CORPUS CHRISTI MEDICAL CENTER

ADMISSION FORM Printed: :

Patient | Unit # | Service/Location | Status | F/C | Date | Account#

PATIENT

Soc Sec No: DOB: Age: Sex: MS: Race: Religion:

Address:

Home Ph: County:

PATIENT EMPLOYER

Work Phone:
Occupation:

GUARANTOR

SS#:

Address:

Home Ph: County:
Relationship to Patient: DOB:

GUARANTOR EMPLOYER

Work Phone:
Occupation:

OTHER GUARANTOR

SS#:

Address:

Home Ph: County:
Relationship to Patient: DOB:

OTHER GUARANTOR EMPLOYER

Work Phone:
Occupation:

PERSON TO NOTIFY

Home: Work:
Rel to Patient

NEXT OF KIN

Home: Work:
Rel to Patient

TEMPORARY ADDRESS

Exp:
Comment:

INSURANCE # 1

Phone:

Ins # 1:
Policy #:
Subscriber:
Rel to Pt:
Eff: To: Rel: Assign:
Group:

AUTHORIZATION

Treat/Precert:
Ins Verif:
Verf Phone:
Pre Cert Phone:
Contact:

INSURANCE # 2

Phone:

Ins # 2:
Policy #:
Subscriber:
Rel to Pt:
Eff: To: Rel: Assign:
Group:

AUTHORIZATION

Treat/Precert:
Ins Verif:
Verf Phone:
Pre Cert Phone:
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INSURANCE # 3

Phone:

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Contact:

OCCURRENCES

Code Type

CONDITIONS

Date Time Code Type

ACCIDENT INFO

Accident:
Type:
Location of Accident:

Date: Time:
Other persons involved :

Adm Priority | Admission Comment | Fin. Class | Special Prgm. | Preferred Lang

PHYSICIANS

Attending Physician: | Admitting Physician: | Emergency Room Physician:

Prime Care Physician: | Family Physican: | Other Physician:

ADMISSION/REGISTRATION

Date: Time: Source: Rm/Bed: Arrival: Principal Admitting Diagnosis/Reason for Visit: Admitted by:
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FACILITY COPY

SPECIMEN ONLY

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INSURANCE # 2

Phone:

Ins # 2:
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Subscriber:
Rel to Pt:
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Group:

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INSURANCE # 3

Phone:

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ADMISSION/REGISTRATION

Date: Time: Source: Rm/Bed: Arrival: Principal Admitting Diagnosis/Reason for Visit: Admitted by:
:

PAS COPY

EADMF0097 NWERRP50 14:55 06−07−07

CORPUS CHRISTI MEDICAL CENTER

Patent Name: _____

Admission/Registration Date: _____

Account Number: _____

I understand that my protected healthcare information may be disclosed to my family members and others as designated by me. I will provide those individuals with a passcode or other verification means specified by the hospital for this purpose.

The password for this visit is:

The passcode is a verification tool to determine the individual's relationship to the patient and to permit the release of protected health information relevant to such individual's involvement with the patient's healthcare or payment.

The passcode does not replace or substitute the patient's authorization to obtain a copy of or access to the patient's medical and/or billing record.

Please Note: This notice contains protected health information which is privileged and confidential and is intended for use only by the above named patient.

If you are not the intended recipient of this document please be advised that you have received this document in error and that any use, dissemination, distribution or copying is strictly prohibited. If you have received this document in error, please promptly return it to an employee of the hospital so that it may be properly disposed.

CHART COPY

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Paciente Nombre: _____

Admisión/Matrícula Fecha: _____

D?é cuenta el Número: _____

Entiendo que mi ha informaci?ón protegida de asistencia sanitaria puede ser revelada a mis miembros de la familia y otros como designado por mí. Proporcionaré esos individuos con un passcode u otra comprobación significan especificado por el hospital para este propósito.

La se?ña para esta visita es:

El passcode es un instrumento de comprobaci?ón de determinar la relación del individuo al paciente y para permitir la liberación de información protegida de salud pertinente a tal envolvimiento del individuo con la asistencia sanitaria de paciente o pago.

El passcode no reemplaza ni substituye la autorizaci?ón de paciente para obtener una copia de ni del acceso al registro médico y/o facturando del paciente.

Favor de notar: Esta nota contiene informaci?ón protegida de salud que se privilegia y confidencial y es pensado para el uso sólo por el encima de paciente denominado.

Si usted no es el recipiente destinado de este documento sea avisado por favor que usted ha recibido este documento en el error y que ning?ún uso, la diseminación, la distribución ni copiar se prohiben estrictamente. Si usted ha recibido este documento en el error, por favor inmediatamente lo vuelve a un empleado del hospital para que lo se pueda disponer apropiadamente.

DOB: MR#

Conditions of Admission

1. **Consent to Treatment**. I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. **Financial Agreement.** In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by the hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rules or statutes permit the hospital to recover.

3. **Consent to Wireless Telephone Calls.** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

4. **Assignment of Benefits**. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent, non-exclusive right of recovery against my insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital based physicians elect to collect such payment. In the event the hospital and/or hospital based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plan, I hereby appoint the hospital as my authorized representative to pursue, any administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

*Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.

5. **Private Room**. I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and/or use of a private room.

6. **Medicare Patient Certification and Assignment of Benefit**. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

7. **Other Acknowledgements**

a. **Personal Valuables**. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient.

b. **Weapons/Explosives/Drugs.** I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

c. **Additional Provision for Admission of Minors**. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

d. **Legal Relationship Between Hospital and Physicians. Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.** I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

e. **This consent includes testing for communicable or blood-borne diseases**, **including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. I** understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

Please initial: Agree_____ Disagree _____

f. **Insurance Network Acknowledgement**. I acknowledge that I have received notice that, based on the information available at this time, this facility IS/IS NOT a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g. radiologists, anesthesiologists, pathologists, neonatologists, and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure, or other services, may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

8. **Patient Self Determination Act**.
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to one of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

9. **Notice of Privacy Practices**. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

Date:	**I**, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.
Time: :	

Patient / Authorized Representative Signature:

X _____

If you are not the patient, please identify your Relationship to the patient.
(Circle or mark relationship(s) from list below):
Spouse Parent Legal Guardian
Neighbor / Friend Sibling
Healthcare Power of Attorney
Other (please specify): _____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:
(required for patients unable to sign without a representative or patients who refuse to sign)

X _____

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

Condiciones de admisión

1.**Consentimiento para el tratamiento**. Autorizo los procedimientos que posiblemente se lleven a cabo durante esta hospitalización o en régimen ambulatorio, por ejemplo, servicios o tratamientos de emergencia, y que pueden incluir, entre ellos, estudios de laboratorio, radiografías, procedimientos de diagnóstico, procedimientos o tratamientos quirúrgicos, médicos o de enfermería, anestesia o servicios hospitalarios que me provean según indicaciones de mi médico o de otro profesional de la salud que forme parte del cuerpo médico del hospital. Entiendo que, a modo de práctica profesional, es posible que los estudiantes de educación sanitaria participen en la prestación de asistencia y tratamientos médicos o actúen como observadores mientras recibo asistencia y tratamientos médicos en el Hospital, y que dichos estudiantes sean supervisados por instructores y por el personal del hospital.

