CONDITIONS OF REGISTRATION AND ADMISSION

CONSENT FOR TREATMENT

I consent to the procedures which may be performed during this hospitalization or during a prescribed series of outpatient episodes of care, including, but not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, diagnostic procedures, medical, nursing or surgical treatment or procedures, telehealth services, anesthesia, or Facility services rendered as ordered by the Provider. 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 Facility 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. This consent also includes routine diagnostic radiological procedures including the administration of radiographic contrast media and radionuclides (e.g. radiopaque dye). I consent to photographic recordings or reproducible images during the surgical, medical, and/or diagnostic procedure(s) and their use for scientific, educational, or research purposes. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Facility, and that these students will be supervised by instructors and/or Facility staff. I understand that the practice of medicine, surgery, physical therapy, and chiropractic manipulation is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made as to the result of treatments or examinations in this Facility and/or outpatient facilities. This consent is valid for up to thirty (30) days during a prescribed series of outpatient episodes of care.

FINANCIAL AGREEMENT

In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the Facility's price list (known as the Charge Master) effective on the date the charge is processed for the service provided, which rates are 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 not price listed on the Charge Master. An estimate of the anticipated charges for services to be provided to the Patient is available upon request from the Facility. 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. Professional services rendered by independent contractors are not part of the Facility bill. These services will be billed to the Patient separately. I understand that physicians and 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 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 Facility services. The Facility 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 Facility will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the Facility's charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services. If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the Facility may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor 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 Facility'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 Facility. I also understand that, as a courtesy to me, the Facility may bill an insurance company offering coverage, but may not be obligate to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

Patient Label

ASSIGNMENT OF BENEFITS

Patient assigns all of his/her rights under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorized direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization of for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during this admission. I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by mutually accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services an treatment. I hereby irrevocably appoint the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party (Responsible Party) for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers 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. I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment,

including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment, I acknowledge that it is my duty and responsibility to immediately pay any such payment to the Provider(s).

RELEASE OF RESPONSIBILITY FOR PERSONAL BELONGINGS

Arise Austin Medical Center encourages you to leave any valuables at home or with your family or friends who are with you are at the facility. This is to certify that I (or) the undersigned patient do hereby release Arise Austin Medical Center from any liability concerning the loss or damage of my personal belongings including but not limited to: Dentures, Hearing Aid, Glasses, Contacts, Clothing Accessories, Electric/Electronic Equipment, Cash, Credit Cards, Jewelry, and other articles of unusual value and small size. The liability of the Facility for loss of personal property is limited to five hundred dollars ($500.00).

THIRD PARTY COLLECTION

I acknowledge that the Providers may utilize the services of a third party Business Associates or affiliates entity as an extended business office (EBO Servicer) for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g. Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustment and payment have been credited, and/or the insurer's denial of claim(s) or benefits in received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider. Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent, it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings. I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

COMMUNICATIONS ABOUT MY HEALTHCARE

I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or your EBO Servicer and collection agent have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

CONSENT TO EMAIL OR TEXT USAGE FOR DISCHARGE INSTRUCTIONS AND OTHER HEALTHCARE COMMUNICATIONS

If at any time I provide an email or text address at which I may be contacted, I consent to receiving discharge instructions and other healthcare communications at that email or text address from the Providers. These discharge instructions may include, but not limited to, post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to, communication to family or designated representatives regarding by treatment or condition, or reminder messages to me regarding appointment for medical care.

MEDICARE PATIENT CERTIFICATION

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 Facility or Facility-based physician by the Medicare or Medicaid program.

OUTPATIENT MEDICARE PATIENTS

Medicare does not cover prescription drugs with only a few exceptions. According to Medicare regulations, I acknowledge that I am responsible for any drugs furnished to me 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 me by Facility personnel. Medicare requires Facility 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.

Patient Label

PHYSICIAN OWNERSHIP DISCLOSURE

The ownership of Arise Austin Medical Center includes physicians. The physician who referred you to this facility for treatment and other physicians involved in your care at the Facility may have an ownership interest. It is understood that you are free to choose another facility for services that have been ordered by your physician. A list of physician owners is available upon request. If you have questions, you should contact your physician regarding his or her participation as an owner.

LEGAL RELATIONSHIP WITH PHYSICIANS

Most or all of the physicians performing services in the Facility are independent and are not Facility agents or employees. Independent physicians are responsible for their own actions and the Facility shall not be liable for the acts or omissions of any such independent physicians.

