GENERAL CONSENT TO TREAT

1. **General Consent** I consent to allowing the applicable Baylor Scott & White Health affiliated facilities listed below ("Facility") to provide me with necessary medical service, evaluation, diagnosis, treatment, and care (collectively, "care"). My consent includes any examinations, imaging, laboratory tests (including, but not limited to, tests to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), medications, medical treatment, and/or other services rendered by physicians, advance practice professionals, technical assistants, their associates, and other healthcare providers including nurses and other Facility staff (collectively, "providers"), which are advisable during the course of my evaluation, diagnosis, care, and treatment. Further, I agree and understand that care provided to me within the Emergency Department is considered an admission to the Facility even if I am not admitted to an inpatient bed. This consent is continuing in nature during the entire course of my care, unless specifically revoked by me.

Baylor Scott & White All Saints Medical Center - Ft. Worth
Baylor Scott & White Ambulatory Endoscopy Center
Baylor Scott & White Continuing Care Hospital
Baylor Scott & White Heart and Vascular Hospital - Dallas
Baylor Scott & White Heart and Vascular Hospital - Ft. Worth
Baylor Scott & White Heart and Vascular Hospital - Waxahachie
Baylor Scott & White McLane Children's Medical Hospital
Baylor Scott & White Medical Center - Austin
Baylor Scott & White Medical Center - Brenham
Baylor Scott & White Medical Center - Buda
Baylor Scott & White Medical Center - Centennial
Baylor Scott & White Medical Center - College Station
Baylor Scott & White Medical Center - Grapevine
Baylor Scott & White Medical Center - Hillcrest
Baylor Scott & White Medical Center - Irving
Baylor Scott & White Medical Center - Lake Pointe
Baylor Scott & White Medical Center - Lakeway
Baylor Scott & White Medical Center - Marble Falls
Baylor Scott & White Medical Center - McKinney
Baylor Scott & White Medical Center - Plano
Baylor Scott & White Medical Center - Pflugerville
Baylor Scott & White Medical Center - Round Rock
Baylor Scott & White Medical Center - Taylor
Baylor Scott & White Medical Center - Temple
Baylor Scott & White Medical Center - Waxahachie
Baylor Scott & White The Heart Hospital - Denton
Baylor Scott & White The Heart Hospital - McKinney
Baylor Scott & White The Heart Hospital - Plano
Baylor University Medical Center
HealthTexas Provider Network
Hillcrest Family Health Center
Hillcrest Physician Services
Scott & White Clinic

2. **Telemedicine** I consent to the Facility providing me with necessary care through telemedicine / telehealth, or through the use of electronic communications such as video or virtual communications, with providers who are located at a different site(s) ("off-site providers"). I agree and understand that I may be billed for any out of pocket costs such as co-pay, deductible, or coinsurance based on my health or insurance plans.
3. **Teaching Location** I agree and understand that the Facility may be a teaching Facility and residents, fellows, and students from various teaching programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my providers. I consent to allow residents, fellows, students, and authorized individuals to participate and observe the care provided to me as determined by my providers and as permitted by Facility policy.
4. **Independent Contractor** I agree and understand that the Facility may have one or more agreements with providers who are not employees of the Facility. I hereby consent to receive care from such providers and recognize that as independent contractors, the Facility is not responsible for the care or lack of care provided by these individuals. I understand that all such medical decisions regarding my care at the Facility are made by such providers and not by the Facility. **I also understand that I may receive a separate bill from these providers.** I may request a listing of the providers who have been granted medical staff privileges to provide medical services at the Facility.
5. **Control Over Decisions** I agree and understand that I have the right to make decisions about my care and that my providers and I will discuss and agree upon my care.
6. **Testing After Accidental Exposure** I consent to the testing for communicable diseases, in the event of an accidental exposure to a provider, healthcare worker, or other individual.
7. **State Reporting Requirements** I agree and understand that the Facility or provider is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or the Centers for Disease Control and Prevention. Also, I understand that the Facility is required by law to report certain activities including abuse or neglect.
8. **Personal Property** I agree and understand that I am responsible for my personal property. I understand that any and all valuables or other articles of personal property should be placed in the care of a family member or other authorized representatives. The Facility is not responsible for the safekeeping of these items. If available, I understand that the Facility maintains a safe or secure area for property and valuables, and that I may utilize this safe or secure area according to Facility policy; however, the Facility cannot guarantee the security of these items.
9. **Notice Regarding Physician Ownership** If I am receiving care at Baylor Scott & White Heart and Vascular Hospital – Dallas/Fort Worth/ Waxahachie, Baylor Scott & White The Heart Hospital – Plano/Denton/ McKinney, Baylor Scott & White Ambulatory Endoscopy Center, or an outpatient department of one of these facilities, I acknowledge that I am aware that one or more of the physicians providing my treatment at the Facility or one of its outpatient departments has an ownership interest in the Facility. A list of the physician owners is available to me upon request.
10. **Financial Responsibility** I agree and understand that regardless of any and all assigned benefits/monies, I am responsible for the total charges for services rendered. I further agree that all amounts are due upon request and are payable to the Facility and any provider providing me care. I agree to pay for any and all charges and expenses incurred or to be incurred. I understand that I will be provided with itemized statements regarding these charges through the MyBSWHealth web page and mobile application, and that I may also contact Customer Service at 1-800-994-0371 or billingquestions@bswhealth.org to request a paper copy. **I understand that independent providers (which could include, for example only, anesthesiologists, radiologists, pathologists, emergency medicine physicians, advance practice professionals, and other independent providers of health care services) providing me care may be considered out-of-network on my health or insurance plans although the Facility may be considered in network. I understand my insurance may not cover some services provided to me. I am responsible for asking about and understanding my insurance coverage for my providers and facilities. I understand if I desire additional information as to the providers who may be involved in providing my care, I can either ask my treating provider (who may know some of the specialists or groups who could be involved) or I can request a list of Facility-based physician groups by calling the following toll free number: (877) 810-0372. This list is updated annually and is subject to change without prior notice. Only my insurance carriers can confirm the nature and extent of my coverage and which facilities and providers will be considered in-network.** I further understand and agree that should my account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I shall pay all charges for reasonable attorneys' fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be

