CONSENTS / AUTHORIZATIONS / DISCLOSURES

I hereby voluntarily consent to such hospital care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examinations in the hospital.

I hereby authorize and consent to the hospital accessing, receiving and viewing my diagnostic test results and reports from any of my healthcare providers, including, but not limited to, current and prior hospitals and physicians, during my treatment and examination.

CARE / FINANCIAL RESPONSIBILITY

The patient is under the care and supervision of the patient's attending physician and consultants selected by this physician. It is the responsibility of the hospital and its staff to carry out the instructions of the physicians. As a patient you will be charged and billed for all hospital services rendered under the care and supervision of your physician. In addition, all physicians furnishing services to the patient, including the Radiologist, Pathologist, Anesthesiologist, Emergency Center Physicians, and other, are independent contractors for the patient and are not employees or agents of the hospital and will bill directly for these services. **Recording or filming may be used for the purposes of identification, diagnosis and/or treatment.**

The hospital provides only general duty nursing care unless the physician orders that the patient be provided more intensive nursing care. If the patient's condition requires the service of a special duty nurse or sitter, this service must be arranged by the patient or the patient's representative since the hospital does not provide this special care. When protective side rails are placed on the patient's bed and raised for patient protection or when protective restraints are ordered, the patient assumes all risks of injury or damage if the patient or representative refuses to permit raised side rails or restraints.

PERSONAL VALUABLES

The hospital maintains a hospital safe for the protection of money and valuables. The hospital is not responsible for the loss of, or damages to, any property not deposited in the hospital safe.

MEDICARE / MEDICARE HMO PATIENTS

I acknowledge that I have been provided a copy of the notice entitled "An Important Message from Medicare" detailing my rights as a Medicare or Medicare HMO patient and the procedure for requesting a review by the Peer Review Organization in this area.

CHAMPUS / CHAMPVA PATIENTS

If the patient is covered by CHAMPUS/CHAMPVA, "An Important Message from Tricare" form has been presented to the patient or guarantor.

AUTHORIZATION TO RELEASE INFORMATION

Your signature authorizes the hospital and any physician rendering service(s) to release medical and other information about you, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be release to third-party payors, including the third-party payor's agent and/or representative. Information may also be shared with drug manufacturers to apply for aid; and gives hospital permission to complete application forms and sign on your behalf. Your signature authorizes viewing of medical records by accrediting and regulating bodies for the purpose of evaluating patient care and/or services. Hospital shall destroy medical records after it has met all retention requirements consistent with state and federal law.

In consideration of services rendered, I hereby irrevocably assign and transfer to the hospital for myself and my dependents, all rights, title and interest in the benefits payable for services rendered by the hospital provided in any insurance policy(ies) under which I or any of my dependents are insured. These services will include payment directly to the Anesthesiologist, Pathologist, and Radiologist and other treating physicians rendering professional services. Each person signing the Admission Consent is financially responsible for charges not collected by this assignment for services rendered. Said irrevocable assignment and transfer shall be for the purpose of granting the hospital an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for this hospitalization or outpatient treatment, but shall not be construed to be an obligation of the hospital to pursue any such rights or recovery. I also irrevocably assign to the hospital all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.

The hospital is a member of a health information exchange (HIE) which includes doctors, hospitals, and health insurers. I authorize the hospital to release my protected health information through the HIE for the limited purposes of treatment, payment, and health operations. Information regarding the HIE is available upon request.

COMMUNICATION

I authorize the Facility and providers, along with any billing service and collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, digital voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication. I understand and acknowledge that I am not required to agree to such communication as a condition of purchasing any goods or services from Facility and providers.

Baptist Hospitals of Southeast Texas

Beaumont
(409) 212-5000

PATIENT RIGHTS / AUTHORIZATIONS

I acknowledge that I received a copy of the "Patient Rights and Responsibilities" statement and the “Summary of Financial Assistance Policy”, and that information regarding discounts and financial assistance is available upon request. I have had a chance to review and ask questions and have had those questions answered.

In consideration of the services to be rendered to the patient, the patient and/or other legally responsible person signing this Admission Consent authorizes credit investigation and individually assumes full financial responsibility for the payment of the patient’s account in accordance with the regular rates and terms of the hospital. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney’s fees and collection expense. All delinquent accounts may bear interest at the legal rate. If charity services are required, eligibility determination should be requested upon admission to the hospital or upon receipt of the itemized bill or statement. Information regarding discounts and financial assistance is available upon request.

