

Conditions of Admission

1. Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. Financial Agreement. In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by the hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rules or statutes permit the hospital to recover.

3. Consent to Wireless Telephone Calls. 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, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

4. Consent to Email Usage for Discharge Instructions. If at any time I provide an email address at which I may be contacted, I consent to receiving discharge instructions at that email address from the hospital. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, prescription information.

5. Consent to Photographs, Videotapes and Audio Recordings. I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's healthcare operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

6. Assignment of Benefits. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty

EADMF0003

DOB: _____ MR# _____
Woman's Hospital of Texas

and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent, non-exclusive right of recovery against my insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital based physicians elect to collect such payment. In the event the hospital and/or hospital based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plan, I hereby appoint the hospital and/or hospital-based physicians as my authorized representative(s) to pursue, any administrative remedies, claims and/or lawsuits on my behalf and, at the election of the hospital and/or hospital-based physicians, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital and/or hospital-based physicians elect to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital and/or hospital-based physicians to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital and/or hospital-based physicians immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital and/or hospital-based physicians (up to the amount of the charges of the hospital and/or hospital-based physicians, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.*

7. Private Room. I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and/or use of a private room.

8. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

9. Outpatient Medicare Patients. Medicare does not cover prescription drugs except for a few exceptions. According to Medicare regulations, you are responsible for any drugs furnished to you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to you by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

10. Other Acknowledgements

a. Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars (\$500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

EADMF0099

DOB: _____ MR# _____
Woman's Hospital of Texas

b. Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

c. 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.

d. Legal Relationship Between Hospital and Physicians. Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

e. Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my support person designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

f. This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

Please initial: Agree _____ Disagree _____

g. Insurance Network Acknowledgement. I acknowledge that I have received notice that, based on the information available at this time, this facility **IS/IS NOT** a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g. radiologists, anesthesiologists, pathologists, neonatologists, and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure, or other services, may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

EADMF0099

DOB: _____ MR# _____
Woman's Hospital of Texas

11. Patient Self Determination Act. I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to one of the following applicable statements:

I executed an Advance Directive and have been requested to supply a copy to the hospital

I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive

I have not executed an Advance Directive and do not wish to execute one at this time

12. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

SAMPLE

Date: _____

I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment 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. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Time: _____
:

Patient/Authorized Representative Signature:

X _____

If you are not the patient, please identify your Relationship to the patient.

(Circle or mark relationship(s) from list below):

- Spouse Parent Legal Guardian
- Neighbor/Friend Sibling
- Healthcare Power of Attorney
- Other (please specify): _____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:

(required for patients unable to sign without a representative or patients who refuse to sign)

X _____
HCA Texas Conditions of Admission English
06.01.2011

EADMF3100

DOB: _____ MR# _____
Woman's Hospital of Texas

Consent for Use and Release of Information

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, _____ or employer's designee when
(Name of Employer)

the services delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

Date	I hereby certify I have read, and fully and completely understand this Authorization for Release of Information/Healthcare Information, and that I have signed this Authorization for Release of Information/Healthcare Information knowingly, freely, and voluntarily.
Time : <input checked="" type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
<input type="checkbox"/> Patient is medically unable to sign the Consent for Use and Release of Information <input type="checkbox"/> Patient Refused to Sign	
Patient/Authorized Representative Signature X	If other than patient, indicate relationship X
Witness (to Signature only) X	Witness (to Signature only) X

EADMF0004

DOB: _____ MR# _____

Consent for Outpatient Services

1. Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or this outpatient episode of care, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. Financial Agreement. In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the Hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rule or statutes permit the hospital to recover.

3. Consent to Wireless Telephone Calls. 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

EADMF3014

DOB: _____ MR# _____
Woman's Hospital of Texas

from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

4. Assignment of Benefits. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent right of recovery against the patient's insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health plan benefit and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital-based physicians elect to collect such payment. In the event the hospital and/or hospital-based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plans. I hereby appoint the hospital as my authorized representative to pursue, any administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.*

EADM3014

DOB: _____ MR# _____
Woman's Hospital of Texas

5. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

6. Outpatient Medicare Patients. Medicare does not cover prescription drugs except for a few exceptions. According to Medicare regulations, you are responsible for any drugs furnished to you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to you by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

7. Other Acknowledgements

a. 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.

