

Ambulatory Services

**Patient Registration and
Consent for Treatment**

Pt. Name: _____
Address: _____

City State Zip
MRN: _____
DOB: _____
SSN: _____ SEX: _____
DOS: _____

I. Consent For Treatment

I, _____, am presenting myself to the University of Texas Southwestern
Print Name of Patient

Medical Center at Dallas (UT Southwestern) for examination, diagnosis and/or treatment of my medical condition. I give consent and authorize my physician(s) or his or her designees to order and/or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the University of Texas Southwestern Medical Center at Dallas, unless revoked by me in writing.

II. Consent for Disclosure of Information

I acknowledge that UT Southwestern is committed to protecting the confidentiality of information contained in my medical records, including my health and financial information ("Medical Records") in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, UT Southwestern requires permission to disclose my Medical Records to certain individuals and entities. Therefore, I give consent and authorize UT Southwestern to disclose any or all information contained in my Medical Records including but not limited to information concerning communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results, to the following individuals and entities:

- physicians and other health care personnel who are involved in the provision, coordination or management of my health care, including but not limited to diagnosis, evaluation, treatment, consultation and referral for treatment;
- my health insurance plan, Medicaid, Medicare, or any other person or entity that may be responsible for paying or processing payment for my medical treatment;
- employees, agents, representatives, volunteers or contractors of UT Southwestern for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operations;
- employees, agents, representatives, volunteers, contractors and medical or house staff physicians of UT Southwestern's affiliated hospitals or other health care facilities, including but not limited to Zale Lipshy University Hospital, St. Paul University Hospital, Parkland Health and Hospital System and Children's Medical Center of Dallas, for purposes of maintaining a shared electronic medical record repository to promote efficiency in the coordination of health care services at UT Southwestern;
- any person or entity whom I give written authorization to receive my Medical Records on a form provided by UT Southwestern or such other form acceptable to UT Southwestern; and
- any other person or entity that is required or permitted by law to have access to my Medical Records.

I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment and that by failing to authorize this disclosure I may be required to pay the entire bill. I understand that I may revoke this consent to disclose my Medical Records in writing at any time, except to the extent that UT Southwestern has taken action pursuant to this consent. Any revocation of this consent will be effective upon receipt by UT Southwestern. I further agree not to hold UT Southwestern, their agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

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III. Assignment of Benefits/Causes of Action

In consideration of services rendered or to be rendered to the patient, I assign and transfer to UT Southwestern all rights, title and interest in all insurance benefits including but not limited to health plan, Personal Injury Protection (PIP), Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I further assign and transfer any and all claims or causes of action relating to any injuries for which I have received treatment, up to the amount of my total financial obligation to UT Southwestern.

IV. Financial Responsibility

In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for any and all charges and expenses incurred or to be incurred. I understand and agree that regardless of any assigned benefits and monies, I am responsible for the charges for services rendered and agree that all amounts are due upon request. If the account becomes delinquent and it is necessary for account to be referred to attorneys' or collection agencies, or suit, I will pay all patient charges, reasonable attorneys fees and collection expenses.

V. Federal and State Programs

If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carrier any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to UT Southwestern on my behalf. I understand that I am responsible for all applicable health insurance deductibles and co-insurances under these programs.

VI. Accidental Exposure of Health Care Worker

I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable diseases, including but not limited to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, Hepatitis B and C, and Syphilis. Such testing will be conducted pursuant to applicable laws and can include but is not limited to the following situations: 1) if a health care worker is exposed to my blood or other bodily fluid 2) if a medical or surgical procedure is to be performed which could expose health care workers to my blood or bodily fluids 3) to screen blood, blood products, organs or tissues to determine suitability for donation, 4) if I am pregnant.

This Patient Registration and Consent Form supercedes all prior consent or other authorization forms signed by me pertaining to the issues discussed herein.

By signing this Patient Registration and Consent Form, I acknowledge that I have read and understand the information contained in this form and I accept its terms, either on behalf of myself as the patient, or on behalf of the patient as an authorized legal representative of the patient.

Date: _____

Patient or Legal Representative (Signature): _____

Patient or Legal Representative (Printed Name): _____

Legal Representative Relationship to Patient: _____

Witness (Signature): _____

Witness (Printed Name): _____

Clinic where consent was obtained: _____