CONDITIONS OF REGISTRATION AND ADMISSION

PATIENT VISITATION RIGHTS

I understand that I have the right to receive the visitors whom I or my Patient Representative 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 my immediate family members would enjoy. Further, I understand that the Facility 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 Facility 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 Facility's complaint resolution system.

RECORDS RETENTION

Unless my records are involved in litigation, the Provider may dispose of my medical records ten (10) years after the date of my last treatment here, or, for minors, the later of ten (10) years after the date of the patient's last treatment or the date of the patient's twentieth (20th) birthday. Mammography records are maintained in accordance with the requirements as outlined by the Texas Department of State Health Services.

INSURANCE NETWORK

I acknowledge that I have received notice that, based on the information available at this time, this facility is 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, pathologist, and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure, or other service, 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).

PATIENT SELF DETERMINATION

I have been furnished information regarding Advance Directives (such as a directive to physicians and family or surrogates, medical power of attorney, out-of-hospital do-not-resuscitate, and declaration of mental health treatment). I understand that information and assistance to complete an Advance Directive is available upon request. Please initial next to one of the following applicable statements:

_____ I have not executed an Advance Directive and do not wish to execute one at this time. I understand that the Facility will make every attempt to resuscitate me if an event occurs.

_____ I have previously executed an Advance Directive and have been requested to supply a copy to the Facility. If no copy is provided, I understand the facility will make every attempt to resuscitate me if an event occurs.

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

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHT AND RESPONSIBILITIES

I acknowledge that I have received the Facility's Notice of Privacy Practices, which describes the ways in which the Facility may use and disclose my personal healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Facility Privacy Officer designated on the notice if I have a question or complaint. I have also received the Facility's Patient Rights and Responsibilities, which outlines expectations of me as well as the Facility during my visit this admission.
Acknowledge:_____(Initial)

COMMUNICATION WHILE IN THE FACILITY

While I am receiving treatment at the facility, I authorize the facility to communicate with the following persons about my care:

Print Name	Relation to Patient	Phone Number

Print Name	Relation to Patient	Phone Number

I, the undersigned, as the patient or legal agent for the patient, hereby certify I have read, and fully and completely understand this Conditions of Admission and authorization for Medical treatment, and 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 charges not paid by the insurer. I have been given the opportunity to review this form and ask any questions.

Patient Label

_____ _____
Patient/Authorized Representative Signature Date/Time

_____
If not the patient, relation to the patient

_____ _____
Witness Signature Date/Time

Arise. AUSTIN MEDICAL CENTER
An Affiliate of SCA

CONDITIONS OF REGISTRATION AND ADMISSION

RELEASE OF INFORMATION/HEALTHCARE 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 Facility. I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Facility and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to benefit payment. I also permit the Facility to release my healthcare information to my employer, _____or employer's designee when 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 by payment of a Medicare claim or to the appropriate state agency for payment of a Medicare 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 organization. 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, and/or such other health care agencies involved in my care during and after transfer or discharge from the Facility. I acknowledge that my medical records will be utilized in the Facility's (and the Facility'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 Facility may be stored electronically and made available through computer networks to the Facility personnel and physicians involved in my case and their offices. I also acknowledge that should I be treated at another facility in the area affiliate with the 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 Facility and its authorized representatives to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Facility'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 or any medical device that I may receive. I authorize that my religious preference may be release to local religious organization(s) if requested by me. I understand that someone from case management may visit me during my stay and I agree to the release of medical/social information to agencies that may be deemed necessary or advisable by my physician and case management staff for the purpose of continuity of care.

In case of transfer, I authorize the receiving facility to communicate with Arise Austin Medical Center in order to obtain and/or release my medical information including discharge summary for continuity of care. I understand that the above information may include records/reports from other health care providers involved in my care or treatment.

I further 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.

_____ _____
Patient/Authorized Representative Signature Date/Time

_____
If not the patient, relation to the patient

_____ _____
Witness Signature Date/Time

Patient Label

Arise. AUSTIN MEDICAL CENTER An Affiliate of SCA

CONDITIONS OF REGISTRATION AND ADMISSION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arise Austin Medical Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed *NOTICE OF PRIVACY PRACTICES* to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our center, on our website, and have copies available for distribution.

I,_____, have received a copy of this center's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

Patient Label

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but the acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.