UNITED MEMORIAL MEDICAL CENTER
510 W TIDWELL RD
HOUSTON TX 77091
TELEPHONE: (281) 618-8500

PATIENT IS NOT ABLE TO SIGN AT THIS TIME DUE TO HEALTH ISSUES.NO FAMILY PRESENT.

AUTHORIZATION FOR INFORMATION SHARED

Print Name: _____
First Middle Last

This authorization is valid only for the admission of: _____/_____/_____
Month/(Fecha) Day (Dia) Year (Año)

Authorization (Valida): (Initial in one of the three boxes below)

	I understand that I have the right to limit the people that can ask for information about my medical care. You can discuss my health and general condition with anyone who asks/calls on the phone. (Yo entiendo que tengo el derecho de limitar las personas que pregunten por informacion sobre mi cuidado. Ustedes pueden discutir mi cuidado o condicion general con cualquier persona que pregunte o llama en el).
	I understand that I have the right to limit the people who can ask for information about my medical care. I DO NOT want you to discuss my health care and medical condition with anyone. I will tell those individuals myself. (Yo entiendo que tengo el derecho de limitar las personas que pueden preguntar por informacion sobre mi cuidado. Yo misma les dare informacion).
	I understand that I have the right to limit the people who can ask for information about my medical care. I authorize you to share my medical information with the individuals I have listed below. I understand that these authorized individuals will need to provide a code when asking about me and my health. It is my responsibility to give them the code number. (Yo entiendo que tengo el derecho de limitar las personas que pregunten por informacion sobre mi cuidado. Yo autorizo que ustedes pueden compartir mi cuidado con los individuos que estan en la lista. Yo entiendo que estos individuos autorizados necesitan proveer un codigo cuando pregunten sobre mi cuidado. Es mi responsabilidad de darles la numeracion del codigo). **THE CODE NUMBER IS**_____ Numeracion De Codigo

Do you want to notify your personal physician if other than your admitting physician? YES ☐ NO ☐
Desea notificar a su medico personal si que no sea su medico de admission?

Physician: _____ **Phone#:** _____
Medico Telefono

Do you want a family member or significant other notified regarding your hospitalization? YES ☐ NO ☐
Quieres un miembro de la familia o pareja notificado acerca de su hospitalizacion?

List of names and the relationships of the persons with whom you can share my medical information:
Nombre de personas con quien pueden compartir informacion.

Name: _____ **Relationship:** _____ **Phone#:** _____
Nombre Relacion Telefono

Name: _____ **Relationship:** _____ **Phone#:** _____
Nombre Relacion Telefono

Signature of Patient _____ **Date:** _____
Firma Del Paciente Fecha

Signature of legally authorized representative _____ **Date:** _____
Firma del representante legalmente autorizado Fecha

PATIENT LABEL

UNITED MEMORIAL MEDICAL CENTER
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PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	M/INITIAL	MAIDEN NAME	SOCIAL SECURITY #

HOME ADDRESS	APT #	CITY	STATE	ZIP CODE

PHONE NUMBER	DATE OF BIRTH	AGE	MALE	FEMALE	RACE
			☐	☐	

MARRIED	SINGLE	WIDOWED	DIVORCED	RELIGION	FAMILY DOCTOR	WHO REFERRED YOU TO OUR FACILITY
☐	☐	☐	☐			

EMPLOYER'S NAME	FT	PT	JOB TITLE	WORK NUMBER
	☐	☐		

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

GUARANTOR'S INFORMATION

GUARANTOR'S LAST NAME	FIRST NAME	M/INITIAL	RELATIONSHIP TO PATIENT	SOCIAL SECURITY #

ADDRESS	APT #	CITY	STATE	ZIP CODE

GUARANTOR'S PHONE NUMBER	DATE OF BIRTH	AGE	MALE	FEMALE	RACE
			☐	☐	

EMPLOYER'S NAME	FT	PT	JOB TITLE	WORK PHONE NUMBER
	☐	☐		

EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

EMERGENCY CONTACT INFORMATION

1ST CONTACT LAST NAME	FIRST NAME	M/INITIAL	RELATIONSHIP TO PATIENT	CONTACT PHONE NUMBER

ADDRESS	APT#	CITY	STATE	ZIP CODE

2ND CONTACT LAST NAME	FIRST NAME	M/INITIAL	RELATIONSHIP TO PATIENT	CONTACT PHONE NUMBRER

ADDRESS	APT#	CITY	STATE	ZIP CODE

PATIENT LABEL

UNITED MEMORIAL MEDICAL CENTER
510 W TIDWELL RD
HOUSTON TX 77091
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UNITED MEMORAL MEDICAL CENTER-CONDITIONS OF ADMISSIONS