2. **Acuerdo financiero.** En consideración a los servicios para me ser dados, o al paciente de quien acepto la responsabilidad, individualmente prometo pagar la cuenta del paciente en los precios declarados en la lista de precios del hospital (conocido como "el Maestro de Precio") eficaz en la fecha el precio es tratado para el servicio a condición de que, qué precios son por este medio expresamente incorporados por la referencia como el término de precios de este acuerdo para pagar la cuenta del paciente. Algunos artículos especiales serán priced por separado si no hay ningún precio puesto en una lista en el Maestro de Precio, o si el precio es puesto en una lista como el cero. Una estimación de los gastos esperados para servicios para ser proporcionados al paciente está disponible sobre la petición del hospital. Las estimaciones pueden variar considerablemente de los gastos finales basados en una variedad de factores, incluso, pero no limitadas con el curso de tratamiento, la intensidad de cuidado, prácticas de médico, y la necesidad de proporcionar bienes adicionales y servicios.

El hospital proporcionará un examen de proyección médico como requerido a todos los pacientes que buscan servicios médicos para determinar si hay una condición médica de emergencia, sin hacer caso de la capacidad del paciente de pagar. Si hay una condición médica de emergencia, el hospital proporcionará el tratamiento que se estabiliza dentro de su capacidad. Sin embargo, los pacientes que no se licencian bajo la política de cuidado de caridad del hospital u otra política aplicable no son aliviados de su obligación de pagar para estos servicios.

Si las provisiones y los servicios son proporcionados a un paciente que tiene la cobertura por un programa gubernamental o por ciertos proyectos de seguro médico privados, el hospital puede aceptar un pago rebajado para aquellas provisiones y servicios. En este acontecimiento cualquier pago requerido del abajo firmante será determinado por los términos del programa gubernamental o plan de seguro médico privado. Si el paciente es no asegurado y no cubierto por un programa gubernamental, el paciente puede ser elegible para hacer rebajar su cuenta o perdonado en descuento no asegurado del hospital o programas de cuidado de caridad en efecto en el momento del tratamiento. Entiendo que puedo solicitar la información sobre estos programas del hospital.

También entiendo que, como una cortesía a mí, el hospital puede facturar mi compañía de seguros, pero no es obligado a hacer así. Regardless, estoy de acuerdo que excepto donde prohibido según la ley, la responsabilidad financiera de los servicios dados me pertenece, el abajo firmante. Consiento en pagar cualquier servicio que no es cubierto y cubrió gastos no pagados en su totalidad por mi compañía de seguros. Este incluye, pero no es limitado con, coaseguro, deductibles, no ventajas cubiertas debido a límites de política o exclusiones de política así como fracaso de cumplir con exigencias de plan de seguros. También estoy de acuerdo que si el hospital debe iniciar esfuerzos de colección para recuperar cantidades debidas por mí, entonces además de cantidades incurridas para los servicios dio pagaré, al grado permitido según la ley: (a) alguno y todos los gastos incurridos por el hospital en la persecución de colección, incluso, pero no limitado con, honorarios de los abogados razonables, (y b) cualquier costo del tribunal u otros gastos del pleito incurrido por el hospital que las reglas aplicables o los estatutos permiten al hospital recuperar.

3. **Consienta en Llamadas Telefónicas Inalámbricas**. Si en cualquier momento proporciono un teléfono inalámbrico número en el cual pueden ponérseme en contacto, consiento para recibir llamadas (incluso llamadas automarcadas y mensajes pregrabados) en aquel número inalámbrico del hospital, sus sucesores y adjudica, y los afiliados, agentes e independiente contratistas, incluso servicers y agentes de colección, de cada uno de ellos en cuanto a la hospitalización, los servicios dado, o mis obligaciones financieras relacionadas.

4. **Asignación de Ventajas**. En la ejecución de esta asignación de ventajas, dirijo al portador de seguro médico u otro plan de beneficios de salud que proporciona mi cobertura (incluso, pero no limitado con, cualquier patrón, grupo de patrón o confianza plan patrocinado u ofrecido) para pagar al hospital y/o médicos a base de hospital directamente para los servicios el hospital y/o médicos a base de hospital proporcionados al paciente durante esta admisión. Si el portador de seguros que proporciona mi cobertura deja de pagar al hospital o médicos a base de hospital directamente, cuando ellos son por este medio ordenados hacer, reconozco que esto es mi deber y responsabilidad de pagar inmediatamente cualquier tal ventaja recibida por mí al hospital o médicos a base de hospital. A cambio de los servicios dados y ser dado por el hospital y/o médicos a base de hospital, Por este medio

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irrevocablemente adjudico y me traslado al hospital y/o médicos a base de hospital bien, título, e interés a todos los pagos para la asistencia médica dada, que son pagados de acuerdo con alguno y todas las pólizas de seguros y planes de beneficios de salud de los cuales tengo derecho a servicios o tengo derecho a recuperarse. Entiendo que cualquier pago recibido de estas políticas y/o proyectos será aplicado a la cantidad que he consentido en pagar para servicios dados durante esta admisión, como adelante descrito bajo la sección 2. Adelante por este medio irrevocablemente adjudico y transfiero al hospital y/o hospital a médicos basados un derecho independiente, no exclusivo de la recuperación contra mi asegurador o plan de beneficios de salud, pero esta asignación no será interpretado como una obligación del hospital y/o hospital médicos basados para perseguir cualquier tal derecho de la recuperación. Reconozco y entiendo que mantengo mi derecho de la recuperación contra mi asegurador o plan de beneficios de salud y la asignación anterior no me despoja de tal derecho. Nunca va al hospital y/o los médicos a base de hospital retienen ventajas superior a la cantidad debida al hospital y/o hospital médicos basados para el cuidado y tratamiento dado durante la admisión. Si a un pagador de tercero (como una compañía de seguros o grupo de patrón o confianza plan patrocinado u ofrecido) pueden obligarlo a pagar unos o todos estos gastos, consiento en tomar todas las acciones necesarias de asistir al hospital y/o el hospital los médicos basados en el pago que se reúne de cualquier tal pagador de tercero deberían el hospital o el hospital phyisicians basado electo para coleccionar tal pago. Tal como resultó después el hospital y/o el hospital médicos basados deciden ejercer su derecho independiente, no exclusivo de la recuperación contra asegurador del paciente o plan de salud, Por este medio designo el hospital como mi representante autorizado para perseguir, cualquier remedio administrativo, reclamaciones y/o pleitos de mi parte y en la elección del hospital, contra cualquier tercero responsable, asegurador médico, o el patrón patrocinó el plan de beneficio médico para objetivos de coleccionar alguno y todo el hospital se beneficia debido mí para el pago de los gastos mandados a en la sección 2 encima. Si el hospital decide perseguir una reclamación o el pleito contra un pagador de tercero como el representante autorizado, consiento en ejecutar una procuración especial, de ser solicitada, autorizando el hospital para tomar todas las acciones necesarias o apropiadas en la búsqueda de tal reclamación o pleito, incluso el permiso del hospital de traer el pleito contra el pagador de tercero de mi nombre. Consiento en pagar al hospital inmediatamente todas las sumas recuperadas en cualquier reclamación o pleito traído de mi parte por el hospital (hasta la cantidad de los gastos del hospital, más gastos y honorarios del abogado). Yo he leído y sido dado la oportunidad de hacer preguntas sobre esta asignación de ventajas, y he firmado este documento libremente y sin el incentivo, además de la interpretación de servicios por el hospital y/o hospital médicos basados.

