

# UT Southwestern Medical Center

## Ambulatory Patient Registration and Consent for Treatment

Welcome to UT Southwestern Medical Center (UT Southwestern). Please take a moment to review and sign this Registration and Consent for Treatment. We regret that we are unable to accept any alterations to this form and will not be able to provide health care to you if the form is not signed as presented. UT Southwestern reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

### 1. Social Security Disclosure Statement

Disclosure of your Social Security Number (SSN) is requested from you in order for UT Southwestern to facilitate positive patient identification. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in a lack of positive patient identification. Further disclosures of your SSN are governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

### 2. Patient Rights and Responsibilities

UT Southwestern acknowledges that I have certain rights as a patient, and I acknowledge I have certain responsibilities as a patient. This information (including how to register complaints I may have) is posted throughout the clinic and a written copy was given to me at the time of my visit.

### 3. Consent For Treatment

I, \_\_\_\_\_, voluntarily present to UT Southwestern for medical and/or dental evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or his or her designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. As a teaching institution, UT Southwestern welcomes medical residents; students in other disciplines, including nursing; and university approved observers engaged in an educational purpose; all of whom are under the direct supervision of a privileged provider or staff member. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s). I authorize and consent to use of recordings, films, or other images of me (i.e., any photographic, video, electronic or audio media) for purposes of identification, diagnosis or treatment in connection with the care provided to me.

### 4. Agreements and Understandings:

- I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic courses of treatment.
- I understand that the physicians participating in my care, including my physician, may be either employees of UT Southwestern or independent contractors who are not employees or agents of UT Southwestern. I understand that the physicians participating in my care have been granted the privilege of using UT Southwestern facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. As a teaching institution, UT Southwestern welcomes medical residents and students in other disciplines, including nursing and University approved observers engaged in an educational purpose, all of whom are under the direct supervision of a privileged provider or staff member.
- I understand that regardless of my assigned insurance benefits, **I AM RESPONSIBLE FOR AND DO HEREBY EXPRESSLY ASSUME FINANCIAL RESPONSIBILITY FOR** the total charges for hospital, physician, medical and other services rendered. I will receive separate bills for physician professional fees and services rendered by outside agencies.
- I understand that UT Southwestern has the right to pursue full collection efforts including asset credit checks and litigation.

### 5. Release of Information

- I understand that as part of my health care, UT Southwestern's personnel and my physician create and maintain a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by UT Southwestern to me, as described in the Notice of Privacy Practices.
- I understand and acknowledge that UT Southwestern participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from UT Southwestern or Exchange Participants, my health information may be shared electronically between UT Southwestern and Exchange Participants in order to provide care and services to me, and I do hereby authorize UT Southwestern to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychotherapy notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.
- I understand and acknowledge that as part of receiving my health care at UT Southwestern, my physician and other personnel engaged in my care may electronically request my prescription medication history from participating pharmacies, pharmacy benefit managers, or payers, and that such prescription medication history may become part of my medical record.

### 6. Assignment of Benefits and Financial Agreements

- I hereby assign to UT Southwestern, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, Tricare, or any reimbursement from a pre-paid health care plan. I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct. This means that UT Southwestern and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to UT Southwestern any interest in any claims I may have to the extent necessary to fully reimburse UT Southwestern for the rendering of services to me.
- I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated by UT Southwestern or its physicians. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to UT Southwestern and authorize my insurance company, governmental program, or other entity to make payment directly to UT Southwestern. I understand that UT Southwestern may disclose a limited amount of health information to third-parties to obtain payment for the health care services provided.
- I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. UT Southwestern will honor any arrangements and/or agreements entered into with my insurance company or third-party payers. I understand that I will not be billed for amounts which UT Southwestern is contractually or legally obligated to discount. If I am injured and receive treatment at UT Southwestern, I agree to assign to UT Southwestern my interest in any lawsuit or settlement to the extent necessary to fully pay UT Southwestern for this treatment. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses.

### 7. Valuables

I understand that UT Southwestern does not assume the responsibility for the safekeeping of any personal property.