CONSENT FOR TREATMENT/ADMISSIONS: I hereby agree and give my consent for the admission/treatment to United Memorial Medical Center, hereafter referred to the hospital under the care of the attending physician, his associates, assistants or designees. I consent to any and all hospital care, which encompasses radiology images, laboratory procedures, diagnostic procedures, anesthesia, and nursing of medical/surgical treatment which my physician, his associates or designees may deem necessary or advisable under the general and special instructions of the same during my hospitalization.

PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me is applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim, except as otherwise provided by applicable State or Federal laws. I request that payment of authorized benefits be made on my behalf. I assign the Physician or organization to submit a claim to Medicare for payment on my behalf.

AGREEMENT TO PAY: I agree to pay all charges resulting from services rendered by this hospital as requested by me personally, by any guarantor or by any attending physician(s) in accordance with the rates set out in the Hospital's Master Charge list including any balance due in excess of any amount paid by any third-party payer including the obligator under my health insurance contact(s) or other health care coverage are due and payable on discharge. I agree that I am responsible for payment of all charges incurred after the hospital or my third-party payer Informs me that inpatient care is no longer required should I decide to remain in the hospital.

In addition, should it be determined by my third-party payer that I obtained unapproved services in an inappropriate setting. I will be responsible For payment of such charges. I am responsible for all charges incurred prior to informing the hospital on my third-party coverage. Provisional credit may be allowed for confirmed health care coverage benefits when assigned to the hospital. All such credits are subject to collection by the hospital unless coverage is subsequently denied in whole or in part. All charges for which my third-party payer(s) deny liability must be paid by me immediately upon receipt of notice thereof from the hospital, it being agreed that the hospital's Master Charge List shall control, even if my health care coverage declines to make payment at the rates contained in that list. Except as otherwise provided by applicable State or Federal Laws, I understand and agree that I am responsible for any costs incurred for legal or collection fees necessary to satisfy my financial obligation at this hospital, incurring reasonable attorney fees, court costs or other collection expenses. I further authorize this hospital to apply any overpayments on any agreements which such third-party payer may have with the hospital.

GUARANTOR'S OBLIGATION: I, the undersigned, Guarantor herein, agree to guarantee payment and collection of all charges incurred by patient. If patient is unable to execute this document for any reason. I assume primary responsibility for payment of all charges incurred by patient. INDEPENDENT STATUS OF PHYSICIAN: I recognize that any or all physicians, residents or medical students (under the supervision of physicians and / or residents) who furnish services to me during this admission are INDEPENDENT CONTRACTORS and are NOT AGENTS OR EMPLOYEES OF THE HOSPITAL I understand and agree that each of the above referenced practitioners, including emergency room physicians, radiologist, pathologist, anesthesiologist, etc., who render professional services to me (or patient), bill and collect independently for their services, I understand that their bills will be separated and apart from the hospital's billing and collections, or the hospital may bill on the physician's behalf, but subject to authorizations granted by me in accordance with this agreement.

ASSIGNMENT OF BENEFITS: In consideration of services rendered, the undersigned irrevocably assigns and transfers to United Memorial Medical Center, (the Hospital), for himself/herself and dependents, all rights, title, and interest in the claims or causes of action regarding benefits payable for the services rendered by the Hospital provided in any insurance policy(ies)of insurance or benefit plan against any third party but shall not be constructed to be an obligation of the Hospital to pursue any such claim or right of recovery. The undersigned hereby irrevocably assigns to the hospital all right, title and interest in all claims or benefits payable out of nay third-party action against any other person, entity of insurance company, or out of recovery under the uninsured/underinsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) under which the patient may be entitled to recover. The undersigned further authorizes and appoints the Hospital as attorney in fact to pursue on his/her behalf, any claims to which he/she may be entitle to pursue or otherwise assert to obtain benefits from any responsible party including but not limited to the Crime Victims Compensation Division of the Texas Attorney General's Office in the event that the patient's hospitalization is necessitated by injuries received as a result of a violent crime but in no event shall this be construed to be an affirmative obligation of the hospital to pursue any such claims(s).The undersigned understands that if the Hospital is not paid in full by proceeds of any insurance policies, benefit plans or other sources of funds then this assignment does not release his/her obligation and liability to the hospital for payment of services and items provided by the hospital.

