Baylor Scott & White HEALTH

SCOTT & WHITE MEDICAL CENTER - TEMPLE
2401 S. 31st St.
Temple, TX 76508-0001

GENERAL CONSENT TO TREAT

IMPORTANT INFORMATION – READ CAREFULLY BEFORE SIGNING

1. **General Consent** I consent to SCOTT & WHITE MEDICAL CENTER - TEMPLE (facility) to provide me with necessary medical services, treatments and diagnostic tests. My consent to this treatment includes any examinations, X-rays, laboratory procedures, tests (including, but not limited to, tests to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), medications, medical treatment, and/or other services rendered by the attending physician or other treating or consulting physicians, their associates, technical assistants and other healthcare providers including nurses and other hospital personnel, which in the judgment of such practitioners, are advisable during the course of evaluation, diagnosis and treatment. This consent is continuing in nature during the entire course of my care, unless specifically revoked by me.

2. **Teaching Institution** I understand that the facility may be a teaching facility. Students and residents from various programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my healthcare providers. I consent to allow medical residents, students and authorized individuals to observe the care provided as determined by the treating physicians and as permitted by hospital policy. Except for students, residents and or fellows, I understand that the physicians participating in my care at hospital are not employees or agents of hospital and are not acting for or on behalf of hospital. They are either independent physicians who are engaged in the private practice of medicine and who have been granted privileges to use this facility to care for their patients or they are licensed physicians who are engaged in a post-graduate medical education program. I understand that all such medical decisions regarding my care and treatment at hospital are made by such physicians and not by hospital.

3. **Control Over Decisions** I have the right to make decisions about my care. My healthcare professionals and I will discuss and agree upon my care.

4. **Testing After Accidental Exposure** I understand that Texas law provides, if any healthcare worker is exposed to the patient's blood or other bodily fluid, that hospital may perform test(s) on the patient's blood or other bodily fluid to determine the presence of any communicable disease. I consent to the testing for other communicable diseases, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient while a patient at hospital.

5. **State Reporting Requirements** I understand that the facility is required by law to report certain infectious

diseases, such as HIV and tuberculosis, to the state health department or the Centers for Disease Control and Prevention. Also, I understand that the facility is required by law to report certain activities including abuse or neglect.

6. **Personal Property** I understand that I am responsible for my personal property. I understand that any and all valuables or other articles of personal property should be placed in the care of a family member or other authorized representatives. The facility is not responsible for safekeeping these items. If available, I understand that the hospital maintains a safe or secure area for property and valuables, and that I may utilize this safe or secure area according to hospital policy, however, hospital cannot guarantee the security of these items.

7. **Financial Responsibility** It is agreed and understood that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the hospital and any practitioner providing me care and agree to pay for any and all charges and expenses incurred or to be incurred. I understand that the practitioners providing me care may be out-of-network on my health or insurance plans although the hospital may be in my insurance network. I understand my insurance may not cover some services provided to me. I am responsible for asking about and understanding my insurance coverage and selecting my healthcare providers and facilities. Only my insurance carriers can confirm the nature and extent of my coverage and which providers will be paid in-network. I acknowledge that I may receive from these practitioners separate bills according to prices set by those practitioners and coverage policies under those plans. It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I, as the designated responsible party, shall pay all charges for reasonable attorneys' fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. Further, I hereby consent to credit bureau inquiries for any and all permissible purposes.

8. **Medicare and Medicaid** If I have Medicare or Medicaid, my financial obligations may be limited by law. Other insurance carriers may limit my obligations by contract or policy benefit guidelines. If I do not have insurance coverage, I may ask for help to determine programs for which I may be eligible

9. **Provider Based Institution** I understand that the facility may include provider based institutions under Medicare. Because of this, I may receive separate bills for facility services (Part A) and physician services (Part B), even if I do not have Medicare.

10. **Assignment of Benefits** I hereby irrevocably assign, transfer and convey to the hospital and any practitioner providing care and treatment to me, any and all benefits, interests and rights (including, but not limited to, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third party reimbursement, or prepaid health care plan for services rendered or products that I receive from the hospital.

11. **Release of Information** I understand that the facility may release my healthcare information for payment purposes and any other purpose permitted by law. Further, the facility may release my information to other providers for my continued care. I also authorize the release of medical information to organ transplantation services should I be identified as a potential organ donor. I agree that any leftover specimens sent to the laboratory may be used for medical education, validation and authorized research confidentially to protect

my privacy.

12. **Communication** I authorize the hospital, my healthcare professionals, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, digital voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

13. **Retention of Records** I understand that the facility will retain my medical records for the required retention period. I acknowledge that the facility may authorize the disposal of patient medical records at the end of this retention period.

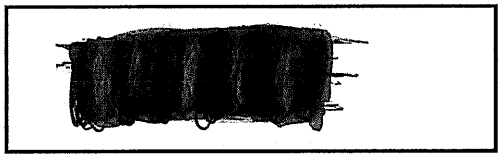
14. **Notice of Privacy Practices** I acknowledge that I have received a copy of the facility's "Notice of Privacy Practices." I acknowledge that I can obtain an additional copy of the "Notice of Privacy Practices" on the facility's website

15. **Patient Rights and Advance Directives** Information has been made available to me about my right to accept or refuse medical treatments. I have the right to make an advance directive, or living will. I am not required to have an advance directive to receive medical treatment. If I give the facility an advance directive, my caregivers will follow it to the extent permitted by law.

16. **Patient Representative** I have the right to name a representative who will make decisions on my behalf in the event I am unable to. I may designate a representative in writing or by telling my healthcare provider. My representative will be involved in my treatment/care plan, unless I expressly withdraw this designation in writing or by telling my healthcare provider.

17. **Photography** I consent to the facility videotaping, photographing, video monitoring, or performing other recording of me or parts of my body for diagnosis, treatment, research, or for patient safety purposes and be utilized for medical education, quality improvement, research, or for other reasons related to treatment and/or operations provided that my identity is not revealed by descriptive texts accompanying the pictures. I will discuss this with my caregiver if I do not want my recordings used for these purposes.

18. **Warranty and Guarantee** I am aware that the practice of medicine is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care and treatment rendered by the hospital or the attending physician.



Patient Signature or Legally authorized Representative signature and Relationship to Patient

Date: **Time:**

Patient Name: **MRN:** **DOB:**

HOSPITAL USE ONLY

When Patient is unable to sign

Clinical Attestation Confirming Patient's Inability to Sign **Date:** [redacted] **Time:** [redacted]

MR FORM H7600-100 9/15

[redacted]

[redacted]

[redacted]