** Entre los integrantes de la plantilla médica se encuentran: médicos del servicio de urgencias, patólogos, radiólogos, anestesistas, psiquiatras, psicólogos u otros profesionales del comportamiento humano .Estos servicios son prestados por con tratistas independientes y no están incluidos en su cuenta del hospital .Estos servicios serán facturados por separado por la empresa de facturación de cada médico.*

5. **Cuarto privado**. Entiendo y estoy de acuerdo que yo o el partido responsable del pago para hospital y servicios médicos somos responsables de cualquier gasto adicional asociado con la petición y/o el uso de un cuarto privado.

6. **Asignacion de beneficios y certificacion de pacientes de Medicare**. Certifico que toda la información que suministro para solicitar el pago según el Título XVIII (Medicare) o el Título XIX (Medicaid) de la Ley de Seguro Social es correcta. Solicito que el programa de Medicare o Medicaid efectúe el pago de los beneficios autorizados en mi nombre al hospital o a la plantilla médica.

7. **Otros Reconocimientos**:

a. **Efectos personales de valor**. Entiendo que el hospital cuenta con una caja de seguridad para custodiar el dinero y otros efectos de valor, y que el hospital está exento de toda responsabilidad por la pérdida o el daño a dinero, joyas, documentos, pieles, tapados de piel, prendas de piel u otro artículos de valor atípico y tamaño pequeño, a menos que se hayan colocado en la caja de seguridad, y no se hace responsable de la pérdida o el daño de cualquier otro bien personal, a menos que se haya dejado en manos del hospital para su protección. La responsabilidad del hospital por la pérdida de cualquier bien personal dejado en manos del hospital para su protección se limita a un máximo de quinientos dólares (US$ 500,00) o al máximo que exige la ley, salvo que el paciente obtenga un recibo por escrito del hospital por una cifra mayor.

b. **Armas/explosivos/drogas**. Entiendo y acepto que si el hospital, en algún momento, considera que puede haber armas, artefactos explosivos, drogas o sustancias ilegales o cualquier bebida alcohólica en mi habitación o entre mis pertenencias, es posible que el hospital revise mi habitación o mis pertenencias, confisque cualquiera de los ítems mencionados que encuentre y se deshaga de ellos según corresponda, por ejemplo, entregándolos a las autoridades judiciales y policiales.

c. **Cláusula adicional para la internación de menores**. Yo, el abajo firmante, reconozco y verifico que soy el custodio o tutor legal del paciente menor/discapacitado.

d. **Relación legal entre el hospital y los médicos**. La mayoría o todos los profesionales sanitarios que prestan sus servicios en el hospital son contratistas independientes, no son empleados ni representantes del hospital. Los contratistas independientes son responsables de sus propios actos, y el hospital está exento de toda responsabilidad por los actos u omisiones de cualquiera de estos contratistas independientes. Entiendo que los médicos u otros profesionales sanitarios pueden tener que brindar servicios o asistencia a mi persona o a mi beneficio, pero esto no implica que vaya a consultar o me vayan a revisar todos los médicos o profesionales sanitarios que participan en mi atención; por ejemplo, posiblemente no consulte a los médicos que prestan servicios de radiología, patología, interpretación de electrocardiogramas y anestesiología. Entiendo que, en la mayoría de los casos, se aplicará un cargo adicional por los servicios profesionales prestados por los médicos a mi persona o a mi beneficio, y que recibiré una cuenta adicional por dichos servicios.

e. Este consentimiento incluye pruebas de enfermedades contagiosas o de transmisión sanguínea, entre ellas, virus de inmunodeficiencia humana (VIH), síndrome de inmunodeficiencia adquirida (SIDA) y hepatitis, si el médico solicita dicha(s) prueba(s) para diagnóstico y/o de tratamiento. Entiendo que, en caso de exposición accidental a sangre o a otros fluidos corporales, la ley estadual permite que el hospital someta a una prueba al paciente que pueda haber expuesto a un profesional sanitario al VIH sin necesidad de obtener su consentimiento. Comprendo que los riesgos y complicaciónes de estos análisis generalmente son minimos y comparables a la rutina colección de espécimen de sangre, incluyendo el dolor de un picor de aguja y/o arder, sangrar, o malestar en el punto del piquete. Los resultados de dicho análisis sera parte de mi registro medico confidencial.

Escriba sus iniciales: _____ Estoy de acuerdo _____ No estoy de acuerdo

f. Reconocimiento de Red de Seguros. Reconozco que he recibido el aviso que, basado en la información disponible en este momento, esta facilidad ES/ NO ES un participante bajo mi plan de salud o plan de seguro (s). También reconozco que entiendo que algunos médicos, incluso médicos en la base de facilidad (tal como radiólogos, anestesiólogos, patólogos, neonatólogos, y/o médicos de departamento de emergencia), u otros proveedores que pueden proporcionarme servicios durante mi admisión, procedimiento, u otros servicios, pueden no participar bajo mi plan de salud o plan de seguro (s), y pueden facturarme por servicios que no son pagados por mi plan de salud o plan de seguro (s).

Yo he recibido la oportunidad de leer y hacer preguntas sobre la información contenida en esta forma y así también sobre está sección de está forma, y yo afirmo que no tengo preguntas, o que mis preguntas han sido contestadas a mi satísfaccíon.

