



CONDITIONS OF ADMISSION AND FINANCIAL RESPONSIBILITY

- 1. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: I understand and acknowledge that none of the physicians and surgeons furnishing services to the patients, including the radiologist, pathologist, emergency physician, anesthesiologist, and the like, are employees, representatives, or agents of the hospital. They are independent contractors who have been granted the privilege of using the hospital for the care and treatment of their patients. 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.

Patient initials: _____

I recognize that all patients are under the care and supervision of their attending physicians and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. My physician or surgeon is responsible for obtaining the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the attending physician.

- 2. RELEASE OF INFORMATION: I understand that the hospital will obtain my consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. I hereby consent to the release of medical information to entities that provide care in post-acute setting. In accordance with the Safe Medical Device Act of 1990, I agree that in the event a permanent medical device is implanted the hospital is hereby authorized to notify the manufacturer of the patient's name, address, telephone number, and social security number (if available) as well as other information about the implantation. I authorize a copy of my record to be sent to my family physician or physician of referral at time of discharge.

Physician Name/Address

I authorize release of information regarding the birth of my child, as applicable.

___ Yes ___ No ___ N/A _____ Patient Initials

The hospital is authorized, without further action by or on behalf of the patient to disclose all or any part of the patient's record to any entity which is or may be liable to the hospital, patient or any entity affiliated with patient for all or part of the hospital's or hospital-based physicians' charges for the patient's services (including, without limitation, hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds, patient's employer, or medical utilization review organization designed by the forgoing).

- 3. ORGAN DONATION: I understand that I may voluntarily participate in organ and tissue donations, and if I would like more information about organ donation, it can be made available to me. I have signed an organ donor card.

___ Yes ___ No ___ Unknown/Not Applicable

- 4. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including but not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon. I understand that the practice of medicine and surgery 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 to me regarding the result of examination or treatment in this hospital.

- 5. NURSING CARE: The hospital provides only general-duty nursing care and additional nursing care when ordered by a physician. If the patient's condition requires a special duty nurse, that must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failing or refusing to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide such additional care.

- 6. PARTICIPATION IN PROFESSIONAL EDUCATION PROGRAM: It is understood that this hospital is a teaching institution and/or may affiliate with medical schools or other professional schools for the purpose of providing clinical experience for students and that unless the hospital is notified to the contrary in writing, the undersigned may participate as a teaching subject in the clinical education program that the hospital affiliates with and may receive



2 COA

PATIENT ID

treatment by residents and students, if approved by the undersigned's attending physician, and those clinical students acting under appropriate supervision as required by such medical education and clinical training programs.

7. **CONSENT TO PHOTOGRAPH:** Photographs may be recorded to document the patient's progress of care and shall be part of the patient's medical records or physician's office medical record. I consent to this and the use of the same for scientific, education or research purposes if approved. As a part of the medical record, these photographs are the property of the hospital or physician, accordingly. I understand and consent to the fact that photographs may also be taken for the purpose of patient identification. I understand that photographs containing protected health information will be kept confidential.
8. **EMERGENCY OR LABORING PATIENTS:** I understand that I have the right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition or am in active labor and, if such a condition exists, stabilizing treatment within the capacity and capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance, and/or am not entitled to Medicaid. If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).
9. **ACCIDENTAL EXPOSURE:** I understand that pursuant to 29 C.F.R. 1910.1030 and Texas Health and Safety Code § 81.095(c), in the event that a healthcare worker involved in my care is exposed to my blood or body fluid (through needlestick or mucous membrane contact), I may be tested for Hepatitis B Virus, Hepatitis C Virus, and Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). I understand that in a case of an accidental exposure, the hospital is not required to obtain my consent before testing me or my blood sample, but it will keep the results of these blood tests confidential and will only release them to those health care practitioners directly responsible for my care and treatment and to others as required by law. The tests will be completed at no cost to me and I can follow up with my primary care provider for these results. Testing for HIV antibody after a healthcare worker is exposed to a patient's blood or body fluids does not infer or imply that the source patient may be a carrier, or have been previously exposed to, or is in a high-risk group for exposure to HIV. I understand that if I have further questions regarding HIV testing, I can request more information at any time during my care and it will be provided.
10. **PERSONAL VALUABLES AND CONTRABANDS:** It is understood and agreed that the hospital maintains a safe for the safe keeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, eye glasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices or other articles of unusual value and small size, or any other personal property, unless placed in the safe and a receipt is issued to me. Property checked into or placed in the safe will not be surrendered back to me or anyone else, other than law enforcement with a valid subpoena or warrant, without that receipt. I understand and agree that if the hospital suspects, at any time, there may be a weapon, explosive device, illegal substance, drugs, alcoholic beverage, or anything that may present a risk to safety and security in the hospital in my belongings or my room, the hospital may search my room and belongings, and if applicable, confiscate, dispose, or deliver the contraband to law enforcement.
11. **FINANCIAL AGREEMENT** I understand that I am responsible, under state and federal law, to the hospital and physician(s) for all reasonable charges listed in the hospital charge description master, incurred by the patient and not paid by third party benefits. These charges may be reduced by the hospital's charity care and discount payment policies as applicable and upon confirmation of my qualification under such policies. In the event that any bill, or any part thereof, is deemed delinquent by the hospital, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if a suit is instituted to resolve that delinquency. I understand that all delinquent accounts may bear interest in the maximum rate allowed by law, all accounts are due and payable at the time of the patient's discharge, and any credit will be applied to outstanding balances prior to being refunded. I authorize the hospital (or collection agency or other entity contracting with the hospital to provide similar services) to obtain a credit report about me from the national credit bureaus in connection with payment of my account.
12. **HOW MY BILL IS DETERMINED:** I understand that Hospital charges include a basic daily rate, which covers the room, nursing care and food service, and/or outpatient/emergency services (not the physician services themselves). I understand that I might be liable for additional charges that are known or unknown at this time. Additional charges are made for special services ordered by your doctor. Operating room, surgical supplies, medications, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. **Physician charges are billed separately.** In addition to receiving bills for services rendered by the hospital and my personal physician, **I will receive separate bills from hospital-based physicians who participate in the care of the patient.** These physicians may represent any of the following areas: anesthesiology, radiology, pathology, nuclear medicine, cardiology diagnostics, and other specialty services.



