

UT ★ PHYSICIANS

CONSENT FOR MEDICAL TREATMENT, DISCLOSURES, AND WAVIER

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 physicians 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, pathologist, anesthesiologist, 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.

FINANACIAL 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) 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 hereby 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 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 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.

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AUTHORIZATION 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 your authorize (permit) IT 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.

PATIENT/LEGAL GUARDIAN SIGNATURE

(Patients over 18 years of age)

Date

PRINT NAME

(If Legal Guardian, state relationship to patient)

PATIENT/LEGAL GUARDIAN EMAIL ADDRESS

GUATANTOR/INSURED SIGNATURE

DATE

PRINT NAME

RELATIONSHIP TO PATIENT

WITNESS SIGNATURE

DATE

PRINT NAME