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applied to any outstanding accounts, either current or bad debt. Further, I hereby consent to credit bureau inquiries for any and all permissible purposes. I understand that I may request information from the Facility on whether it has a contract with my health or insurance plans and under what circumstances I may be responsible for payment of amounts not paid by my health or insurance plans.

11. **Medicare and Medicaid** If I have Medicare or Medicaid, I acknowledge my financial obligations may be limited by law. Other insurance carriers may limit my obligations by contract or policy benefit guidelines. If I do not have insurance coverage, I may ask for help to determine my eligibility.
12. **Outpatient Department** Charges I agree and understand if I receive care in an outpatient department, I may receive two bills including a bill for Facility services (also known as a facility fee) and a separate bill for the physician or other provider services (also known as professional services).
13. **Assignment of Benefits** I hereby irrevocably assign, transfer and convey to the Facility and any provider providing care to me, any and all benefits, interests and rights (including, but not limited to, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third party reimbursement, or prepaid healthcare plan for services rendered or products that I receive from the Facility. Notwithstanding the foregoing, my assignment of benefits, interests, and rights is not effective if I have signed an agreement with the Facility assuming responsibility for paying for services rendered by the Facility providers as out-of-network and retaining the responsibility to bill my insurance company.
14. **Responsible Parties** Upon receiving any care from the Facility and any provider providing care to me, I have assigned my rights of recovery from any Responsible Party to the Facility and any provider providing care to me. I understand that I may not assign, waive, compromise or settle any rights or causes of action that I may have against any Responsible Party, person or entity who causes an injury or illness treated by a Facility provider, without the express prior written consent of the Facility. This right is independent, separate and apart from any other right acquired by the Facility. I also agree to reimburse, first, the Facility for services provided out of any claim made against a Responsible Party. I acknowledge that for any financial assistance, uninsured patient discount or any other discount from the Facility covering medical benefits for illness or injury caused by an act or omission of a Responsible Party, the Facility reserves the right to reconsider and reverse the financial assistance, uninsured patient discount, or any other discount. Financial assistance, uninsured patient discount, or any other discounts/adjustments are considered an action of last resort. Therefore, the Facility reserves the right to dismiss, or reverse any such adjustments or discount on any account at any time. For purposes of this document, a Responsible Party includes any of the following: a tortfeasor individually, a tortfeasor's insurance company, any underinsured / uninsured automobile insurance coverage that provides benefits to a patient, no fault insurance coverage, any award, settlement or benefit paid under any worker's compensation law, claim or award, any indemnity agreement or contract, and/or any other payment for a patient as compensation for injuries sustained or illness suffered as a result of the negligence or liability of any individual or entity.
15. **Release of Information** I agree and understand that the Facility may release my healthcare information for payment purposes and any other purpose permitted by law. Further, the Facility may release my information to other providers for my continued care. I also authorize the release of medical information to organ transplantation services should I be identified as a potential organ donor. I agree that any leftover specimens sent to the laboratory may be used for medical education, validation, and authorized research.
16. **Communication** I authorize the Facility and providers, along with any billing service and collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, digital voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.
17. **Retention of Records** I agree and understand that the Facility will retain my medical records for the required retention period. I acknowledge that the Facility may authorize the disposal of medical records at the end of this retention period.
18. **Notice of Privacy Practices** I acknowledge that I have received a copy of the Facility's "Notice of Privacy Practices." I acknowledge that I can obtain an additional copy of the "Notice of Privacy Practices" on the Facility's website.
19. **Patient Rights and Advance Directives** I acknowledge that I have received information about my right to accept or refuse care. I have the right to make an advance directive, or living will. I am not required to have an advance directive to receive care. If I give the Facility an advance directive, my provider will follow it to the extent permitted by law.
20. **Patient Representative** I acknowledge that I have the right to name a representative who will make decisions on my behalf in the event I am unable to. I may designate a representative in writing or by telling my provider. My representative will be involved in my care plan, unless I expressly withdraw this designation in writing or by telling my provider.
21. **Photography** I consent to the videotaping, photographing, and/or other recording of myself and/or the portion(s) of my body involved in my care for medical education, internal quality control, performance improvement, and/or other related uses. I understand that for the purposes listed above I have the right to request cessation of the recording or filming. I also understand that for those purposes I have the right to rescind consent for the use of the recordings, videotapes and/or photographs up until a reasonable time before the recording or film is used. I understand the recording or film is the property of the Facility.
22. **Warranty and Guarantee** I agree and understand that the practice of medicine is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care rendered by the Facility or providers.

Patient or Legally Authorized Representative / Responsible Adult	Date and Time	Relationship to Patient
	/ / :	

BSWH USE ONLY

☐ Patient Unable to Sign

BSWH Witness Attestation Confirming Patient's Inability to Sign	Date and Time
	/ / :

(Refer to Facility Informed Consent Policy for Legally Authorized Representative.)