2 COA

PATIENT ID

CONDITIONS OF ADMISSION

13. **NON-COVERED CHARGES.** In the event that insurance or other third party payors do not cover particular procedures, medications, and/or services provided to the patient during the hospital visit to which this consent applies, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.
14. **MEDICARE INSURANCE, BENEFITS AND EXCLUSIONS:** If the patient is a Medicare beneficiary or will apply for Medicare benefits, I certify that the information given about the patient is correct. I also agree and understand that the hospital may release certain medical information about the patient to the Social Security Administration and/or its intermediaries and/or its carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on the patient's behalf. Some services may not be covered by Medicare, such as the following: 1) Worker's Compensation, 2) Dental, 3) Cosmetic Surgery, 4) Custodial Care, 5) Personal Comfort Items, and/or 6) any services determined to be unnecessary or unreasonable by Medicare. If the patient is not on file with the Social Security Administration, the usual billing procedures will be used independent of the data access.
15. **ASSIGNMENT OF RIGHTS AND APPOINTMENT OF REPRESENTATIVE.** I understand that disputes may arise between insurance companies or state agencies and the hospital regarding payments for healthcare services, so I assign to hospital all of my rights to legal causes of action, claims, fair hearings, or appeals, as those rights may apply to payments potentially due to hospital or hospital based physicians from automobile accident related insurance, health insurance, disability, liability, self-insurance, employment-based benefits, liable third party, third-party insurance coverage and any other type of insurance coverage or legal recovery, including Employee Retirement Income Security Act (ERISA) benefits. I appoint hospital or its designated agent as my authorized representative in any and all such matters and to initiate and complete any documents, forms or appeals required to commence such actions, claims, fair hearings, or appeals, and further authorize and direct any insurance carrier, including third-parties or benefits administrator, responsible for payment to accept claims from, and to pay directly to hospital all the insurance, benefits or funds otherwise payable to me for such care and services, not to exceed the hospital's total billed charges, and to release and provide medical reports, X-ray reports, narrative reports, and investigative reports or claim valuations as appropriate. Hospital is under no obligation to bring any action against any party, may transfer this assignment at its discretion and apply it to any of its agents or associated organizations, such as physicians, which provide services associated with the hospital care. Any waiver of this assignment, or appointment, must be in writing from an authorized hospital representative.
16. **ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. I understand that I am financially responsible for allowed charges not paid pursuant to this assignment. In the event my insurance company or health plan makes payment directly to me for services provided by the hospital, I will send such payment to the hospital within 15 days of my receipt of such payment.
17. **ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL-BASED PHYSICIANS:** I agree and authorize, whether I am acting as agent or as patient, direct payment to any hospital-based physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization or for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment to the extent permitted by state and federal law.
18. **IF I DO NOT HAVE INSURANCE:** I may be eligible for a Charity Care and/or Discounted Payment Program and I can contact the business office for more information.
19. **WAIVER OF LIABILITY:** I understand that some or all of these services may not be covered by Medicare or Medicaid and that I am financially responsible if these services are denied. See the paragraph on Charity Care and/or Discounted Payment Programs for more information regarding financial assistance that may be available.
20. **TELEPHONIC AND ELECTRONIC CONTACT:** By providing a telephone number to Pampa Regional Medical Center, I consent to calls, texts, SMS messages, artificial voice and prerecorded messages, or other communications of any kind whatsoever placed or sent to me at this number or any obtained by skip tracing by Pampa Regional Medical Center and its contractors, agents, collection agencies and billing services (hereafter "Authorized Entities") at that number or on a device connected to or associated with that number, including calls, texts, SMS messages, artificial voice and prerecorded messages, or other communications placed or sent with an automatic telephone dialing system, auto-dialer, or predictive dialer. I acknowledge I am not obligated to provide this consent and can revoke my consent at any time by contacting the Authorized Entities or calling 956-291-1700 ext 7062.



2 COA

PATIENT ID

CONDITIONS OF ADMISSION

