UNIVERSITY HEALTH SHREVEPORT GE [redacted]

Patient Name: [redacted]

1. **CONSENT FOR TREATMENT**
I authorize and give consent to my physician, and whomever they may designate as their assistants, for medical treatment and for reasonable and necessary services including but not limited to, emergency care, administration of approved drugs, nursing care, radiology and pathology, as well as other medical services provided as part of my medical treatment.
I am aware that University Health Shreveport is a teaching facility, and, as a result, medical students, nursing students, and other medical career students may be involved in my care.

FINANCIAL AGREEMENT (ASSIGNMENT OF BENEFITS)
I assign to University Health Shreveport all benefits covering medical expenses. I further agree that, should the amount paid be insufficient to cover the entire medical expense, I will be responsible for payment of any differences. I understand that my physician(s) will send me a separate bill for their services, and that this authorization and assignment also applies to them. I authorize the release of any information about me to any insurance company or other payer source when this information is required for payment to University Health Shreveport. If I do not want my insurance company billed, I realize that I must request in writing that no information be released and payment in full will be due at the time of treatment.

2. **MEDICARE (TITLE XVIII), MEDICAID, (TITLE XIX), AND FREE CARE APPLICATION (If Applicable)**
I certify that the information that I give in applying for free care, payment under Medicare or Medicaid is correct.

FOR INPATIENT ADMISSIONS ONLY:

3. **DESIGNATED MEDICAL DECISION MAKER**
If I am unable to make medical decisions for myself for any reason, I have authorized _____ to make decisions on my behalf.
Name of person
I have ☐ I have not ☐ given written authorization to anyone to make medical decisions for myself.

4. **VALUABLES**
I understand University Health Shreveport assumes no responsibility for personal possession including cash, jewelry, dentures, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that valuables should be placed in the care of my family or deposited in the Hospital's vault by University Police.

5. **AUTHORIZATION FOR INPATIENT DRUG ASSISTANCE PROGRAMS**
University Health Shreveport is participating in programs with drug manufacturers that can offer assistance in providing medications for low-income/non-insured inpatients who meet certain standards. Signing this form means that you are giving University Health Shreveport permission to send your medical and financial information to these drug manufacturers to apply for aid. You also are giving University Health Shreveport, or its agents, permission to complete the drug manufacturers' application forms for you and to sign on your behalf.

6. **PATIENT RIGHTS AND RESPONSIBILITIES**
I understand that as an outpatient, a copy of the Patient Rights and responsibilities is available upon request. If admission to the hospital is necessary a copy of the Patient Rights and Responsibilities will be provided to me. I understand that upon my first visit to a University Health Shreveport Facility I will receive a Notice of Privacy Practices. On return visits to the facilities this notice is available on request and is also located on the University Health Shreveport Website.

[redacted]
Authorized Signature

Date: 12.01

[redacted]
Guarantor Signature (if different from above)

Time