1. **Consent to Treatment:** I voluntarily consent to be treated by Methodist Health System. I grant permission to the physicians and their assistants, physicians in post-graduate medical education training, medical, nursing, and other clinical students and employees affiliated with Methodist Health System to perform such medical treatment(s) and/or diagnostic procedure(s).
2. **Physicians Not Agents of Hospital:** I understand that the physicians or physician assistants who treat or otherwise provide professional services to me either directly or indirectly through such services as, but not limited to, emergency medicine, radiology, pathology/laboratory medicine, anesthesiology and perinatology (with the exception of physicians in post-graduate medical education training) **are not** employees or agents of Methodist Health System. These physicians are independent practitioners, and are solely responsible for their own judgment and conduct. I also understand that for emergency or unscheduled services, the hospital may aid my selection of physicians by an established "on-call" roster provided through departments of the hospital. I agree the hospital is not responsible for the independent judgment or conduct of any of the physicians identified above.
3. **Risks of Treatment:** I understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to surgical, medical, and/or diagnostic procedures planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death.
4. **Financial Agreement:** In consideration of Methodist Health System furnishing services and supplies to the above named patient, I agree to pay Methodist Health System, its agents and assigns, all sums of money which shall become due on the account of the patient receiving services made the subject of this consent in accordance with Methodist Health System’s regular rates and terms related to COVID-19 Testing.

I understand that I have the right by Texas law to receive an itemized statement of billed services within 30 days of my discharge and before receiving collection activity from the hospital.    Methodist Health System maintains certain policies related to billing and collections on our website at methodisthealthsystem.org under the section Patients and Visitors, then select Financial Assistance.    For questions related to billing or payment after discharge, please contact our customer service department at (214) 947-6300.

\_\_\_\_  By opting in, I agree to receive itemized statements electronically through my health care portal, MyChart and all future itemized statements will be provided electronically.   I understand that itemized statements are available in MyChart no later than 4 days from the date of discharge.

\_\_\_\_  By opting out, I do not agree to receive itemized statements electronically through my health care portal, My Chart.   Itemized statements will be mailed to the address on file no later than 14 days from the date of discharge.

1. **Consent for Wireless Calls, Mail, and Email:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, agents, and independent contractors, including servicers and collection agencies regarding the hospitalization, the services rendered, or my related financial obligations. I consent to receive information about Methodist Health System events such as: upcoming health fairs, health and wellness updates, new locations and services via email and mail. In addition, the Methodist Health System patient portal uses your email as the initial access to the portal.
2. **Authorization to release information:** I authorize Methodist Health System to furnish requested information from the patient's medical and other records to (1) any insurance company or third party payor for the purpose of obtaining payment on the account of Methodist Health System, (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, and federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's record for purposes of conducting any medical audits, utilization reviews, or quality assurance reviews. I authorize Methodist Health System to release information or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which the patient may be transferred.
3. **Assignment of insurance Benefits:** In consideration of services rendered, I hereby transfer and assign to Methodist Health System and to Pathologist, Radiologist, Anesthesiologist, and other licensed physicians, individuals or groups who perform services for my care and treatment at Methodist Health System all right title and interest in any payment due me for services described herein as provided in any health insurance or similar policy or employee benefit plan. I understand that I am responsible for providing to Methodist Health System all insurance information at the time of admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and items supplied. In the event a procedure, service or item provided is deemed experimental or investigational or for any other reason is deemed not covered by my Managed Care Insurance Plan, responsibility for payment falls solely to me and the patient and/or patients guarantor.
4. **Medicare/Medicaid Assignment of Benefits:** I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare/Medicaid.

# Medicaid

I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, initial duration, and/or scope of the Texas Medicaid Program, as determined by the Medicaid department or its health insuring agency. All payments for non-covered services are due and payable at time of discharge.

1. **Disclosure of Health Care Information:** Methodist Health System Notice of Privacy Practices and Methodist Health System Medical Staff Practitioners Notice of Privacy Practices provide information about how Methodist Health System and Methodist Health System Medical Staff Practitioners may use and disclose protected health information about you. Copies of the current Notices are available through our website, methodisthealthsystem.org. The notices contain on the first page, in the top right corner, the effective date. As provided in the Notices, the terms of the Notices may change. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
2. **Additional Provision for Admission of Minors:** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient and have legal authority to consent to the treatment to be provided to said patient and understand, acknowledge and agree to be responsible for the cost of all care provided to said patient.
3. **Financial Assistance Program:** Methodist Health System maintains an established policy to provide health care services to those unable to pay. Information and application forms are available upon request. Please ask to speak with a Financial Counselor for more information or to answer any questions.

I, the undersigned, as the patient or legal agent of and responsible for the patient, hereby certify I have read, and fully and completely understand this Conditions of Admission, Authorization for Treatment and Financial Agreement, and that I have signed this Conditions of Admission, Authorization for Treatment and Financial Agreement knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services provided or to be provided. If insurance coverage is insufficient, denied altogether or otherwise unavailable, I agree to pay all charges not paid by the insurer.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_