Reconocimiento: _____ (Inicial)

8. Acto de autodeterminación del paciente He sido debidamente informado con respecto a las Directivas Anticipadas (tales como poderes legales duraderos para cuidados de salud y testamento en vida). Se me ha informado por escrito acerca de los derechos y responsabilidades del paciente, así como otras informaciones relativas a mi estancia. Por favor, inicialice o coloque una marca en el sepacio adyacente a una de las declaraciones aplicables siguientes:

	He ejecutado una Directiva Anticipada, y se me ha pedido que entregue una copia de la misma al Hospital.		No he ejecutado Directiva Anticipada alguna, deseo ejecutar una y he recibido información acerca de cómo debo ejecutar una Directiva Anticipada.		No he ejecutado Directiva Anticipada alguna, y no deseo ejecutar una Directiva Anticipada en este momento.

9. Información sobre prácticas de confidencialidad. Reconozco que he recibido una copia de la Información sobre las prácticas de confidencialidad del hospital, que describe las formas en las que el hospital puede utilizar y divulgar la información sobre los cuidados de mi salud para su tratamiento, pago, operaciones de cuidados de la salud y otros usos y divulgaciones descritos y permitidos; comprendo que puedo comunicarme con el funcionario de confidencialidad del hospital designado en la información si tuviese alguna pregunta o queja.
Reconozco: _____ (Iniciales)

Fecha:	Yo, el abajo firmante, como el agente paciente o legal del paciente, por este medio certifique que he leído, y totalmente y completamente entienda que este Condiciona de Admisión y Autorización para el tratamiento Médico, y esto he firmado este Condiciona de Admisión y Autorización para el Tratamiento Médico a sabiendas, libremente, voluntariamente y consentir en estar ligado por sus términos. No he recibido ningunas promesas, aseguramientos, o garantías de alguien en cuanto a los resultados que pueden ser obtenidos por cualquier tratamiento médico o servicios. Si la cobertura de seguros es insuficiente, negada totalmente, o por otra parteno disponible, el abajo firmante consiente en pagar todos los gastos no pagados por el asegurador.
Hora: :	

Firma del Paciente/Representante Autorizado:

X _____

Si usted no es el paciente, identifique su relación con el mismo.
(Encierre en un círculo o marque la(s) relación (es) en el listado de abajo:
Cónyuge Padre o madre Guardián Legal
Vecino/Amigo Hermano/Hermana

Proveedor de cuidados asignado por poder jurídico
Otra (especifique):_____

Firma y título del testigo:

X _____

Firma y título de testigo adicional:
(se exige en caso de pacientes que no puedan firmar sin un representante presente, o de pacientes que se nieguen a firmar)

X _____

CONDICIONES DE ADMISION (4/4)
(CONDITIONS OF ADMISSION)

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

Consent for Use and Release of Information

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, _____ or employer's designee when the services

(Name of Employer)

delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

Date Time : ☒ A.M. ☐ P.M.	I hereby certify that I have read, and fully and completely understand this Authorization for Release of Information/Healthcare Information, and that I have signed this Authorization Release of Information/Healthcare Information knowingly, freely, and voluntarily. ☐ Patient is medically unable to sign the Consent for Use and Release of Information ☐ Patient Refused to Sign
Patient/Parent/Guardian X	If other than patient, indicate relationship X
Spouse (if Married/Available) X	Witness (to Signature only) X

CONSENT FOR USE AND RELEASE OF INFORMATION

EADMF0004 NWERRP50 14:55 06-07-07

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

CONSENTIMIENTO PARA EL USO Y REVELACION DE INFORMACION

Por el presente autorizo la revelación de información sobre mi atención médica para propósitos de comunicar los resultados, hallazgos y decisiones de atención a los miembros de mi familia y otras personas responsables de mi atención o designadas por mi, proporcionándoles una contraseña u otro medio de verificación de acuerdo con lo que especifique el Hospital.

Yo (en mi calidad de padre o tutor, cónyuge, aval, representante del paciente) le permito a el hospital y los medicos, o otros profesionales de salud participando en el cuidado como paciente hospitalizado, o paciente externo, la entrega de informacion sobre este cuidado para las intenciones relacionadas a el tratamiento, el pago, o las funciones administrativas de salud. Informacion sobre el cuidado como paciente puede ser entregada a cualquier persona, o entidad responsible por pagar en nombre del paciente y asi poder verificar cobertura o hacer preguntas sobre el pago, o otra funcion relacionada a el pago del beneficio.También permito al Hospital que revele la información sobre mi atención médica a mi patrón (nombre del patrón) _____ o la persona que designe cuando los servicios prestados se lleven a cabo debido a una lesión relacionada con el trabajo. Si el paciente está amparado por Medicare o Medicaid, autorizo la revelación de la información sobre mi atención médica a la Administración del Seguro Social (Social Security Adminstration) o sus intermediarios o a las compañías aseguradoras por el pago de una reclamación de Medicare o la agencia estatal adecuada a cargo del pago de una reclamación de Medicaid. Esta información puede incluir, sin limitación, los antecedentes y registros de exploraciones físicas, registros del departamento de urgencias, informes de laboratorio, informes operativos, notas de avance de los médicos, notas del personal de enfermería, interconsultas, informes psicológicos y/ o psiquiátricos así como resúmenes de egreso. El consentimiento incluye específicamente información referente a los padecimientos relacionados a drogas, alcolismo, psicológicos, psiquiátricos y/ o enfermedades infecciosas que incluyen, pero no se limitan a, enfermedades transmitidas por la sangre tales como Hepatitis, Virus de la Inmunodeficiencia Humana (VIH) y Síndrome de Inmunodeficiencia Adquirida (SIDA). Reconozco y doy mi autorización para que los datos de mi expediente como paciente queden al alcance de todos los proveedores de servicios de salud que participen en mi atención o tratamiento, incluyendo, sin limitarse a médicos, personal de enfermería y otros trabajadores de la salud del Hospital, agencias de atención médica en casa, compañías de ambulancias y/ o agencias de servicios de salud implicados en mi atención durante y después de la transferencia o egreso del Hospital.

Reconozco que se debe utilizar mi expediente médico en las revisiones de utilización del Hospital (y las afilaciones del Hospital), en la mejora de desempeño, la revisión de colegas y otros procesos o estudios similares. También reconozco que mi expediente médico se pondrá a disposición de las organizaciones o autoridades gubernamentales en la medida en que la ley lo autorice o requiera. La información contenida en mi expediente médico puede tomarse o recabarse para propósitos de investigación y los resultados agregados (sin identificarme individualmente) pueden publicarse.