### 8. Notice of Privacy Practices

I acknowledge that I received a Notice of Privacy Practices as part of this encounter. I understand that a copy of the Notice of Privacy Practice is available to me at any time upon my request.

I have read the above document and understand its contents. I acknowledge that I am the patient or I am the patient's legally authorized representative, and/or guarantor and consent to the above items and make the acknowledgments hereby made.

Signature of Patient/Responsible Party (Relationship to Patient)

Time AM/PM

Date

Signature and Printed Name of Interpreter or Language Line Interpreter ID#

Time AM/PM

Date

\*Note Proof of legal authority may be required for legal representatives.



**UT Southwestern  
Medical Center**

**PATIENT COMPLAINT PROCEDURE**

While we hope every patient's visit goes smoothly, it is important that we are notified of patient concerns so we can take the appropriate steps to address them.

A patient has the right to communicate a verbal or written complaint or concern regarding any aspect of his/her visit (i.e. medical care, service, conditions, billing) and expect a timely response. If you have comments, questions, or concerns, we recommend that you or your representative:

- Discuss them with your immediate caregiver, or
- Speak to the manager of the clinic or service in which you are receiving care, or
- If you believe your questions or concerns have not been adequately addressed, you may request a review by contacting the Patient Assistance Office. Grievance forms are available from Guest and Patient Services or the Patient Assistance Office should you wish to use one. You may also contact the Patient Assistance Office by phone at **214-648-0500** or in writing at the address below:

**Patient Assistance Office  
UT Southwestern Medical Center  
5323 Harry Hines Blvd.  
Dallas, TX 75390-8831**

**NOTICE CONCERNING COMPLAINTS**

Complaints regarding quality of care at a Joint Commission-accredited health care organization may be reported for investigation at the following address:

**The Joint Commission, Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181**

Assistance in filing a complaint with The Joint Commission is available by calling toll-free: **1-800-994-6610**.

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board  
Attention: Investigations  
333 Guadalupe, Tower 3, Suite 610  
P.O. Box 2018, MC-263  
Austin, TX 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**.

For more information please visit the Texas Medical Board website at [www.tmb.state.tx.us](http://www.tmb.state.tx.us).

If you are with a health maintenance organization and wish to file a complaint, you may do so by contacting the Texas Department of Insurance at **1-800-252-3439**.

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**Authorization for Verbal Release of  
Protected Health Information to  
Designated Persons**

Authorization for Verbal Release of  
Protected Health Information to  
Designated Persons

**AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.**

**I AUTHORIZE** UT Southwestern Medical Center to communicate my health information to the person(s) listed below (Designated Persons") for the following purposes: to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by UT Southwestern Medical Center.

Please print the following information for each Designated Person:

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Alternate Telephone: \_\_\_\_\_

**I UNDERSTAND** that this authorization applies to all departments, healthcare providers and/or employees at UT Southwestern Medical Center.

**I UNDERSTAND** that this authorization is voluntary.

**I UNDERSTAND** that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

**I UNDERSTAND** that this authorization will be effective for this hospital admission, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time

If I revoke the authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

**I UNDERSTAND** that my refusal to sign this authorization will not negatively affect my health care services at UT Southwestern Medical Center.

**BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT UT SOUTHWESTERN MEDICAL CENTER WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.**

**PATIENT:**

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

**IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:**

Print Name of Patient: \_\_\_\_\_

Print Name of Legal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative\*.

Signature of Legal Representative: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*



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Protected Health Information to  
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**Revocation of Authorization**

**This section is to be completed ONLY in the event the patient seeks to revoke the authorization on Page 1 after signature.**

By my signature below, I am revoking this authorization. I understand that this revocation will be effective when received by UT Southwestern Medical Center and will not be effective to the extent that UT Southwestern Medical Center has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked: \_\_\_\_\_

**PATIENT:** \_\_\_\_\_

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

**IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:**

Print Name of Patient: \_\_\_\_\_

Print Name of Legal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative\*:

Signature of Legal Representative: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

**This Section for Internal Use Only**

Date revocation received: \_\_\_\_\_ Date revocation processed: \_\_\_\_\_

Name of employee processing request: \_\_\_\_\_