CONDITIONS OF ADMISSION & CONSENT FOR TREATMENT

Patient's Name:_____

Visit Number: _____ Date: _____

CONSENT FOR TREATMENT: I authorize OGH and DEWITT CLINIC and all of their physicians, technicians, nurses and other health care personnel to provide any medical/surgical treatment, laboratory and other diagnostic procedures, radiology examinations, administration of routine drugs, biologicals and other therapeutics, during this hospitalization or outpatient care as ordered by my attending physician or designee(s) and deemed necessary or beneficial for my health. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health.

This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis, if a physician orders such test(s) for diagnostic or treatment purposes or in the case of an accidental exposure to my blood or other body fluids by health care personnel.
I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I understand and acknowledge that the results of any treatments, tests or care cannot be guaranteed, and that no guarantees or assurance of results have been made to me by OGH or DEWITT CLINIC.

I consent to allowing medical, nursing and other health care personnel in training to observe or participate in the delivery of my medical care or treatment, and that these personnel will be supervised by instructors or authorized OGH/DEWITT CLINIC personnel.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY: I assign and transfer to OGH/DEWITT CLINIC all of my benefits under existing health insurance policies, health benefit plans and other sources of payment for my inpatient or outpatient care. I authorize direct payment to OGH/DEWITT CLINIC of all insurance, health plan benefits and other payments for this hospitalization or outpatient care. I agree to cooperate with, and take all steps reasonably requested to perfect, confirm or validate this assignment. I appoint OGH/DEWITT CLINIC as my authorized representative to pursue any claims, penalties, and administrative/legal remedies on my behalf for collection against any responsible third party payer for any and all benefits due me. If I receive payment

directly from any payer, I acknowledge it is my duty and responsibility to immediately pay any such payment to OGH/DEWITT CLINIC.

I hereby promise to pay OGH/DEWITT CLINIC for its full billed charges for all services and goods provided to me. If OGH/DEWITT CLINIC are not paid in full by my health insurance policy, health benefit plan or other source of payment for my care, I will pay for any charges not covered and covered charges not paid in full including any charges payable as copayment, deductible, coinsurance and non-covered charges. I agree to be responsible for payment of the full amount of charges less any amounts already paid by me or on my behalf, unless expressly prohibited by law or contract. I am providing OGH/DEWITT CLINIC all health insurance, health plan or other source of payment information to allow for verification. Charity care may be available if eligibility criteria are met.

I understand that physician services are not part of OGH's charges for inpatient and outpatient care and will be billed to me separately. I assign and transfer to such physicians the benefits payable under existing health insurance policies, health benefit plans and other sources of payment for their medical services provided to me. I authorize direct payment to such physicians of the benefits and other payments for their medical services.

MEDICARE/MEDICAID/THIRD PARTY PAYOR CERTIFICATION: I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I assign the benefits payable for services rendered to OGH/DEWITT CLINIC, and request payment of any and all authorized benefits to be made on my behalf to OGH/DEWITT CLINIC or OGH/DEWITT CLINIC based physician(s) by the Medicare or Medicaid program.

RELEASE OF INFORMATION: To obtain payment for services, I authorize OGH/DEWITT CLINIC to furnish and release to my insurance carrier(s) or their representatives insuring the patient named, any or all portions of my medical record which may be necessary for completion of my patient care insurance claims. I understand that billing agencies for specialized services such as radiology, emergency services, and anesthesia will also receive information necessary for billing.

I authorize the release of copies or summaries of my medical record to any health care facility or other provider to which I may be transferred or referred. I further authorize release of my medical information to any physician involved in providing my care. I hereby release OGH/DEWITT CLINIC from all legal liability that may arise from the release of the information requested and provided. A photocopy of this authorization shall be as binding as the original.

NOTICE OF PRIVACY PRACTICES: OGH/DEWITT CLINIC provides information about how protected health information about me (the patient) may be disclosed. I have been offered an opportunity to review the Notice of Privacy Practices before signing this consent. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the OGH/DEWITT CLINIC Business Office. I understand that I have the right to request restrictions on how my

protected health information is used or disclosed for treatment, payment or healthcare operations. By signing this form, I acknowledge that I have been offered and/or received the Ochiltree County Hospital District/Ochiltree General Hospital Notice of Privacy Practices.

Complete for Inpatient, Outpatient Procedures/Surgery, Observation and PHC/DEWITT CLINIC patients

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware that OGH/DEWITT CLINIC provides special facilities for the safekeeping of valuables. I release the Hospital from any responsibility for the loss or damage to any valuable possession (including valuables brought in to me by other persons) that I choose to keep in my personal possession and do not deposit with the Hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law.

OGH/DEWITT CLINIC shall not be liable for the loss of or damage to any money, jewelry, documents, eyeglasses, hearing aids, dentures, electronic devices or any other articles unless placed in the safe.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

_____ | I have executed an Advance Directive and have been requested to supply a copy to OGH/DEWITT CLINIC.

_____ | I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive.

_____ | I have not executed an Advance Directive and do not wish to execute one at this time.

AUTHORIZATION TO DISCLOSE INFORMATION

I _____DO authorize disclosure of my location and general condition to family and friends who ask for me by name.

I _____DO NOT authorize disclosure of my location and general condition to family and friends who ask for me by name.

Patient Rights & Responsibilities Brochure: _____ Received _____ Declined

Physicians who treat patients or otherwise provide professional medical services at OGH and DEWITT CLINIC may be employees, contractors or independent practitioners. All physicians must be licensed in the State

of Texas, meet and comply with credentialing requirements, and must be members of the OGH Medical Staff and granted clinical privileges to provide services to patients. Physicians act independently, are not controlled or directed by OGH or DEWITT CLINIC in treating patients or providing services, and are solely responsible for their own judgment and conduct. OGH and DEWITT CLINIC are not responsible for the independent judgment or conduct of any of their physicians.

I understand that I am under the care and supervision of my attending physician. OGH, DEWITT CLINIC, their nurses and other health care personnel are responsible for carrying out my physician's instructions.

My physician or surgeon is responsible for obtaining my informed consent, when required by Texas law, to certain medical or surgical treatment, diagnostic or therapeutic procedures and other specialized hospital services.

I have read this consent form have had it explained to me and understand its contents. I hereby agree to all terms and conditions set forth above.

_____ Date: _____

Patient's Signature

_____

Authorized Representative's Signature & Relationship (if patient unable to sign)

Relationship to Patient: _____