Reconozco que en el Hospital pueden almacenarse en medios electrónicos los expedientes médicos de los pacientes poniendo dicha información a disposición del personal y médicos del Hospital implicados en mi atención así como de los consultorios de tales médicos, a través de las diversas redes de cómputo. También reconozco que, de recibir tratamiento en otra unidad en el área que esté afiiada al Hospital, mi expediente médico quedará a disposición de tal unidad y los médicos implicados en mi atención así como de los consultorios de tales médicos, por vía electrónica, lo cual ayudará a mi médico y otros proveedores de servicios de salud en la revisión de tratamientos anteriores ya que podrían afectar mi padecimiento y tratamiento en ese momento. Las unidades que no estén afiliadas al Hospital y las unidades afiliadas que no cuentan con registros médicos electrónicos no podrán ofrecer este servicio.

Por el presente autorizo al Hospital o su representante autorizado, o a los encuestadores de la organización Gallup u otras similares, para que se comuniquen conmigo por vía telefónica después de mi egreso al llevar a cabo encuestas sobre satisfacción de los pacientes y otros estudios.

De conformidad con las leyes y reglamentos federales, doy mi autorización para que se revele mi número de afiliación a la Seguro Social al fabricante de cualquier dispositivo médico que me pudieren entregar.

Por el presente, autorizo la revelación de mi preferencia religiosa a la o las organizaciones religiosas locales, si así lo solicito.

Fecha	*Por el presente, el que suscribe certifica haber leído y comprendido plena y totalmente esta Autorización para la Revelación de Información/Información Sobre Atención Médica y haber firmado dicha Autorización con conocimiento de causa, libre y voluntariamente.*
Hora : ☒ A.M. ☐ P.M.	☐ El paciente no tiene la capacidad, desde el punto de vista médico, para firmar el *Autorización para la Revelación de Información* ☐ El paciente se rehusó a firmar

Paciente/Padre/Tutor X	En caso de ser una persona distinta al paciente, favor de indicar su relación con el paciente X
Cónyuge (si está casado/disponible) X	Testigo (sólo de la firma) X

CONSENTIMIENTO PARA EL USO Y REVELACION DE INFORMACION (CONSENT FOR USE AND RELEASE OF INFORMATION)

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

Consent for Outpatient Services

1**. Consent to Treatment**. I consent to the procedures which may be performed during this hospitalization or this outpatient episode of care, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. **Financial Agreement.** In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the Hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rule or statutes permit the hospital to recover.

3. **Consent to Wireless Telephone Calls**. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

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4. **Assignment of Benefits.** In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent right of recovery against the patient's insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health plan benefit and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital-based physicians elect to collect such payment. In the event the hospital and/or hospital-based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plans. I hereby appoint the hospital as my authorized representative to pursue, any administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.*

5. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

6. Outpatient Medicare Patients. Medicare does not cover prescription drugs except for a few exceptions. According to Medicare regulations, you are responsible for any drugs furnished to you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to you by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the

Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

7. **Other Acknowledgements**

a.Additional Provision for Admission of Minors. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

b.Legal Relationship Between Hospital and Physicians. Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

c.This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

Please initial: Agree_____ Disagree _____

d. Insurance Network Acknowledgement. I acknowledge that I have received notice that, based on the information available at this time, this facility **IS/IS NOT** a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g. radiologists, anesthesiologists, pathologists, neonatologists and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure or other services may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

8. Patient Self Determination Act.
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to one of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

9. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

Date:	I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Consent for Outpatient Services and Authorization for Medical treatment, and that I have signed this Consent for Outpatient Services and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. This agreement is in effect and applies to care and treatment received during this outpatient episode of care. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.
Time: :	

Patient / Authorized Representative Signature:

X _____

If you are not the patient, please identify your Relationship to the patient.
(Circle or mark relationship(s) from list below):
Spouse Parent Legal Guardian
Neighbor / Friend Sibling
Healthcare Power of Attorney
Other (please specify): _____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:
(required for patients unable to sign without a representative or patients who refuse to sign)

X _____

CONSENT FOR OUTPATIENT SERVICES (4/4)

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

Consentimiento para servicios de paciente ambulatorio

1.Consentimiento para el tratamiento. Autorizo los procedimientos que posiblemente se lleven a cabo durante esta hospitalización o en régimen ambulatorio, por ejemplo, servicios o tratamientos de emergencia, y que pueden incluir, entre ellos, estudios de laboratorio, radiografías, procedimientos de diagnóstico, procedimientos o tratamientos quirúrgicos, médicos o de enfermería, anestesia o servicios hospitalarios que me provean según indicaciones de mi médico o de otro profesional de la salud que forme parte del cuerpo médico del hospital. Entiendo que, a modo de práctica profesional, es posible que los estudiantes de educación sanitaria participen en la prestación de asistencia y tratamientos médicos o actúen como observadores mientras recibo asistencia y tratamientos médicos en el Hospital, y que dichos estudiantes sean supervisados por instructores y por el personal del hospital.

2.Acuerdo financiero. En consideración a los servicios para me ser dados, o al paciente de quien acepto la responsabilidad, individualmente prometo pagar la cuenta del paciente en los precios declarados en la lista de precios del hospital (conocido como "el Maestro de Precio") eficaz en la fecha el precio es tratado para el servicio a condición de que, qué precios son por este medio expresamente incorporados por la referencia como el término de precios de este acuerdo para pagar la cuenta del paciente. Algunos artículos especiales serán priced por separado si no hay ningún precio puesto en una lista en el Maestro de Precio, o si el precio es puesto en una lista como el cero. Una estimación de los gastos esperados para servicios para ser proporcionados al paciente está disponible sobre la petición del hospital. Las estimaciones pueden variar considerablemente de los gastos finales basados en una variedad de factores, incluso, pero no limitadas con el curso de tratamiento, la intensidad de cuidado, prácticas de médico, y la necesidad de proporcionar bienes adicionales y servicios.

El hospital proporcionará un examen de proyección médico como requerido a todos los pacientes que buscan servicios médicos para determinar si hay una condición médica de emergencia, sin hacer caso de la capacidad del paciente de pagar. Si hay una condición médica de emergencia, el hospital proporcionará el tratamiento que se estabiliza dentro de su capacidad. Sin embargo, los pacientes que no se licencian bajo la política de cuidado de caridad del hospital u otra política aplicable no son aliviados de su obligación de pagar para estos servicios.

Si las provisiones y los servicios son proporcionados a un paciente que tiene la cobertura por un programa gubernamental o por ciertos proyectos de seguro médico privados, el hospital puede aceptar un pago rebajado para aquellas provisiones y servicios. En este acontecimiento cualquier pago requerido del abajo firmante será determinado por los términos del programa gubernamental o plan de seguro médico privado. Si el paciente es no asegurado y no cubierto por un programa gubernamental, el paciente puede ser elegible para hacer rebajar su cuenta o perdonado en descuento no asegurado del hospital o programas de cuidado de caridad en efecto en el momento del tratamiento. Entiendo que puedo solicitar la información sobre estos programas del hospital.