b. Legal Relationship Between Hospital and Physicians. Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

c. Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my support person designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

d. This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

Please initial: Agree _____ Disagree _____

e. Insurance Network Acknowledgement. I acknowledge that I have received notice that, based on the information available at this time, this facility **IS/IS NOT** a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g. radiologists, anesthesiologists, pathologists, neonatologists and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure or other services may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

EADMF3014

DOB: _____ MR# _____
Woman's Hospital of Texas

8. Patient Self Determination Act.

I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to one of the following applicable statements:

<input type="checkbox"/> I executed an Advance Directive and have been requested to supply a copy to the hospital	<input type="checkbox"/> I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive	<input type="checkbox"/> I have not executed an Advance Directive and do not wish to execute one at this time
---	---	---

9. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ **(Initial)**

Date:	<p>I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Consent for Outpatient Services and Authorization for Medical treatment, and that I have signed this Consent for Outpatient Services and Authorization for Medical Treatment 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. This agreement is in effect and applies to care and treatment received during this outpatient episode of care. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.</p>
Time: :	

Patient / Authorized Representative Signature:

X _____

If you are not the patient, please identify your Relationship to the patient.

(Circle or mark relationship(s) from list below):

- Spouse Parent Legal Guardian
- Neighbor / Friend Sibling
- Healthcare Power of Attorney
- Other (please specify): _____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:

(required for patients unable to sign without a representative or patients who refuse to sign)

X _____

HCA Texas Consent for Outpatient Services English
01.18.2011

EADM3014

DOB: _____ Woman's Hospital of Texas	MR# _____
---	-----------



The Woman's Hospital of Texas

Patient Name: _____

Admission/Registration Date: _____

Account Number: _____

I understand that my protected healthcare information may be disclosed to my family members and others as designated by me. I will provide those individuals with a passcode or other verification means specified by the hospital for this purpose.

The password for this visit is:

The passcode is a verification tool to determine the individual's relationship to the patient and to permit the release of protected health information relevant to such individual's involvement with the patient's healthcare or payment.

The passcode does not replace or substitute the patient's authorization to obtain a copy of or access to the patient's medical and/or billing record.

Please Note: This notice contains protected health information which is privileged and confidential and is intended for use only by the above named patient.

If you are not the intended recipient of this document please be advised that you have received this document in error and that any use, dissemination, distribution or copying is strictly prohibited. If you have received this document in error, please promptly return it to an employee of the hospital so that it may be properly disposed.

7600 Fannin
Houston, TX 77054
713-790-1234

Patient Copy EADMF0002

PATIENT RIGHTS ACKNOWLEDGEMENT

I acknowledge that I have been given information and instructions regarding my patient rights at the Hospital. I understand that my patient rights include, but are not limited to, the right to make medical decisions, the right to accept or refuse medical treatment, participate in my plan of care, make advance directives (such as a medical power of attorney or a living will), and receive considerate and respectful care in a safe setting, free from verbal or mental abuse or harassment. I acknowledge that I have received information about the Hospital's patient complaint/grievance process.

ORGAN DONATION ACKNOWLEDGEMENT

In March 2003, HCA joined the Workplace Partnership for Life, a Department of Health and Human Services campaign to create awareness for voluntary organ, tissue, marrow and blood donations. While organ donation is a personal choice, HCA encourages you to make this an informed decision that takes into consideration the number of lives you could save. If you would like to become an organ donor, simply sign the organ donation option on your driver's license or fill out an application through HCA by logging onto www.hcaorgandonation.com. Be sure to tell your family of your intention. You never know whose life you could save. I understand that I have the right to donate any of my organs and / or tissues and that I may do so by completing an organ donor card or other organ donor consent form. I understand that my receipt of care, treatment and services at the Hospital is not conditioned upon my signing an organ donor card. Please initial if applicable: _____ I have signed an organ donor card and have been requested to supply a copy to the Hospital.

SAMPLE

Date	
Time	<input checked="" type="checkbox"/> A.M. : <input type="checkbox"/> P.M.
Signature of Patient or Legal Representative/Guardian X	Printed Name X
Relationship to Patient if Patient Is Unable To Sign X	Witness Signature and Printed Name X

DOB:	MR#
------	-----



Advance Directives Act (see 166.163, Health and Safety Code)

Before signing this document, you should know these important facts.

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician. Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had. It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you. This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility;
- or a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.



