UT★Physicians

PERMISSION FOR VERBAL COMMUNICATIONS

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip code: _____

Phone Number: _____

I permit UT Physicians, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care (list family members/friends and state the person's relationship to the patient):

Name	Phone Number	Relationship to patient
1.		
2.		

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding my medical condition for which the patient has received care)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the UT Physicians Health Information Dept.

PATIENT/LEGAL GUARDIAN SIGNATURE

DATE/TIME

PRINT NAME

IF LEGAL GUARDIAN, STATE RELATIONSHIP TO PATIENT

UT★Physicians

AUTHORIZATION TO ESCORT A MINOR FOR TREATMENT

Name of minor: _____

Minor's birthdate: _____ Medical Record Number: _____

Adult giving authorization: _____

Home address and phone number of adult giving authorization:

_____

I confirm that I am the minor's:

_____ Biological or adoptive parent having legal custody since birth, i.e., not separated or divorced

_____ Managing conservator (this status requires legal documents)

_____ Other legal guardian and I have been granted guardianship by the court or the biological parents (this requires legal documents)

_____ Guardian

_____ Other, please specify: _____

I authorize the following person or persons to deliver the minor to U.T. Physicians for diagnosis and treatment:

Authorized Name: _____

_____ The above mentioned person can receive confidential health information regarding the minor from UT Physicians for the purpose of delivering such information to the parent or legal guardian

_____ Only confidential health information regarding the minor can be given to the parent or legal guardian

This **AUTHORIZATION TO ESCORT A MINOR FOR TREATMENT does not** affect my parental rights regarding the care, custody, and control of the minor. This authorization **does not** constitute consent for the diagnosis and treatment of the minor or authority of the individual(s) listed above to consent to the diagnosis and treatment of the individuals listed above.

Signature: _____ Date/Time: _____

UT★Physicians

STATEMENT OF FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY

Thank you for choosing UT Physicians, as your healthcare provider. As courtesy, we are providing you with this Statement of Financial Responsibility and encourage you to ask questions regarding this statement.

In consideration for the services to be rendered to the Patient; the Patient and/or guarantor assumes full financial responsibility for the payment of the Patient's account.

Accurate insurance information and a copy of the insurance card(s) must be supplied by the Patient or guarantor. The Patient or the guarantor will be responsible for any co-payment, deductible and/or coinsurance deemed by the Patient's medical insurance plan, at the time services are rendered.

The Patient or guarantor will contact the medical insurance plan to determine what benefits and services provided are covered. The Patient or guarantor understands they are financially responsible to UT Physicians for all services whether or not a covered benefit. The Patient or guarantor is responsible for all balances on the account; in which their insurance has determined patient responsibility based on plan benefits. UT Physicians recommends the Patient or guarantor confirm UT Physicians practitioners are In-network providers for the Patient's medical insurance plan.

If the Patient and/or guarantor does not present proof of medical insurance, the patient will be deemed "self-pay" at time of service. A pre-determined minimum payment is required prior to services being rendered.

ASSIGNMENT OF BENEFITS

UT Physicians may submit requested medical information as required for payment to the Patient's insurance plan(s). Such medical information will include the diagnoses and treatments provided by UT Physicians.

STATEMENT OF FINANCIAL RESPONSIBILITY

Information provided by the patient and/or guarantor should be true and complete to the best of your knowledge. It is important for you to understand any financial responsibilities based on the terms of this document and have your questions fully answered.

UT★Physicians

CONSENT FOR MEDICAL TREATMENT, TELEMEDICINE, DISCLOSURES, AND WAIVERS

CONSENT FOR MEDICAL CARE AND TREATMENT

Knowing that I (the Patient) or the legal guardian (of the Patient) have (has) a condition requiring medical care, I hereby voluntarily consent to such care encompassing examinations, diagnostic procedures and medical treatment by the Patient's physician, his/her assistants and consignees as may be necessary in their judgment. I acknowledge that no guarantees have been made as to the result of diagnostic procedures, medical treatments or examinations by UT Physicians clinicians.

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 UT Physicians and its staff to carry out the instructions of these physicians.

PATIENT RESPONSIBILITIES

In order to receive proper care, Patients must accept certain responsibilities. Patients and/or their legal guardians are responsible for providing accurate and complete information about matters relating to the Patient's health and for reporting changes in the Patient's condition. Patients and/or their legal guardians are responsible for following the treatment plan recommended for the Patient and reporting any side effects to the Patient's physician(s) and/or nurse(s). If treatment is refused or the directions of Patient's physician(s) are not followed, Patients and/or their legal guardians are responsible for their actions and the consequences of those actions. Patients and/or their legal guardians and their visitors are responsible for following the physician office guidelines and for being considerate of the rights of others while in the physician office (for example, assisting in the control of noise, not smoking, limiting the number of visitors, etc.)

