UT★Physicians

CONSENT FOR MEDICAL TREATMENT, DISCLOSURES, AND WAIVERS

CONSENT FOR MEDICAL CARE AND TREATMENT

Knowing that I or the individual for which I am a legal guardian (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 UTP and its staff to carry out the instructions of these physicians. Some physicians furnishing services to the Patient, including radiologists, pathologists, anesthesiologists, emergency room physicians and others are independent contractors, are not employees or agents of UTP, and may directly bill the Patient or other legally responsible person (Guarantor) signing this consent for services rendered.

FINANCIAL RESPONSIBILITY

In consideration for the services to be rendered to the Patient, the Patient and/or Guarantor signing this consent authorizes credit investigation and individually assumes full financial responsibility for the payment of the Patient's account in accordance with the regular rate and terms of UTP. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS

In consideration for services rendered, I hereby irrevocably assign and transfer to UTP for myself, my dependents and those for which I am financially responsible all rights, title and interest in the benefits payable for services rendered by UTP provided in any insurance policy(ies) under which I, any of my dependents or those for which I am financially responsible are insured. Said irrevocable assignment and transfer shall be for the purpose of granting UTP an independent right of recovery in any policy(ies) of insurance to which benefits may be payable for services rendered, but shall not be construed to be an obligation of UTP to pursue any such rights or recovery. I herby authorize and direct all insurance company(ies) under which I, any of my dependents or those for which I am financially responsible are insured to pay directly to UTP all benefits due under said policy(ies) by reason of services rendered therein. I will pay UTP for all charges incurred, or alternately, for all charges in excess of the sums actually paid by said policy(ies). I also irrevocably assign to UTP all rights, title and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which the Patient may be entitled to recover.

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 are responsible for the Patient's financial obligations. 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 entire staff strives to provide excellent care and service, and we hold ourselves to high 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 sincerely want to correct it. Usually, a word to your nurse is all that is needed, but if you prefer, call Patient Relations to speak confidentially with a patient representative. Your question or concern will be promptly addressed. We appreciate 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 OF EMAIL ADDRESS

You are requested to provide your email address to UT Physicians. The provision of your email address is entirely voluntary. Your email address may be used by UT Physicians, its affiliated entities, and business associates for the following purposes: appointment reminders, to inform you of benefits and services related to your health, through the use of online surveys emailed to you by UT Physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received, as required by law and for certain law enforcement activities, as otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) UT Physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation. As the patient email addresses UT Physicians collects will be assembled into a mailing list, group mailings will not be sent in a manner in which recipients are visible to one another.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize UTP and the Patient's physician(s) to disclose the Patient's health care information to any person, Social Security Administration, insurance or benefit payer, health benefit plan, worker's compensation carrier or other entity specified in UTP's Joint Notice of Privacy Practices, and to the extent specified in said Notice, which is or may be liable for all or a portion of the treating physician's charges, and to complete claim forms on behalf of the Patient.

I understand that special written authorization from me (the Patient or legal guardian of the Patient) will be requested by UTP prior to releasing health care information if the Patient is receiving mental health services or care in an alcohol or drug treatment program or facility.

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 other than the rendition of services. All of my questions have been fully answered.

PATIENT/LEGAL GUARDIAN SIGNATURE
(Patients over 18 years of age)

DATE

PRINT NAME
(If Legal Guardian, state relationship to patient)

PATIENT/LEGAL GUARDIAN EMAIL ADDRESS

GUARANTOR/INSURED SIGNATURE

DATE

PRINT NAME

RELATIONSHIP TO PATIENT

WITNESS SIGNATURE

DATE

PRINT NAME

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MEDICAL HISTORY

Patient Name: _____ **Today's Date:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Are you?** Right handed Left handed Ambidextrous

Referring Doctor: _____ or **Referring Friend:** _____

Other Physicians who are caring for you: _____

Describe your problem: _____

Have you had this problem in the past? Yes No **If yes, describe**: _____

Duration of Symptom: _____ or **Date of Injury**: _____

Cause of Injury: _____ **Is the injury work related?** Yes No N/A

Will there be any legal actions with respect to this problem? (circle one) Yes No Maybe

Are you represented by an attorney? Yes No **Name:** _____

Seen in an ER for your presenting problem? Yes No **Location:** _____ **Date:** _____