Medical Power Of Attorney

Advance Directives Act (see ?§166.164, Health and Safety Code)

Designation of Health Care Agent:

I, _____ (insert your name) appoint:

Name & Phone Number

Address, City, State, Zip Code

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician. Limitations On The Decision Making Authority Of My Agent Are As Follows:

Designation of an Alternate Agent:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.) If the person designated as my agent is unable or unwilling to make health care decisions for me, designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Second Alternate Agent

Name

Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Phone Number

The original of this document is kept at:

Name

Address, City, State, Zip Code

The following individuals or institutions have signed copies:

Name

Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Phone Number

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself. (If Applicable) This power of attorney ends on the following date:

Prior Designations Revoked

I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

Continued on next page.



**You Must Date and Sign this Power of Attorney
Advance Directives Act (see §166.164, Health and Safety Code)**

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

City & State

Signature, Print Name

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature

Printed Name & Date

City, State, Zip Code

Signature

Printed Name & Date

City, State, Zip Code



Directive to Physicians and Family or Surrogates

Advance Directives Act (see ?§166.033, Health and Safety Code)

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences.

Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences. In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I _____ recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored: If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (This selection does not apply to Hospice care.)

Additional Requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

Continued on Next Page.



If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

Person 1

Person 2

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me, following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signature

Printed Name & Date

City, State, Zip Code

Two witnesses must sign in the spaces below.

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness (1) may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1

Witness 2

DEFINITIONS

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

- a. that may be treated, but is never cured;
- b. that leaves a person unable to care for or make decisions for the person's own self; and
- c. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

EADMF0040



Room Assignments

The Woman's Hospital of Texas makes every effort to accommodate our patient's requests, including private and semi-private rooms.

On the Medical Surgical Unit where both private and semi-private rooms are available, there is a fee for private rooms. Payment must be made prior to moving into the private room. If your condition warrants staying beyond your expected discharge day, fees for the additional days will be due at the time of your discharge.

Due to the nature of our services, we are unable to take room reservations in advance. If you would like a private room, please let your admitting nurse know when you arrive at the hospital.

There may be times when all the private rooms are occupied. You will be notified by your nurse if one becomes available during your stay.

We regret we are unable to provide overnight accommodations for family members or friends in our semi-private rooms. This policy, as well as all others, applies to all patients, regardless of insurance or financial status.

The Woman's Suites

Every woman who chooses The Woman's Hospital of Texas receives the personal, compassionate care for which The Woman's Hospital is renowned. But for those who prefer luxury accommodations, The Woman's Suites offer the extra touches not usually found in a hospital room.

The Woman's Suites feature hotel-like accommodations. Amenities include a fold-down sofa bed for an overnight guest, satellite television, DVD player and complimentary Wi-Fi high speed internet access.

Your stay in the Woman's Suite will also include:

- *Gourmet Room Service
- *A Fresh Flower Arrangement
- *An Assorted Fruit & Cheese Tray
- *A Refrigerator Stocked with Bottled Water & Soft Drinks (one complimentary re-stock)
- *A Free Parking Pass

Suites may not be reserved in advance. Please check on suite availability upon admission. If you would like to know more about The Woman's Suites, contact Nursing Administration at 713-791-7283. A representative can provide information about the additional cost and suite availability.

Date/Fecha		<i>I acknowledge that I have read the above and understand the private room/suite policy, and have also had an opportunity to have all my questions answered by the hospital staff.</i>
Time/Hora	<input checked="" type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
Patient Signature		Patient's Representative Signature
X		X
Witness Signature		
X		X

PATIENT IDENTIFICATION

Private Room and Suite Policy

NOTICE OF PRIVACY PRACTICES
Effective Date: 2/17/2010

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made.

Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health related benefits or services;
- To contact you as part of fundraising efforts, unless you elect not to receive any such communications;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

● **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

● **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

● **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

● **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

● We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

● **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

● **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Estella Gonzalez
Telephone Number: 713-791-7142



The Woman's Hospital of Texas

PATIENT RIGHTS AND RESPONSIBILITIES

We consider you a partner in your hospital care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This hospital encourages respect for the personal preferences and values of each individual.