También entiendo que, como una cortesía a mí, el hospital puede facturar mi compañía de seguros, pero no es obligado a hacer así. Regardless, estoy de acuerdo que excepto donde prohibido según la ley, la responsabilidad financiera de los servicios dados me pertenece, el abajo firmante. Consiento en pagar cualquier servicio que no es cubierto y cubrió gastos no pagados en su totalidad por mi compañía de seguros. Este incluye, pero no es limitado con, coaseguro, deductibles, no ventajas cubiertas debido a límites de política o exclusiones de política así como fracaso de cumplir con exigencias de plan de seguros. También estoy de acuerdo que si el hospital debe iniciar esfuerzos de colección para recuperar cantidades debidas por mí, entonces además de cantidades incurridas para los servicios dio pagaré, al grado permitido según la ley: (a) alguno y todos los gastos incurridos por el hospital en la persecución de colección, incluso, pero no limitado con, honorarios de los abogados razonables, (y b) cualquier costo del tribunal u otros gastos del pleito incurrido por el hospital que las reglas aplicables o los estatutos permiten al hospital recuperar.

3. Consienta en Llamadas Telefónicas Inalámbricas. Si en cualquier momento proporciono un teléfono inalámbrico número en el cual pueden ponérseme en contacto, consiento para recibir llamadas (incluso llamadas automarcadas y mensajes pregrabados) en aquel número inalámbrico del hospital, sus sucesores y adjudica, y los afiliados, agentes e independiente contratistas, incluso servicers y agentes de colección, de cada uno de ellos en cuanto a la hospitalización, los servicios dado, o mis obligaciones financieras relacionadas.

4. Asignación de Ventajas. En la ejecución de esta asignación de ventajas, dirijo al portador de seguro médico u otro plan de beneficios de salud que proporciona mi cobertura (incluso, pero no limitado con, cualquier patrón, grupo de patrón o confianza plan patrocinado u ofrecido) para pagar al hospital y/o médicos a base de hospital directamente para los servicios el hospital y/o médicos a base de hospital proporcionados al paciente durante esta admisión. Si el portador de seguros que proporciona mi cobertura deja de pagar al hospital o médicos a base de hospital directamente, cuando ellos son por este medio ordenados hacer, reconozco que esto es mi deber y

responsabilidad de pagar inmediatamente cualquier tal ventaja recibida por mí al hospital o médicos a base de hospital. A cambio de los servicios dados y ser dado por el hospital y/o médicos a base de hospital, Por este medio irrevocablemente adjudico y me traslado al hospital y/o médicos a base de hospital bien, título, e interés a todos los pagos para la asistencia médica dada, que son pagados de acuerdo con alguno y todas las pólizas de seguros y planes de beneficios de salud de los cuales tengo derecho a servicios o tengo derecho a recuperarse. Entiendo que cualquier pago recibido de estas políticas y/o proyectos será aplicado a la cantidad que he consentido en pagar para servicios dados durante esta admisión, como adelante descrito bajo la sección 2. Adelante por este medio irrevocablemente adjudico y transfiero al hospital y/o hospital a médicos basados un derecho independiente, no exclusivo de la recuperación contra mi asegurador o plan de beneficios de salud, pero esta asignación no será interpretado como una obligación del hospital y/o hospital médicos basados para perseguir cualquier tal derecho de la recuperación. Reconozco y entiendo que mantengo mi derecho de la recuperación contra mi asegurador o plan de beneficios de salud y la asignación anterior no me despoja de tal derecho. Nunca va al hospital y/o los médicos a base de hospital retienen ventajas superior a la cantidad debida al hospital y/o hospital médicos basados para el cuidado y tratamiento dado durante la admisión. Si a un pagador de tercero (como una compañía de seguros o grupo de patrón o confianza plan patrocinado u ofrecido) pueden obligarlo a pagar unos o todos estos gastos, consiento en tomar todas las acciones necesarias de asistir al hospital y/o el hospital los médicos basados en el pago que se reúne de cualquier tal pagador de tercero deberían el hospital o el hospital phyisicians basado electo para coleccionar tal pago. Tal como resultó después el hospital y/o el hospital médicos basados deciden ejercer su derecho independiente, no exclusivo de la recuperación contra asegurador del paciente o plan de salud, Por este medio designo el hospital como mi representante autorizado para perseguir, cualquier remedio administrativo, reclamaciones y/o pleitos de mi parte y en la elección del hospital, contra cualquier tercero responsable, asegurador médico, o el patrón patrocinó el plan de beneficio médico para objetivos de coleccionar alguno y todo el hospital se beneficia debido mí para el pago de los gastos mandados a en la sección 2 encima. Si el hospital decide perseguir una reclamación o el pleito contra un pagador de tercero como el representante autorizado, consiento en ejecutar una procuración especial, de ser solicitada, autorizando el hospital para tomar todas las acciones necesarias o apropiadas en la búsqueda de tal reclamación o pleito, incluso el permiso del hospital de traer el pleito contra el pagador de tercero de mi nombre. Consiento en pagar al hospital inmediatamente todas las sumas recuperadas en cualquier reclamación o pleito traído de mi parte por el hospital (hasta la cantidad de los gastos del hospital, más gastos y honorarios del abogado). Yo he leído y sido dado la oportunidad de hacer preguntas sobre esta asignación de ventajas, y he firmado este documento libremente y sin el incentivo, además de la interpretación de servicios por el hospital y/o hospital médicos basados.

** Entre los integrantes de la plantilla médica se encuentran: médicos del servicio de urgencias, patólogos, radiólogos, anestesistas, psiquiatras, psicólogos u otros profesionales del comportamiento humano .Estos servicios son prestados por con tratistas independientes y no están incluidos en su cuenta del hospital .Estos servicios serán facturados por separado por la empresa de facturación de cada médico.*

5. Asignación de beneficios y certificación de pacientes de Medicare. Certifico que toda la información que suministro para solicitar el pago según el Título XVIII (Medicare) o el Título XIX (Medicaid) de la Ley de Seguro Social es correcta. Solicito que el programa de Medicare o Medicaid efectúe el pago de los beneficios autorizados en mi nombre al hospital o a la plantilla médica.

6. Paciente ambulatorio de "Medicare". "Medicare" no cubre medicinas recetadas excepto en ciertas excepciones. Según las regulaciones de "Medicare", usted es responsable por cualquier medicina proporcionada a usted mientras sea paciente ambulatorio y que "Medicare" defina como medicina de prescripción. Estas medicinas también son referidas como medicinas auto-administradas, pues son generalmente auto-administradas pero pueden ser administradas por el personal de hospital. "Medicare" requiere que los hospitales facturen a los pacientes de "Medicare" u otros planes por estas medicinas. Beneficiarios de "Medicare Parte D" pueden presentar una reclamación a su plan para posible reembolso de estas medicinas en acuerdo con los materiales de inscripción en el "Medicare Drug Plan".