Rate your pain (circle one) No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Do your symptoms wake you from your sleep? Yes No **Does your pain interfere with daily life activity?** Yes No

Describe your symptoms: sharp aching dull stabbing shooting burning throbbing

The pain (circle one) is constant comes and goes is only occasional morning evening

Since you made your appointment, is your problem getting better or worse? Getting better Getting worse Unchanged

What makes your pain worse? Squatting Kneeling Sitting Bending Stairs Twisting Moving Running

Lying in Bed Walking Athletics Standing Gripping Reaching Overhead Weight Bearing Activity Lifting

Are there any other symptoms associated to this problem? Redness Bruising Swelling Numbness Stiffness

Limping Clicking Locking Popping Tingling Weakness Giving Way

What relieves your symptoms? _____

You are able to walk (circle one) Unlimited >10 blocks 5-10 blocks < 5 blocks Housebound Unable

You use stairs by (circle one) Alternating Steps Up and Down Alternating Steps Up and Down with Railing

One Step at a Time without Railing One Step at a Time with Railing Unable to do stairs

Do you use one of the following? Cane Crutches Walker Wheelchair Brace **If so, for how long?** _____

You are able to tie your shoes or put on your socks (circle one) With ease With difficulty Unable

You are able to sit (circle one) In any chair 1 hour or greater In a high chair ½ hour or less Unable to sit ½ hour in any chair

You are able to rise from a chair (circle one) With ease (no arms) With ease (with arms) With difficulty Unable

Are you able to enter public transportation? Yes No

Studies already performed for this problem (circle all that apply) N/A x-rays CAT scan MRI nerve study bone scan

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MEDICAL HISTORY

Treatment so far (circle all that apply)

None | Anti-inflammatories | Physical Therapy | Injections | Bracing

Activity Modification | Home Exercises | Rest | Chiropractor | Surgery | Ice | Heat

Your Own Personal Medical History (check all that apply to you)

___ Heart Attack ___ Stroke ___ Sleep Apnea ___ Hepatitis (A, B, C) ___ HIV

___ Pulmonary Embolus ___ TIA ___ Stomach Ulcers ___ High Blood Pressure ___ Congestive Heart Failure

___ Kidney Stones ___ Seizures ___ Phlebitis (blood clot) ___ Asthma/Emphysema ___ Cancer _____

___ Kidney/Renal Failure ___ Pneumonia ___ Abnormal Bleeding ___ Depression/psychiatric disease _____

___ Bladder Infections ___ Diabetes ___ Angina (chest pain) ___ Prior Infection _____

Other: _____

Are you experiencing any of the following symptoms? (circle all that apply)

None | Fevers | Night Sweats | Loss of appetite | Weakness | Frequent Falls

Unintentional weight loss | Loss of coordination | Change in bowel or bladder habits | Frequent Rashes

Do you have any metal in your body? Yes No **If yes, where?** _____

Are you allergic to Metal? Yes No

Your Own Personal Medical History (continued)

List **all surgeries** you have had (include orthopedic surgeries)	Surgery dates

List all **allergies** to medications

_____

List all **medication** you are **currently taking** (include over the counter medication)

_____

Are you taking blood thinners? Yes No If so, how long? _____

Are you taking immunosuppressants? Yes No

Family Medical History (describe conditions that run in your family)

Father: _____

Mother: _____

Sibling: _____

Social History

Occupation: _____ **If retired, for how long?** _____

Employer: _____

With whom do you live? _____ **Marital Status:** Single Married Widowed

Do you smoke? Yes No **If so, how many packs per day?** _____ How long? _____

Other tobacco products? Yes No **If so, what and how often?** _____

Did you quit using tobacco? Yes No **If so, when did you quit?** _____

Do you use narcotics? Yes No **If so, what and how often?** _____

Do you drink alcohol? Yes No **If so, how much?** _____

Have you visited a dentist in the past twelve months? Yes No

How often do you brush your teeth? _____ **Floss?** _____

Do you have a history of any of the following? Broken teeth Tooth decay/infections Pulled teeth Root canal

Pharmacy Information

Please list your pharmacy information for prescriptions and refills.

_____ _____
Name **Location/Address**

_____ _____
Phone Number **Fax Number**