USMD HOSPITAL AT ARLINGTON

ADMISSION ACKNOWLEDGEMENT

Notice of Privacy Practices: I acknowledge receipt of the USMD Hospital at Arlington Notice of Privacy Practices.

1. I wish to receive third party marketing ☐ Yes ☐ No 2. I wish to receive USMD fund-raising mail ☐ Yes ☐ No **Initial:** ________

Patients Rights and Responsibilities: I have received written information regarding my rights and responsibilities as a patient. This information tells me how to register complaints I might have. **Initial:** ________

Advance Directives:

<u>**Outpatient and Emergency Room patients only:**</u>

1. Are you presenting an Out-of-Hospital Do-Not-Resuscitate order or bracelet? ☐ Yes ☐ No 2. Copy provided? ☐ Yes ☐ No

<u>**Inpatients, Observation and Outpatients undergoing invasive procedures only (all patients occupying a bed):**</u>

1. Do you have a Directive to Physician (living will)? ☐ Yes ☐ No 2. Do you have a Medical Power of Attorney? ☐ Yes ☐ No
3. Do you have a Mental Health Directive? ☐ Yes ☐ No 4. Copy of Directive provided? ☐ Yes ☐ No
5. Was printed information about Advance Directives offered to you? ☐ Yes ☐ No
6. Would you like to execute an Advance Directive during this hospital visit? ☐ Yes ☐ No
7. Do you understand that you are to provide a copy of your Advance Directive to the hospital? ☐ Yes ☐ No
8. Are you aware an Advance Directive remains in effect until it is revoked, or until it expires if it contains a date of expiration? ☐ Yes ☐ No
9. Who answered the above questions? ☐ Patient ☐ Person with Patient: ______________________ **Initial:** ________

Name & Contact Number

Financial Agreement / Assignment of Benefits: I hereby irrevocably assign to the hospital and any practitioner providing care and treatment to me, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. If my treatment was caused by events which result in legal action, I assign to the hospital an interest in any claims I may have. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment. I understand I am responsible for all health insurance co-payments and deductibles and they are due at the time of the first service. Charity care may be available if hospital eligibility criteria are met. Venue: If legal action is required for the collection of goods or services delivered during this visit, I agree that such legal action shall be brought in Tarrant County, Texas. Upon request, Itemized Statements are available to patient/guarantor no earlier than the 30th day after the date of the hospital discharge. Please contact 817-472-2850 to request. **Initial:** ________

Physicians Providing Service: I understand that physician members and other providers on staff who provide professional services are not employees of USMD Hospital at Arlington. My surgeon, surgical assistants, anesthesiologist, radiologist, pathologist, physician assistants, cardiologists, emergency room physicians and other specialists will bill me or my insurance carrier separately from the hospital. Some or all of my physicians may be out-of-network with my insurance carrier. This may result in possible additional charges and financial responsibility to me. Questions regarding the status of any provider's participation in my insurance plan's network should be directed to the Insurance Plan Administrator or the specific provider. **Initial:** ________

Release of Information: I authorize the hospital to release any information or records contained in the hospital patient records related to alcohol or substance abuse diagnosis or treatment, mental health treatment, or any communicable disease, including HIV/AIDS to (a) any of my treating practitioners, (b) my insurance company or health plan, (c) any other person or entity that is responsible for payment or processing for payment of my hospital bill, (d) any other healthcare provider to which I am transferred for care, (e) entities using this information for quality management and peer review and (f) any other person or entity as authorized by law. This release shall remain valid until I notify the hospital, in writing, of my desire to revoke it. **Initial:** ________

Primary Care Physician Notification: To ensure continuity of care, the hospital would like to notify your primary care physician of your visit/admission. Please provide your primary care physician name and phone number: ______________________

Authorization for Verbal Release of Protected Health Information: I understand that Directory Information, such as my presence in the hospital as described in the USMD Hospital Notice of Privacy Practices, may be released to all who ask for me by name, unless I object and specifically request to be a No Information patient as described below.

<u>**Standard Disclosure:**</u> I authorize this hospital and medical staff to discuss my medical history, diagnosis, treatment and prognosis with those on my record and with the additional people that I list below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS- related illness, mental health, and drug, alcohol or chemical abuse. I authorize the hospital to place my name on a board which may be visible to the public.

Name: ______________________ Relationship: ____________

Name: ______________________ Relationship: ____________

<u>**Confidential / No Information:**</u> I specifically request the hospital not to release any information concerning my admission or treatment. I understand that this includes Directory Information and my name being placed on a board. I choose to be a **Confidential** / **No Information** patient and I realize that mail, flowers, telephone calls, and visitors will be refused on my behalf. The hospital staff will not be able to acknowledge or deny my absence or presence. I also understand that if I make phone calls from the hospital, caller identification systems will result in my location being disclosed to persons who receive the calls.

Disclosure Type (Check One): ☐ **Standard Disclosure** ☐ **Confidential / No Information** **Initial:** ________

Valuables: I understand that the hospital does not assume responsibility for personal property I have with me during my treatment / hospitalization. I understand that unnecessary items should be sent home. **Initial:** ________

I have read, understand and acknowledge the information above. I have notified hospital staff of any exceptions to this acknowledgement.

______________________ ____________ ____________

Signature of Patient or of an Authorized Representative **Relationship to Patient** **Date**

______________________ ____________

Witness Signature **Date**

USMD Hospital at Arlington
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