OAKBEND MEDICAL CENTER

Consent To Be Treated

FINANCIAL AGREEMENT

The undersigned agrees, whether he signs as agent or as a patient, that In consideration of the services to be rendered to the patient, he hereby individually obliges himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. All delinquent account balances are subject to bear interest at the legal rate.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

In consideration of services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title, and Interest In any payment due me for services described as provided in the stated policy or policies of insurance, or pursuant to any no fault or liability insurance providing accident coverage or any settlement paid there from. I further assign all right to payment due me for medical and/or surgical services under said policies to Oak Bend Medical Center, my attending physician, consulting physician, anesthesiologists, radiologists, ER physicia11s, professional laboratory and pathological services. I understand that tam financially responsible for the Indicated physician's services. I authorize the hospital and/or physicians indicated to release medical information about me as It may be necessary for the completion of my Insurance claims for this occasion of service to any insurance carrier, Health er Hospital Plan. I further appoint hospital, or Hs agent, to act as my authorized representative for purposes of obtaining a Texas accident report, as needed to identify potential third-party payers.

MEDICARE PAYMENTS (Patient's Certification, Authorization to Release Information, and Payment Requests)

I certify that the Information given by me in applying for payment under the Title XVIII 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 its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES AUTHORIZATION

I have been informed and understand that OakBend Medical Center will not assume responsibility for any personal property, including but not limited to, dentures, partial plates, eyewear, hearing aids, orthotics, prosthetics, purse/wallet, etc. that I may bring and/or keep with me during my hospital stay.

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL PROCEDURES AND TREATMENT

I hereby authorize the attending physician, and whomever he may designate as an assistant, to administer such medications and treatment as is necessary, and such operations or procedures as are considered therapeutically necessary on the basis of findings in my case. I also consent to the administration of such anesthetics as are necessary. I grant authority now and during the course of the patient care as deemed advisable or necessary to review medication history from other sources of medical information for the purposes of making available information to the .medical provider in order that a thorough plan of care can be developed, Permission for observation of procedure for visiting physicians, nurses, nursing or medical students, interns and residents Is hereby granted at the discretion of the physician in charge, subject to current rules and regulation of the hospital. This (these) Physician(s) are independent contractors and are not employees of OakBend Medical Center.

PAIN MANAGEMENT

I have the right to appropriate assessment and management of pain. OakBend Medical Center supports my right to the highest level of pain relief that can be realistically and safely provided. I may discuss my options with the health care team.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER

I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the hospital my perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that such testing is taken under these circumstances are confidential and do not become part of my medical record.

PRIVATE ROOM ASSIGNEMENT/ ACKNOWLEDGEMENT

I acknowledge and understand that if I request a private room, I may be responsible for the price difference between a private room and a semiprivate room which is $30.00 per day. If I request a semiprivate room and one is not available at that time, I understand I will be charged the private room rate until a semiprivate room becomes available at which time I will be given the option to move. If a private room is deemed medically necessary by the hospital and/or my physician, I will not be responsible for the additional cost of the private room.

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PATIENT RESPONSIBILITIES

I consent to respect and follow the rules and regulations regarding patients while I am at the hospital. I will be considerate of the rights of other patients and hospital personnel. I will also be considerate of the property of others and the hospital. I further agree that I will refrain from any behavior that may offend others or be dangerous lo health, including the use of alcohol, tobacco products, non-prescribed medications, or drugs. I understand that failure to do so may result in my being discharged from OakBend Medical Center and denial of payment of my claims by my insurance provider, including Medicare and/or Medicaid. I understand that I will be responsible for all medical expenses incurred should I be asked to leave 0akBend Medical Center and/or discharged for failure to comply with physician orders, treatment protocols, and hospital rules and regulations. _____ (Initial)

CONSENT TO TELEPHONE CALLS, EMAILS, OR TEXT COMMUNICATION

I hereby grant permission and consent to the hospital, its assignees, and third party collection agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers; (2) to leave voice messages for me, and include in any such messages Information regarding amounts owed by me, reminder messages regarding appointments for medical care, as well as other Information related to my healthcare services: (3) to send me text messages and/or emails using any email address I provide; (4) to use pre-recorded or artificial voice messages and/or automatic dialing device in connection with any communications made to me or related to my account. ___ (Initial)

FACILITY DIRECTORY

I do not object to my name, location, general condition, and religion being put on the hospital directory. _____ (Initial)

NOTICE OF PRIVACY

I have been given written materials about 0akBend Medical Center's Notice of Privacy Practices. _____ (Initial)

CONTINUITY OF CARE DOCUMENT

I authorize the release of an electronic summary record of my episode of care for the purpose of information exchange with other providers involved in my care and/or my services. _____ (Initial)

IMMUNIZATION REGISTRY

I authorize release of my immunization to the Texas Department of State Health Services (DSHS). I understand that DSHS will Include this information In the State's central immunization registry ("lmmTrac"). Once in lmmTrac, my immunization Information may, by law, be accessed by authorized health care providers of care and/or service.
_____ (Initial)

ADVANCED MEDICAL DIRECTIVE/PATIENT RIGHTS AND RESPONSIBILITIES

I have been given written materials about my right to accept or refuse medical treatments and I have been informed of my rights to formulated Advanced Directives. YES ES/NO I also acknowledge receipt of a written statement regarding my rights and responsibilities as a patient which tells me how to register any complaint I might have.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT, TO EXECUTE AND ACCEPT THE ABOVE TERMS.

_____ _____
Date Patient, Patient's Agent or Representative

_____ _____
Witness Relationship to Patient