7. Otros Reconocimientos:

a. Cláusula adicional para la internación de menores. Yo, el abajo firmante, reconozco y verifico que soy el custodio o tutor legal del paciente menor/discapacitado.

b. Relación legal entre el hospital y los médicos. La mayoría o todos los profesionales sanitarios que prestan sus servicios en el hospital son contratistas independientes, no son empleados ni representantes del hospital. Los contratistas independientes son responsables de sus propios actos, y el hospital está exento de toda responsabilidad por los actos u omisiones de cualquiera de estos contratistas independientes. Entiendo que los médicos u otros profesionales sanitarios pueden tener que brindar servicios o asistencia a mi persona o a mi beneficio, pero esto no implica que vaya a consultar o me vayan a revisar todos los médicos o profesionales sanitarios que participan en mi atención; por ejemplo, posiblemente no consulte a los médicos que prestan servicios de radiología, patología, interpretación de electrocardiogramas y anestesiología. Entiendo que, en la mayoría de los casos, se aplicará un cargo adicional por los servicios profesionales prestados por los médicos a mi persona o a mi beneficio, y que recibiré una cuenta adicional por dichos servicios.

c. Este consentimiento incluye pruebas de enfermedades contagiosas o de transmisión sanguínea, entre ellas, virus de inmunodeficiencia humana (VIH), síndrome de inmunodeficiencia adquirida (SIDA) y hepatitis, si el médico solicita dicha(s) prueba(s) para diagnóstico y/o de tratamiento. Entiendo que, en caso de exposición accidental a sangre o a otros fluidos corporales, la ley estadual permite que el hospital someta a una prueba al paciente que pueda haber expuesto a un profesional sanitario al VIH sin necesidad de obtener su consentimiento. Comprendo que los riesgos y complicaciónes de estos análisis generalmente son minimos y comparables a la rutina colección de espécimen de sangre, incluyendo el dolor de un picor de aguja y/o arder, sangrar, o malestar en el punto del piquete. Los resultados de dicho análisis sera parte de mi registro medico confidencial.

Escriba sus iniciales: _____ Estoy de acuerdo _____ No estoy de acuerdo

d. Reconocimiento de Red de Seguros. Reconozco que he recibido el aviso que, basado en la información disponible en este momento, esta facilidad **ES/ NO ES** un participante bajo mi plan de salud o plan de seguro (s). También reconozco que entiendo que algunos médicos, incluso médicos en la base de facilidad (tal como radiólogos, anestesiólogos, patólogos, neonatólogos, y/o médicos de departamento de emergencia), u otros proveedores que pueden proporcionarme servicios durante mi admisión, procedimiento, u otros servicios, pueden no participar bajo mi plan de salud o plan de seguro (s), y pueden facturarme por servicios que no son pagados por mi plan de salud o plan de seguro (s).

Yo he recibido la oportunidad de leer y hacer preguntas sobre la información contenida en esta forma y así también sobre está sección de está forma, y yo afirmo que no tengo preguntas, o que mis preguntas han sido contestadas a mi satísfaccíon.

Reconocimiento: _____ (Inicial)

8. Acto de autodeterminación del paciente He sido debidamente informado con respecto a las Directivas Anticipadas (tales como poderes legales duraderos para cuidados de salud y testamento en vida). Se me ha informado por escrito acerca de los derechos y responsabilidades del paciente, así como otras informaciones relativas a mi estancia. Por favor, inicialice o coloque una marca en el sepacio adyacente a una de las declaraciones aplicables siguientes:

	He ejecutado una Directiva Anticipada, y se me ha pedido que entregue una copia de la misma al Hospital.		No he ejecutado Directiva Anticipada alguna, deseo ejecutar una y he recibido información acerca de cómo debo ejecutar una Directiva Anticipada.		No he ejecutado Directiva Anticipada alguna, y no deseo ejecutar una Directiva Anticipada en este momento.

9. Información sobre prácticas de confidencialidad. Reconozco que he recibido una copia de la Información sobre las prácticas de confidencialidad del hospital, que describe las formas en las que el hospital puede utilizar y divulgar la información sobre los cuidados de mi salud para su tratamiento, pago, operaciones de cuidados de la salud y otros usos y divulgaciones descritos y permitidos; comprendo que puedo comunicarme con el funcionario de confidencialidad del hospital designado en la información si tuviese alguna pregunta o queja.

Reconozco: _____ (Iniciales)

Fecha:	Yo, el abajo firmante, como el agente paciente o legal del paciente, por este medio certifique que he leído, y totalmente y completamente entienda que este Condiciona de Admisión y Autorización para el tratamiento Médico, y esto he firmado este Condiciona de Admisión y Autorización para el Tratamiento Médico a sabiendas, libremente, voluntariamente y consentir en estar ligado por sus términos. No he recibido ningunas promesas, aseguramientos, o garantías de alguien en cuanto a los resultados que pueden ser obtenidos por cualquier tratamiento médico o servicios. Si la cobertura de seguros es insuficiente, negada totalmente, o por otra parteno disponible, el abajo firmante consiente en pagar todos los gastos no pagados por el asegurador.
Hora: am	

Firma del Paciente/Representante Autorizado:

X _____

Si usted no es el paciente, identifique su relación con el mismo.
(Encierre en un círculo o marque la(s) relación (es) en el listado de abajo:
Cónyuge Padre o madre Guardián Legal
Vecino/Amigo Hermano/Hermana

Proveedor de cuidados asignado por poder jurídico
Otra (especifique):_____

Firma y título del testigo:

X _____

Firma y título de testigo adicional:
(se exige en caso de pacientes que no puedan firmar sin un representante presente, o de pacientes que se nieguen a firmar)

X _____

CONSENTIMIENTO PARA SERVICIOS A PACIENTES EXTERNOS (3/3)

(CONSENT FOR OUTPATIENT SERVICES)

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

PATIENT RIGHTS ACKNOWLEDGEMENT

I acknowledge that I have been given information and instructions regarding my patient rights at the Hospital. I understand that my patient rights include, but are not limited to, the right to make medical decisions, the right to accept or refuse medical treatment, participate in my plan of care, make advance directives (such as a medical power of attorney or a living will), and receive considerate and respectful care in a safe setting, free from verbal or mental abuse or harassment. I acknowledge that I have received information about the Hospital's patient complaint/grievance process.

