Consent for Treatment. I consent to medical care and treatment as recommended by the health care providers caring for me at Kirby Medical Center and/or Kirby Medical Group (collectively "Facility"). My consent includes all Facility services, diagnostic procedures and medical treatment rendered, including without limitation, infectious/communicable disease testing, clinical examinations, diagnostic imaging, laboratory procedures and other tests, interventions, treatments and medications and monitoring that do not require my specific informed consent. I understand that the health care providers who provide treatment to me while I am at the Facility may or may not be Facility employees. I understand that the Facility has affiliations with medical schools and other educational institutions, and I agree that medical residents and students may participate in my care, under supervision as appropriate.

Consent to Photographs / Videotapes / Recordings. I authorize the Facility to obtain photographs, videotapes and/or recordings of me for identification, diagnosis, treatment, and internal health care operations. I understand I may revoke this consent up until a reasonable time before such images/recordings are used. Any further use and/or disclosure of these images/recordings is restricted to those purposes I consent to at a later time.

Valuables. I understand and agree that the Facility assumes no liability for any loss or damage to any money, jewelry, documents, or other articles brought by or for me to the Facility. No employee or other person is authorized to recommend storage of such articles at Facility.

Assignment of Insurance Benefits / Charges / Refunds. I hereby request, authorize, assign and direct any payment or benefit otherwise payable to me (including benefits available through Medicare, Medicaid and other third party payors) to be paid directly to the Facility for the services provided to me. My health care providers may consult with physicians on the medical staff that I may not meet, such as radiologists, pathologists, anesthesiologists, etc. I realize these physicians will likely produce a bill for services that is separate from the Facility's bill. I am aware that some physicians may not participate in the health plan or payment program that pays for my care and, thus, I may be subject to additional or out-of-network charges. I certify that the information provided by me to assist in identifying third party payors and applying for payment is complete and accurate.

Financial Disclosure Statement & Agreement. You, the undersigned are about to sign a FINANCIAL AGREEMENT obligating yourself to pay all Facility charges. Before you sign the FINANCIAL AGREEMENT, the Facility is required by federal law to supply you with certain information. That information is as follows: There will be NO (0) FINANCE CHARGE assessed against you and there will be NO (0) ANNUAL PERCENTAGE RATE as a result of the terms of the FINANCIAL AGREEMENT. If you fail to make one or more payments when due as specified in the FINANCIAL AGREEMENT, collection costs including court costs and reasonable attorney fees will be assessed against you. The undersigned agrees, whether he/she signs as agent, relative, or as patient, that in consideration of the services to be rendered to the patient, he/she will himself/herself pay the account of the Facility for such services in accordance with its regular rates and terms. The undersigned further agrees that if this account becomes delinquent he/she will himself/herself pay all costs of collecting the same including court costs and reasonable attorney fees. No extension of time or payment shall operate to release the undersigned from this obligation. I understand that I am financially responsible to the Facility and the independent physicians who render services to me. I agree to pay the Facility's regular charges as set forth in its then current chargemaster and pay all charges of physicians and others, including co-insurance and deductibles, not covered by my insurance, subject to applicable Medicare and Medicaid advance notice requirements. I authorize the Facility and its designees to call me at any contact number I provided to Facility, including calls to mobile/cellular or similar devices for any lawful purpose. The Facility will not reimburse me for any fees or charges that I may incur for incoming/outgoing calls to/from Facility or its designees, to or from any such number. Methods of contact may include an automated dialing device, as applicable.

Plain Language Summary: I acknowledge that the Facility has offered me a copy of the Plain Language Summary. A copy of the Plain Language Summary is in Kirby Medical Center's Financial Assistance Policy. I can request a copy of the Plain Language Summary at this time, or I can obtain copies at any time in Kirby Medical Center's Emergency Department and Registration Departments, by mail, or on Kirby Medical Center's website.

Home Health, Hospice and Durable Medical Equipment. Even at the time of admission/registration, it is important to plan for post-discharge care. I understand that I have the freedom to choose and the right to select my provider/supplier for post-discharge care and equipment. The Facility does not own, endorse or recommend any agency, company, facility or provider. The Facility will provide me with a list of providers/suppliers, and I may ask a staff member for a copy of the list at any time.

Patient Name:

Date of Birth:

Account Number:

KIRBY MEDICAL CENTER

CONSENT FOR TREATMENT-NPP

Release of Information. I understand that the Facility is authorized by law to use and disclose all or part of my general patient health care records for treatment, payment and health care operations without my authorization. Nonetheless, I hereby authorize the Facility to disclose all or part of my health care records for treatment, payment, and operational purposes, to medical service companies, insurance companies, Medicare, Medicaid, any other federal or state reimbursement programs, the Social Security Administration or its intermediaries or carriers, and worker's compensation carriers. However, I recognize that the Facility needs my authorization to disclose, if applicable, my HIV test results and treatment records related to mental health, developmental disabilities or alcohol and drug abuse (collectively, "Sensitive Information") for payment and health care operations. Accordingly, I hereby authorize the Facility to disclose my Sensitive Information, as applicable, to Facility billing personnel, my health plan and any other identified payers as necessary for the purpose of billing, collection or payment of claims. This authorization will remain in effect for as long as my Sensitive Information is needed for these purposes. The Facility is also authorized to release copies of my record(s) to my primary care physician and to all subsequent treatment providers. I am aware that I may revoke my authorization in writing at any time, except to the extent the Facility has already acted in reliance upon the authorization. In addition, I understand that I have a right, upon request, to inspect and receive a copy of all such information being disclosed.

I have read and understand this Consent / Agreement and I have provided the Facility with complete and accurate information. I hereby authorize, permit, certify, agree, and acknowledge as indicated above.

X _____ _____ _____ _____

Signature of Patient / Representative | Print Name | Relationship (as applicable) | Date

Acknowledgement of Receipt of Notice of Privacy Practices.

I acknowledge that the Facility has provided me a copy of its *Notice of Privacy Practices (Notice)*, which provides information about how the Facility may use and disclose protected health information. I understand the *Notice* is subject to change and that I may obtain a copy of the revised *Notice* on the Facility's website http://www.kirbyhealth.org or on request from the Facility.

X _____ Initials of Patient/Representative

For Staff Use Only

Reason Acknowledgement Not Obtained

☐ Patient refused to initial Acknowledgement of Receipt statement

☐ Obtained previously

☐ Other_____

_____ _____

Witness | Date

Patient Name:

Date of Birth:

Account Number:

KIRBYMEDICAL CENTER

CONSENT FOR TREATMENT-NPP