As a patient of The Woman's Hospital of Texas you have the **RIGHT** to:

- Receive reasonable access to care and response to requests and needs for treatment or service, within the hospital's capacity, its stated mission and applicable law and regulation.
- Receive, at the time of admission, information about the hospital's patient rights policies.
- Have your special communication needs met through the best efforts of the hospital.
- Care that is considerate and respectful of your personal values and beliefs.
- Appropriate assessment and management of pain.
- Participate, with your physician, in the development and implementation of your plan of care and make decisions regarding your care, including pain management.
- Consent to or refuse a treatment, as permitted by law, throughout your hospital stay. If you refuse a recommended treatment, you will be informed of the medical consequences other needed and available care.
- Formulate advance directives and to have employees and practitioners who provide care in the hospital comply with these directives in accordance with the law.
- Participate in ethical issues that may arise in the course of your care.
- Receive care in a safe setting and be free from all forms of abuse or harassment.
- Be free from the use of seclusion or restraint, unless clinically necessary and used only as a last resort, in the least restrictive manner possible.
- Unrestricted access to communication, visitors, mail, telephone calls, unless clinically contraindicated.
- Personal privacy and confidentiality of patient health information.
- Expect that treatment records are confidential unless you have given permission to release information or reporting as required or permitted by law.
- Access information contained in your clinical record within a reasonable time frame.
- Receive information about clinical experiments, research or educational projects affecting your care or treatment including the expected benefits, potential discomforts and risks and alternatives that may also be available.
- Consent or decline to take part in research affecting your care.
- Know about hospital rules and regulations applicable to patient care and conduct that affect you and your treatment.
- Request and receive a detailed explanation of your bill.
- Notification of a family member or patient representative and a physician of your choice regarding your admission to the hospital.
- Be informed of the hospital's patient complaint/grievance process. You may voice complaints, concerns and/or grievances without affecting your care or treatment, through the Patient Advocacy Department at 713-791-7287. If you are not satisfied with the process, you may contact The Texas Department of Health by phone or in writing at 1-800-228-1570, 1100 West 49th Street, Austin, Texas 78756-3199 or The Joint Commission by phone or email at 1-800-994-6610, complaint@jointcommission.org
- Have your guardian, next of kin or legally authorized responsible person exercise, to the extent permitted by law, your patient rights.
- Receive the visitors whom you designate and the right to withdraw or deny visitors at any time.

As a patient of The Woman's Hospital of Texas, you have the **RESPONSIBILITY** of:

- Providing information about your health, including past illnesses, hospital stays and use of medicine.
- Asking questions when you do not understand information or instructions.
- Telling your doctor, if you believe you cannot follow through with your treatment.
- Being considerate of the needs of other patients, staff and the hospital and for assisting in the control of noise, smoking and the number of visitors.
- Being respectful of the property of other persons and of the hospital.
- Providing insurance information and working with the hospital to arrange payment, when needed for hospital services provided.

A hospital serves many purposes. Hospitals work to improve people's health, treat their injuries and diseases; educate doctors, health professionals, patients and community members; and improve understanding of health and disease treatment. In carrying out these activities, this institution works to respect your values and dignity.

Understanding Price and Payment

Your hospital bill and payment can be confusing.



Up-Front Payment

Our practice is to collect all known fees when you register at the hospital, including deductibles, co-payments, and co-insurance, based on **estimated** charges. Your final bill may be higher or lower than the estimates we use at registration, since it is based on actual charges for services provided. If it is higher, we may ask for additional payment at discharge; if it is lower, we will promptly refund the amount you overpaid.

Payment by Insurance

If you carry health insurance, we will bill your insurance carrier shortly after your visit and then send you an informational letter (**not a bill**) to let you know about it. Your insurance carrier should pay your bill within 60 days.

Your insurance company may contact you for additional information to process your claim. Please respond as quickly as possible to ensure you receive the maximum benefit from your coverage.

You will not receive further communication from the hospital unless the insurance company has not paid your claim or a balance is due from you (e.g., part not covered by your insurance.)

Payment Without Insurance

Our facility offers a discount for patients without health insurance, unless you receive an elective cosmetic procedure. You may ask for information about our Uninsured Discount Program upon registration or at any time during your visit.

After your discount is applied, we will ask for payment of the balance at the time of service. If you are unable to pay, we will work with you to:

- Set up a payment plan
- Obtain coverage through Medicaid
- Apply for a Charity discount

Other Charges

Your hospital bill contains charges or hospital services only - you will be billed separately for other professional services including:

- Your physician
- ER physicians
- Radiologists
- Hospitalists
- Pathologists
- Cardiologists
- Neonatologists
- Anesthesiologist



Please call the customer service number on that bill if you have questions about any of these charges.

