



LASER CENTER FOR VISION
ZALE LIPSHY UNIVERSITY HOSPITAL
SOUTHWESTERN MEDICAL CENTER

CONSENT FOR ADMISSION

1. **APPLICATION FOR ADMISSION AND CONSENT FOR TREATMENT:**

I, _____ (Name of Patient), hereby make application for admission to Zale Lipshy University Hospital, as a voluntary patient.

I voluntarily content to Hospital observation, evaluation, care and treatment including diagnostic tests and examinations and/or surgical procedures and medical treatment deemed necessary by my doctor, and/or his/her assistant or designee. This may include the taking of blood, urine, tissue, fluids and other bodily samples, blood transfusions, x-rays or other radiographic or diagnostic procedures. Hospital nurses and other hospital employees are authorized to carry out the instructions of my doctors with respect to those examinations, diagnostic procedures and treatment as necessary. I understand other conditions may be diagnosed which may require treatment during my stay at the Hospital. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantee have been made to me as to the result of any treatment or examinations provided by the hospital. Any supplies, medical devices or other goods sold or given to me are provided "as is," and Zale Lipshy University Hospital disclaims any express or implied warranties.

2. **AGREEMENTS AND UNDERSTANDINGS:**

- a. I have the right to consent or refuse consent, to any proposed procedures or therapeutic courses.
- b. I will not be involved in any research or experimental procedure without my full knowledge and consent. I understand that the **PHYSICIANS PARTICIPATING IN MY CARE**, including the doctor **ARE NOT EMPLOYEES OR AGENTS OF THE ZALE LIPSHY UNIVERSITY HOSPITAL, BUT RATHER INDEPENDENT CONTRACTORS** who have been granted the privilege of using its facilities for the care and treatment of their program. **ZALE LIPSHY UNIVERSITY HOSPITAL IS NOT RESPONSIBLE FOR THE JUDGEMENT OR CONDUCT OF ANY PHYSICIAN WHO TREATS OR PROVIDES CARE OR TREATMENT TO ME.** The independent relationship of these physicians is not affected by any billing for their services done by **ZALE LIPSHY UNIVERSITY HOSPITAL**.

3. **VALUABLES:** I understand that Zale Lipshy University Hospital does not assume the responsibility for safekeeping of any personal property.

4. **ACCIDENTAL EXPOSURE OF HEALTHCARE WORKER:** I also understand and acknowledge that if any health care provider is exposed to my blood or bodily fluids, Texas Law permits the Hospital to perform tests, with or without my consent, on my blood or other bodily fluids to determine the presence of hepatitis B, hepatitis C, Human Immunodeficiency Virus (the causative agent of AIDS) or other diseases. I understand this testing is necessary to protect those caring for me while I am at the Hospital. I also understand that the results of the tests under these circumstances are confidential and do not become part of my medical record.

5. **CONSENT TO RELEASE INFORMATION:** In order to permit reimbursement, upon request, the Hospital may disclose such treatment information pertaining to my hospitalization to any corporation, organization, or agent thereof, which is, or may be liable under contract to the Hospital or to me, or to any of my family members or other person, for I understand that the purpose of any release of information is to facilitate reimbursement for services rendered. In admission, I authorize the Hospital to release information as is necessary to permit the review. This authorization will expire once the reimbursement for services rendered is complete.

6. **TEACHING INSTITUTION:** I acknowledge that the Hospital sometimes functions as a teaching institution and agree that unless I notify the Hospital to the contrary, in writing, I may be a teaching subject in various educational programs at the Hospital. (Student nurses and others in professional training may be among the individuals who provide my care.)
7. **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS:**
I hereby assign to the Hospital, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid or Tricare, or any reimbursement from a pre-paid health care plan. This means that the Hospital and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to the Hospital any interest in any claims I may have to the extent necessary to fully reimburse Hospital for the rendering of services to me. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment, including, but not limited to all health insurance co-payments and deductibles. I understand and agree that my account is due in full upon discharge, with allowances made for insurance coverage approved and verified prior to discharge.
8. **MEDICARE/MEDICAID ONLY-PATIENT CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT:**
I certify that the information given me in applying for payment is correct. I authorize the holder of medical information about me to release information to the Social Security Administration or its intermediaries needed for this or a related Medicare/Medicaid claim.
9. **I ACKNOWLEDGE RECEIPT OF THE WRITTEN MATERIAL ENTITLED, "IMPORTANT MESSAGE FROM MEDICARE/TRICARE"*****
10. **DO YOU HAVE THE FOLLOWING?**
- | | | | | |
|----------------------------------|-------|-----|-------|----|
| a. Advance Directive/Living Will | _____ | Yes | _____ | No |
| b. Medical Power of Attorney | _____ | Yes | _____ | No |
| c. Mental Health Directive | _____ | Yes | _____ | No |
- If yes, do you choose to provide a copy to the hospital? _____ Yes _____ No
- If no, would you like information regarding Advance Directives? _____ Yes _____ No
- Would you like someone from the hospital to follow up with you? _____ Yes _____ No
- I understand it is my responsibility to provide a copy of these documents to the Hospital. A hospital representative is available to discuss the above documents if I decide I would like to prepare and sign them.
11. I have read the above document and understand its contents. I have received written information regarding my rights and responsibilities as a patient, including how to register a complaint I might have. I acknowledge that I am the patient or I am the patient's legally authorized representative, guarantor and/or duly authorized by the patient as the patient's general agent to consent to the above items and make the acknowledgements hereby make.

Patient Signature _____ Date _____

Printed Name of Parent/Guardian/ _____ Signature _____ Relationship to Patient _____
Legal Representative

***NOTE: (Signature of Parent or legally authorized representative is required if patient is under the age of 18)

Witness Name _____ Signature _____ Date _____