient Assistance Office. Grievance forms are available from Guest and Patient Relations or the Patient Assistance Office should you wish to use one. You may also contact the Patient Assistance Office by phone at 214-648-0500 or in writing at the address below:

**Patient Assistance Office
UT Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390-8831
214-648-0500**

NOTICE CONCERNING COMPLAINTS

Complaints regarding quality of care at a Joint Commission-accredited health care organization may be reported for investigation at the following address:

**The Joint Commission, Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181**

Assistance in filing a complaint with The Joint Commission is available by calling toll-free: **1-800-994-6610**.

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, TX 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**.

For more information please visit their website at www.tmb.state.tx.us

If you are with a health maintenance organization and wish to file a complaint, you may do so by contacting the Texas Department of Insurance at 1-800-252-3439.