PATIENT CONCERNS

Our staff strives to provide excellent care and service, and we hold ourselves to the highest personal and professional standards. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never adversely affect the care and service we provide. If there is a problem, we want to correct it. Usually, a word to any staff member is all that is needed, but if you prefer, you may call Patient Relations at 713-486-1875 to speak confidentially with a patient representative or you may email patientexperience@uth.tmc.edu. Your question or concern will be promptly addressed. UT Physicians appreciates the opportunity to assist you and to make your visit as pleasant as possible. You also have the right to register a complaint with Health Care Financing Administration, Texas Medical Board and/or Texas Department of Insurance.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize UT Physicians to release any medical information including diagnostic, x-rays, test results, reports and records pertaining to any treatment or examination rendered to the Patient. I understand that this medical information may be used for any of the following purposes: diagnostics, insurance, legal and at times when the attending physician deems it necessary in order to ensure the best medical care on my behalf. I authorize UT Physicians and the Patient's physician(s) to disclose the Patient's health care information to any entity specified in UT Physicians' Joint Notice of Privacy Practices. I further understand that any person(s) that receive(s) these medical records will not release any of the medical information disclosed by this authorization to any other person or organization without authorization signed by me for release of the information.

AUTHORIZATION TO CONTACT USING TELEPHONE, CELLULAR, AND/OR ELECTRONIC COMMUNICATIONS

I authorize UT Physicians and/or any third party organization assigned to the account to contact me at the telephone number, cellular number or email provided. Contact may be performed with the use of pre-recorded messages, automatic dialing services, electronic email, artificial voice messaging, or personal calls regarding health care related notices, my account, or my obligation of payment for services.

_____ **By initialing here, I agree to have messages left via voicemail or with the person designated as my emergency contact regarding my personal health information to include test results, diagnosis, and other medical information.**

I understand that UT Physicians may also contact me through SMS text messaging directly or through its vendor(s). I understand that UT Physicians will periodically send me an encrypted link containing a brief questionnaire regarding my health status that will be discussed at subsequent clinic appointments. I understand that data rates may apply to

messages sent to my cell phone. I may opt-out of receiving these communications from UT Physicians at any time by replying “STOP” to any of these text messages or by notifying a member of the UT Physicians clinic team. I understand that I may request assistance by replying “HELP” to any of these text messages.

In the event of a discovered data breach, I agree to allow UT Physicians to provide written notification and/or electronic mail (Email) detailing the specifics surrounding the data breach, as well as what steps I may take to further protect myself.

AUTHORIZATION FOR TELEMEDICINE VISITS

"Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced audio-video conferencing technology. Telemedicine allows the provider to see and communicate with the patient in real-time."

I understand that I have an option to participate in telemedicine visits if made available to me.

"If the option arises, and I agree to a Telemedicine visit, I consent to allow UT physicians, technical assistants and other health care providers to access, view and discuss my medical information to participate in my medical care through the use of audio-video technology. I understand that a telemedicine visit is not the same as a face to face patient/health care provider visit due to the fact that I will not be in the same room as my health care provider."

I understand that precautions to avoid unauthorized access have been made, but that there is not a guarantee that the confidential information being transferred electronically will not be compromised by failures of security safeguards or illegal and improper tampering.

I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. My health care provider or I may discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation. "If the telemedicine visit is discontinued, my provider may request a face to face visit to adequately address my medical needs."

I understand that healthcare personnel and others involved in my care may be present during the telemedicine visit. Personnel operating the video equipment may also be present during the telemedicine visit. All personnel will maintain confidentiality of any information shared during the telemedicine visit. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and or (3) terminate the visit at any time.

I understand that the expectations of my visit will be reviewed with me before my appointment with my provider.

I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

_____ **ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL RESPONSIBILITIES**

I acknowledge that I have received a copy of the Statement of Financial Responsibility. The statement is an explanation of required financial responsibility for the payment of the Patient’s account.

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement. All of my questions have been fully answered.

_____ Patient/Legal Guardian Signature / Initials (must be over 18 years of age)	_____ Date/Time	_____ Interpreter Name and ID (if necessary)
_____ Print Name	_____ If Legal Guardian, state relationship to patient	
_____ Guarantor/Insured Signature / Initials (if different from above)	_____ Date/Time	_____ Print Name and Relationship to patient
_____ Witness Signature	_____ Print Name	_____ Date/Time