CONDITIONS OF ADMISSIONS

Initials indicate that I, or my personal representative, have read and acknowledged the following information.

CONSENT TO TREAT

I am presenting myself for admission to Legent inpatient/outpatient for care and treatment, and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the hospital, its medical staff, or other designees, as may be deemed necessary or beneficial for my care. This consent is valid during the course of my admission unless revoked by me in writing. I acknowledge that no guarantees have been made to me regarding the effect of such care or treatment of my condition.

Patient's Initials_____

ADVANCED DIRECTIVE ACKNOWLEDGEMENT

An Advanced Directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. Written materials about my right to accept or refuse medical treatment are available.
I have been informed of my rights to formulate Advanced Directives; I understand that I am not required to have an Advance Directive to receive medical treatment. I understand that the terms of any Advance Directive that I have executed will be followed by the Hospital and my caregivers to the extent permitted by law.

1. I have been informed of my rights to formulate Advance Directives.
2. I understand that I am not required to have an Advance Directive in order to receive medical treatment.
3. I understand that the terms of any Advance Directives that I have executed will be followed by the Hospital and my caregivers to the extent permitted by law.

☐Yes ☐No I have executed an Advance Directive.
☐Yes ☐No A copy of the Advance Directive was obtained at admission.
☐Yes ☐No I understand it is my responsibility to provide the hospital with a copy of my Advance Directive, I understand that until I provide this document, the hospital may not be able to honor my wishes.

If no copy available, what is the intent? (Use patient's or healthcare surrogate's own words)

☐Yes ☐No I would like additional information regarding Advance Directives.
☐Yes ☐No I have a Durable Power of Attorney for Healthcare.
☐Yes ☐No A copy of the Durable Power of Attorney for healthcare was provided

If no copy, who is the Agent? _____

Contact Information of Agent: _____

Patient's Initials_____

CONSENT TO USE AND DISCLOSE INFORMATION

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulation promulgated there under, I hereby agree and consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations. I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for further care or treatment. I understand that this information serves as:

1. A basis of planning my care;
2. A means of communication among the many health professionals who contribute to my care;
3. A source of information for applying my diagnosis and surgical information to my bill;
4. A means by which a third-party payor can verify that services billed were actually provided and may be used as a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Protected Privacy Practices which provides a more complete description of Protected Health Information, its uses and appropriate disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and

CONDITIONS OF ADMISSIONS

practices, and prior to implementation, will mail a copy of any revised notice to the address I have provided.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that the organization is not required to agree to the restrictions requested.

I/authorized representative agree, by providing my information including a landline phone number, a wireless phone number, VOIP number(s), or any other numbers/methods of communication, consent to receive calls and/or text messages including autodialed calls and artificial or prerecorded messages from the hospital, physicians, agents and independent contractors (including service agencies and collection agencies) regarding hospital/medical services and any related financial obligations. This consent applies to all services and billing associated with any account for me regardless of the date of service. I/authorized representative acknowledge that text messages may be susceptible to certain privacy and security risks, such as being viewed by others with access to the phone or device on which the text is received or stored. I understand that charges may be incurred in receiving such communication by a third party and that I am fully responsible for such charges. These charges could include but are not limited to cell phone minutes, text message minutes, airtime minutes, VOIP fees, and taxes imposed for the use of the communication services.

I understand and consent that records generated as a result of my healthcare treatment and/or admission to the hospital for treatment or for one whom the undersigned has legal responsibility or authority to execute this consent form for, or by a third-party payor who may provide insurance payments to the hospital for charges incurred for the service rendered to me, I expressly authorize the hospital to release such records to such payor or to any person or organization authorized by law to review these records for any lawful purpose.

I realize that during the course of my care at Legent, or my follow-up care it may be necessary for the hospital or my attending physician(s) to make available to other health care providers, including referring facilities and physicians, copies of my medical record(s) or information relating to my care.

Patient's Initials_____

COMPLIANCE AND DISCLOSURE UNDER TEXAS OCCUPATIONS CODE-SECTION 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the lime of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code. Admitting Physician: _____

Patient's Initials_____

PERSONAL VALUABLES

It is understood and agreed that the hospital is not responsible for the safekeeping of money and personal valuables. You are encouraged to send all money and personal valuables home with family or trusted friends. If this is not possible, please ask for assistance from the hospital in securing your personal valuables. The hospital shall not be liable for the loss or damage to any money, jewelry, or other articles of value.

Patient's Initials_____

CONDITIONS OF ADMISSIONS

FIREARMS NOTICE

Restriction of firearms on this property: “Pursuant to section 30.06., penal code (Trespass by holder of license to carry a handgun), a person licensed under Subchapter H, Chapter 411, Government Code (handgun license law), may not enter this property with a concealed handgun.”

Patient's Initials_____

NON-SMOKING NOTICE

It is the policy of Legent to provide a healthy and smoke-free environment for all who enter the facility. Therefore, smoking is not permitted in any hospital structure and only at interior locations marked as smoking areas. “NO SMOKING” signs are posted throughout the building and areas controlled by Legent where patients are seen or housed. Patients who are non-compliant will be warned and their smoking materials removed until the time of discharge. Visitors who are non-compliant may be asked to leave the facility.

Patient's Initials_____

RECEIPT OF PATIENTS’ BILL OF RIGHTS AND NOTICE OF PRIVACY PRACTICES

I have received or been explained the Patients’ Bill of Rights and Notice of Privacy Practices.

Patient's Initials_____

ACKNOWLEDGEMENT AND RECEIPT OF SIGNATURES

The undersigned certifies that he/she has read the foregoing, and it is the patient, or duly authorized patient's general agent, who accepts the above terms and executes the document. All guarantors certify that they have read the foregoing and accept these terms.

_____

Patient Signature/Personal Representative

Relationship to Patient: _____ Date: _____ Time: _____

_____

Witness Signature:

Date: _____ Time:_____

_____

Second Witness Signature:

Date: _____ Time: _____

(Required on Verbal Authorization)

Patient Identification Label