_____ Patient Initials

Date:_____/_____/_____

PATIENT LABEL

UNITED MEMORIAL MEDICAL CENTER
510 W TIDWELL RD
HOUSTON TX 77091
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Disclosure of Non-Covered Charges for Health Care Coverages: I understand that certain hospital services and charges I may choose to have are not eligible charges under health care coverage. Some examples of these charges are private room are differential, television rental, telephone rental or cot rental. I further understand that I will personally, be held responsible for payment of such non-covered charges should I choose to have them.

_____ Patient Initials

Release of Liability: I agree to hold the hospital and its employees harmless and free from all responsibility for injuries or losses received by me (or Patient) as a result of falling from bed, or falls on the floor, or from other causes and while out of bed contrary to the instructions of physicians or nurses. I also absolve this hospital from any and all responsibility for burns, injuries, property damages or loss which may result from or because of my use whether proper or improper of an electrical item/appliance brought to this hospital by me.

_____ Patient Initials

Valuable Release: I hereby release this hospital and its employees from any liability that may be incurred from the loss or damage of valuables and personal items that I have kept in my possession while in the hospital as a patient unless they are deposited in the hospital safe.

Patient Self Determination Act: I have been furnished information regarding Advance Directive (such as medical power of attorney for health care and living wills).

Please initial the following applicable statements:

_____ I have executed an Advance Directive and have received request to furnish a copy to the hospital.

_____ I have not executed an Advance Directive.

_____ I have received information regarding an Advance Directive.

_____ I do not wish to receive information regarding an Advance Directive.

_____ I have a Power of Attorney for Healthcare and have received request to furnish a copy to the hospital.

_____ I have received information regarding a Medical Power of Attorney.

_____ I do not wish to receive information regarding a Medical Power of Attorney.

Notice of Privacy Practices: I acknowledge that I have received the hospital's Notice of Privacy Practices, which describe the way in which the hospital may use and disclose my health care information for its treatment, payment health care operations and other described and permitted uses and disclosures. I understand that I may contact the hospital Privacy Officer designated if I have a question or complaint.

_____ Patient Initials

Rights and Responsibilities: I have been furnished with written information regarding patient rights and responsibilities.

_____ Patient Initials

Signature of Patient: _____ Date: ____/____/_____

Signature of Representative: _____ Date: ____/____/_____

Signature of Witness: _____ Date: ____/____/_____

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UNITED MEMORIAL MEDICAL CENTER – PATIENT RIGHTS AND RESPONSIBILITIES

As a Patient You are Responsible:

- To provide to the best of your knowledge, accurate and complete information. You have the responsibility to report unexpected changes in your condition to your doctor and your nurses.
- For reporting whether you understand clearly the treatment plan or procedure that is planned and what you are expected to do.
- For following the treatment plan recommended by your doctor.
- For following the instructions of nurses and other health personnel as they carry out the coordinated plan of care and your doctors' orders.
- For following the hospital rules and regulations as they apply to your care and your conduct.
- For your own actions if you refuse treatment or if you do not follow instructions.
- For making sure that any financial obligations for health care are paid.
- For being considerate of the rights of other patients and hospital personnel.
- You are responsible for being respectful of the property of other patients and of the hospital.

How to File a Complaint:

I understand that I may follow hospital procedure for voicing a complaint or grievance. I may voice my complaint directly to any staff member. I may voice my grievance to the manager/director of the area in which I am located. Notwithstanding hospital policy and procedure, I may also submit my grievance to:

Texas Department of Health
1100 W. 49th Street
Austin, TX 78756-3199
888-973-0022

or

UMMC Hospital Compliance Hotline
1-877 888-4804
all calls toll free

I acknowledge I received a copy of the "Patient Rights and Responsibilities" statement I have had a chance to review it to ask questions if I had any and have had those questions answered.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Representative **Relationship** **Date**

_____ _____
Signature of Witness **Date**

PATIENT LABEL

UNITED MEMORIAL MEDICAL CENTER
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UNITED MEMORIAL MEDICAL CENTER – PATIENT RIGHTS AND RESPONSIBILITIES

As a Patient You Have the Right to:

- A reasonable response to requests and needs for treatment or services within the hospital's capacity, its stated mission and applicable law and regulation.
- Information necessary to help you to make treatment decisions that are what you would like to have done.
- Receive, at the time of admission, information about the hospital's Patient Right Policy.
- Informed of your right to notify a family member of your hospitalization.
- Informed of the right to notify your personal physician of your hospitalization.
- Informed of your right to visitation.
- Know how to make a complaint concerning the quality of care and to have someone review the complaint and, when possible, resolve the complaint.
- Considerate and respectful care based upon your psychosocial, spiritual, and cultural needs.
- Care that provides comfort and dignity through treatment based upon the wishes of you or your appointed decision- maker.
- Effective management of any pain that you have.
- Psychosocial and spiritual support regarding dying and the expression of grief.
- Make decisions, in partnership with your physicians, involving your healthcare.

This includes the right to:

  - Accept medical care or to refuse medical care or treatment to the extent allowed by law and be informed of the medical outcomes of refusal.
  - Prepare an Advance Directive and appoint someone to make healthcare decisions on your behalf as allowed by law. The provision of care shall not be conditioned on the existence of an Advance Directive.
  - Have your Advance Directive placed in your medical record and have it reviewed to make sure that it is still what you want.

- Participate in solving of any ethical issues that arise during your care.
- Be informed of any human experimentation or other research or educational projects affecting your care treatment.
- Personal privacy and confidentiality of information within the limits of the law.
- Access to the information contained in your medical records, within the limits of the law.

Your guardian, next of kin, or legally authorized responsible person can apply these rights as allowed by the law on your behalf if you are:

- Found to be incompetent by a court of law.
- Found by a physician to be medically incapable of understanding the proposed treatment or procedure.
- Unable to communicate your wishes regarding treatment.
- A minor.

PATIENT LABEL

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

- FOR TREATMENT - We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital.
- FOR PAYMENT - We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party.
- FOR HEALTHCARE OPERATIONS – We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care.
- AS REQUIRED BY LAW – We will disclose medical information about you when required to do so by federal, state or local law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

- Right to NOT be listed in the Hospital Directory
- Right to Confidential Communications
- Right to inspect and to Request a Copy – You have the right to inspect and to request a copy of medical information that may be used to make decisions about your care. Usually, this include medical and billing records, but may not include some mental health information.
- Right to request an Amendment – If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
- Right to an Accounting of Disclosures – You have the right to request an "accounting of disclosures". This is a list of the disclosure we made of medical information about you other than our own uses for treatment, payment and healthcare operations.
- Right to Request Restrictions – You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations.

I have received a copy of the **Notice of Information Practices.**

_____ _____

Signature of Patient or Authorized Representative Date

Legal Relationship:

_____Guardian _____Conservator _____Medical Power of Attorney _____Parent, Un-emancipated Minor

PATIENT LABEL

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO
TMF Health Quality Institute Bridge I, Ste 300 5918 West Courtyard Dr., Austin, Texas 78730-5036

Telephone Number of QIO
800-725-8715

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor, and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call: **House Supervisor: 281-770-8095**

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copay and deductibles).
  - Here is the contact information for the QIO:

Name of QIO (in bold) **TMF Health Quality Institute Bridge I, Ste 300 5918 West Courtyard Dr., Austin, Texas 78730-5036**

Telephone Number of QIO **800-725-831**

- You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
- Ask the hospital if you need help contacting the QIO
- The name of this hospital is:

Hospital Name	Provider ID Number
UNITED MEMORIAL MEDICAL CENTER	**189174146**

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4:** The QIO will review your medical records and other important information about your care.
- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds that you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

ELECTION TO USE LIFETIME RESERVE DAYS

I WISH _____

I DO NOT WISH _____

To have Medicare benefits paid on my behalf under the lifetime reserve provisions of Section 18 12 (b) of the Social Security Act for services furnished me by United Memorial Medical Center beginning:

_____.

I understand that if I DO NOT WISH to have Medicare benefits paid under the lifetime reserve provisions, I will be responsible for all the hospital's charges not reimbursed by Medicare because of this election except those covered under supplementary medical insurance. Where supplementary medical insurance payments may be made for services furnished during the period covered by the election, I will be responsible for the deductible and 20 percent coinsurance amount.

N/A

PATIENT NAME

LEGAL GUARDIAN

DATE TIME

WITNESS

510 W. Tidwell Rd Houston, Tx 77091 Phone: (281) 618-8500 Fax: (281) 6184618