I acknowledge that I received a copy of this form, and it has been fully explained to me and I certify that I understand its contents.

Signature of Patient or Legal Representative

Date / Time

Relationship to Patient

Patient Unable to Sign Because

Signature of Witness

Date / Time

Baptist Hospitals of Southeast Texas

Beaumont
(409) 212-5000

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have the right to:

1. Receive a written statement of your rights.
2. Receive visitors, subject to your consent, whom you designate while being treated in the hospital. You will be notified of any clinical restrictions or limitations if applicable. You have the right to withdraw such consent at any time.
3. Receive healthcare without discrimination based on race, color, religion, national origin, sex (including transgender), sexual orientation, age or disability.
4. Communication assistance for individuals with limited English proficiency or appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, where necessary for effective communication.
5. Participate in the development and implementation of your plan of care, and if you choose, to appoint a representative to make health care decisions on your behalf. As a patient you are responsible for following directions and providing information about your history or current condition.
6. Make informed decisions regarding your care. By asking questions, you can participate in your Care Plan, and you are responsible to let us know if you do not understand the treatment course of care decisions.
7. Receive, in accordance with 42 CFR 489.27(b), as a Medicare beneficiary the "An Important Message from Medicare Notice" (IM) within two days of admission. In addition, the IM is to also be given to each Medicare beneficiary within two days of their anticipated discharge when the length of stay is longer than two days.
8. Care that is considerate and respectful of your personal values and beliefs.
9. Formulate Advanced Directives and to have the hospital staff and practitioner caring for you comply with these Directives.
10. Have a family member or representative of your choice and/or your own physician notified promptly of your admission.
11. Pastoral counseling upon request.
12. Personal privacy. You will be treated with respect and consideration. You are responsible to be respectful in return.
13. Receive care in a safe setting and be free from all forms of abuse and/or harassment.
14. The confidentiality of your clinical record and the right to limit the release or disclosure of information such as the presence in the facility or location in the hospital, or personal information such as name, age, address, income, health information without prior consent from the patient in accordance with law and regulation.
15. To obtain information contained in your clinical record within a reasonable time frame.
16. Be free from restraints and/or seclusion of any form that is not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
17. To accept or refuse care to the extent permitted by law, and to be informed of the expected medical consequences of such actions. In the event that care is refused, you are responsible for the outcomes and consequences of those decisions.
18. Access protective services.
19. Be informed about the outcomes of care, including unanticipated outcomes.
20. Appropriate assessment and management of your pain.
21. Participate in ethical questions that arise in your care, including issues of conflict resolution, withholding or resuscitative services, foregoing or withdrawal of life sustaining treatment and participation in investigational studies or clinical trials.
22. Expect responsible continuity of care, including the right to be informed of continuing health care needs following discharge.
23. Examine and receive an explanation of your hospital bill regardless of source of payment. The patient / guarantor is responsible for meeting the financial commitments to the facility.
24. Access to a Patient Advocate for assistance in resolution of complaints and/or to file a grievance when an issue cannot be resolved promptly by staff present.

The hospital has a designated Patient Advocate. This person will act on your, or your representative's behalf. They are responsible for reviewing, investigating and analyzing complaints and making recommendations to hospital Administration for resolution of complaints. If at any time you wish to speak to our Patient Advocate, you may do so via the address or phone number below:

Baptist Hospitals of Southeast Texas
C/O Patient Advocate
P. O. Box 1591
Beaumont, Texas 77704
Phone: (409) 212-5638

Any patient, or their surrogate decision-maker, who believes his or her rights have been violated or has complaints regarding quality of care concerns or safety issues and who wishes to file a grievance directly with a regulatory agency may, at any time, contact our accrediting body, **Center for Improvement in Healthcare Quality (CIHQ)**, by any of the methods: **Online**: https://cihq.org/complaint; **Phone**: (512) 661-2813; **Fax:** (805) 934-8588; **Mail:** P.O. Box 1540, Mexia, TX 76667 ATTN: Chief Executive Officer.

Or you may contact the Health & Human Services Commission Complaint and Incident Intake, Mail Code E-249, P.O. Box 149030 Austin, TX 78714-9030 or call (888) 973-0022.