Online Bill Payment

If you have a balance after discharge, the **Patient Financial Resource** website enables you to pay your bill online with a debit or credit card. Just click the **Patient Pricing & Financial Information** logo from our hospital's home page and then click the **Pay Bill** icon to find and pay your bill. You can call Customer Service at **1-800-361-3974** if you have questions; one of our representatives will be happy to help you.



**Knowing your price
can help you prepare.**

This pamphlet will help you understand your hospital charges, billing procedures, and payment options.

Knowing your price and understanding your bill

Questions and Answers

What services are included in my hospital bill estimate?

If you are viewing estimates provided on the website, pricing includes estimated room and board (for inpatients), supplies, nursing care, equipment use, nutritional services, and any services handled by the staff of the hospital within the walls of the hospital.

Can I get an exact pricing quote?

Unfortunately, no. We will do our best to provide you with a pricing range based on our hospital's historical pricing for comparable services. Price quotes are not guaranteed since the services used to compute the quote can vary from services you receive due to treatment decisions, unforeseen complications, additional tests or services ordered by your physician, and variation in the clinical needs of each patient.

More Questions? Check out the **Patient Financial Resource** website for a complete set of questions & answers.

Knowing your price

Our facility now offers you access to the **Patient Financial Resource**, a website that provides pricing estimates for the most frequently used hospital services, online bill payment, and other helpful information such as:

- **Payment options and alternatives for uninsured patients**
- **Guidelines about our billing process**
- **Frequently Asked Questions**



Finding your price

Just click the **Patient Pricing and Financial Information** logo from our hospital's home page to get started.

If you're already in the hospital, can't get to the internet, or wish to speak with one of our friendly Customer Service representatives, you can call the hotline at **1-888-246-3812**.

We are available to answer any questions you may have concerning your hospital bill.

Customer Service:

Look for this icon on the facility website- click it!



Marketing Communications Authorization

The Woman's Hospital of Texas would like to notify you when additional medical services, promotions, special offers and similar services are available and/or send other marketing materials that may be of interest to you. This notification may be in the form of a written or electronic communication and may include, but not be limited to, the receipt of promotional announcements, newsletters, information about various health care conditions and preventative care services and other forms of communication about the facility's services (collectively, referred to as "Marketing Communications"). To be able to communicate and offer such information to you, your written permission is required to comply with state and federal laws. If you would like to receive Marketing Communications, please review and sign the authorization below.

I also authorize The Woman's Hospital of Texas to send Marketing Communications, in writing or email format, to me about medical services, special offers, marketing and/or other medical information that may be of interest. I authorize The Woman's Hospital of Texas to disclose my name, address and personal health information ("PHI") about the types of services received from The Woman's Hospital of Texas to its business partners. This disclosure may be made in exchange for compensation or other remuneration to The Woman's Hospital of Texas. I understand that if The Woman's Hospital of Texas provides my name and address to its business partners, the business partners may or may not contact me and may or may not disclose my name and address to other persons.

This authorization will expire 10 years after the date it is signed. I understand that any PHI disclosed pursuant to this authorization to an individual or entity that is not covered by state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I may revoke this authorization at any time by providing written notice stating that this authorization is cancelled to the Marketing Department of The Woman's Hospital of Texas. I understand that upon receipt of my cancellation notice of this authorization, The Woman's Hospital of Texas has 45 days to remove my name from any mailing list. I also understand that my revocation of this authorization is not effective to the extent that The Woman's Hospital of Texas or any of its business partners has relied upon it for the use or disclosure of PHI prior to receiving my written cancellation notice.

I understand that I have a right to receive a copy of this authorization. I also understand that I can still receive services from The Woman's Hospital of Texas even if I refuse to sign this form.

I authorize the release of the information for the purpose and to the extent described above. I hereby release The Woman's Hospital of Texas from any and all liability that may arise from the release of my information as I have directed.

Patient/Authorized Representative Signature: X _____ If you are not the patient, please identify your Relationship to the patient. (Circle or mark relationship(s) from list below): Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Other (please specify): _____	Witness Signature and Title: X _____ Additional Witness Signature and Title: (required for patients unable to sign without a representative or patients who refuse to sign) X _____
--	---