ORGAN DONATION ACKNOWLEDGEMENT

In March 2003, HCA joined the Workplace Partnership for Life, a Department of Health and Human Services campaign to create awareness for voluntary organ, tissue, marrow and blood donations. While organ donation is a personal choice, HCA encourages you to make this an informed decision that takes into consideration the number of lives you could save. If you would like to become an organ donor, simply sign the organ donation option on your driver's license or fill out an application through HCA by logging onto www.hcaorgandonation.com. Be sure to tell your family of your intention. You never know whose life you could save. I understand that I have the right to donate any of my organs and / or tissues and that I may do so by completing an organ donor card or other organ donor consent form. I understand that my receipt of care, treatment and services at the Hospital is not conditioned upon my signing an organ donor card. Please initial if applicable: _____ I have signed an organ donor card and have been requested to supply a copy to the Hospital.

Date	
Time : ☒ A.M. ☐ P.M.	
Signature of Patient or Legal Representative/Guardian X	Printed Name X
Relationship to Patient if Patient Is Unable To Sign X	Witness Signature and Printed Name X

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

Reconocimiento de los Derechos de Paciente

Reconozco que he sido informado e instruido acerca de mis derechos como paciente en el hospital. Comprendo que mis derechos incluyen, mas no limitan al derecho de tomar decisions médicas, el derecho de aceptar o reahusar tratamiento médico, paricipar en mi plan de cuidado, hacer las directivas por adelantado (tal como un poder médico legal o testamento de vida), y recibir cuidado considerado y respetuoso en un medio ambiente libre de abuso/acoso verbal o mental. Reconozco que he recibido información acerca del proceso a seguir en caso de quejas o agravios.

Reconocimiento de Donacion de Organos

Comprendo que tengo el derecho de donar cualquiera de mis órganos y/o tejidos y que puedo hacerlo al llenar una tarjeta de donante de órganos o cualquier otro formulario de consentimiento. Comprendo que mi tratamiento y los servicios del hospital no estarán condicionados al firmar la tarjeta de donante de órganos. Por favor ponga sus iniciales si aplica: _____ He firmado una tarjeta de donante de órganos y puedo brindar una copia cuando se me pida.

Fecha	
Hora : ☒ A.M. ☐ P.M.	
Firma de paciente o representante legal/Tutor X	Nombre en letra de molde X
Parentesco con el paciente si el paciente no puede firmar X	Firma y nombre de Testigo X

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Separate Billing For Professional Services

This information is provided to help you understand which charges are for hospital services and which charges are for professional associates who are independent contractors at Corpus Christi Medical Center.

ER Services −Patients who are seen in the Hospital's Emergency Department or Patients having studies done at the Hospital Laboratory, Radiology, EEG/EKG, Radiation Therapy or Anesthesia will also receive a SEPARATE bill from the physician/specialist rendering services or interpreting studies.

Bay Area, Doctors	**GHEP−CCPLLC** **3765 S. Alameda, Corpus Christi** **281−784−1111**
NorthWest	**The Schumacher Group** **4849 Greenville Ave, Dallas Tx 75206** **866−816−2822**

Anesthesia −For the services of an anesthesiologist to stand by or administer anesthesia during a surgical or invasive procedure, or to assist in an emergency care situation, call

Bay Area, Doctors	**Premier Anesthesia Group** **3650 Mancell Rd. Suite 310, Alpharetta, GA 3002** **800.562−8663**
Bay Area, Doctors	**Bay Area Anesthesia Group** **4444 Corona St, Suite 232, Corpus Christi, TX 78411** **361−857−8525**

Pathology −For professional service rendered in the clinical laboratory by a physician specializing in clinical laboratory and pathological interpretation. These services including laboratory test results, microscopic examination and medical management. Please contact:

Bay Area, Doctors	**Pathology Associates** **PO Box 3758, Corpus Christi, TX 78463−3703** **361−992−4040**

Radiology −For interpretations of all X−Raystudies, fluoroscopic and special procedures by a physician who is a specialist in the field of radiology, you may receive a bill from:

Bay Area, Doctors, NorthWest	**Radiology Associates** **4444 Corona St, Suite 200, Corpus Christi, TX 78411** **361−561−3100**

Additionally, some of the physicians may be out of network with your insurance plan.

I have read and understand that I will receive a SEPARATE bill from the physician/specialist rendering services or interpreting studies as indicated above.

CHART COPY

Corpus Christi Medical Center
Separate Bills for Professional Services

DOB: MR#

SMOKING CESSATION INSTRUCTIONS / GETTING READY FOR DISCHARGE INFORMATION

Quitting takes hard work and a lot of effort, but you can quit Smoking.

Five Keys for Quitting:

1. GET READY.
Set a quit date and stick to it−not even a single puff!

2. GET SUPPORT AND ENCOURAGEMENT.
Tell your family, friends, and co−workersyou are quitting.

3. LEARN NEW SKILLS AND BEHAVIORS.
When you first try to quit, change your routine. Reduce stress.

4. GET MEDICATION AND USE IT CORRECTLY.
Talk with your health care provider about which medication will work best for you.

5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.
Avoid alcohol.
Eat a healthy diet and stay active.

ADDITIONAL RESOURCES:

American Cancer Society Quitline
1−877−YES−QUIT (1−877−937−7848)

American Heart Association
713−610−5000/www.americanheart.org

American Lung Association
www.lungusa.org

CDC−Tobacco Information and Prevention Source
www.cdc.gov/tobacco

Date/Fecha Time/Hora ☒ A.M. ☐ P.M. :	I acknowledge that I have been given information / instruction regarding Smoking Cessation and Getting Ready for Discharge Information.
Patient/Parent/Guardian X	If other than patient, indicate relationship X
Spouse (if Married/Available) X	Witness (to Signature only) X

CHART COPY

Corpus Christi Medical Center
Smoking Cessation
Getting Ready for Discharge Information

DOB: MR#

Patient Name:

Patient ID Number:

Physician:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938−0692

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: **TMF Health Quality Institute**
1−800−725−8338 (TTY 1−877−486−2048)

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 the 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 361−761−1518.

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

_____ _____
Signature of Patient or Representative Date

DOB: MR#

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 copays and deductibles).

Here is the contact information for the QIO:

TMF Health Quality Institute
Instructions on Filing an Appeal:
1−800−725−8339 (TTY 1−877−486−2048)

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 Corpus Christi Medical Center 45−0788

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 case.

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 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 (1−800633−4227), or TTY: 1−877−486−2048.

Additional Information:

DOB: MR#

Nombre del paciente:

Nœmerode identificaci n del paciente:

MØdico:

DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS
Centros de Servicios de Medicare y Medicaid
No de aprobaci n OMB 0938-0692

MENSAJE IMPORTANTE DE MEDICARE SOBRE SUS DERECHOS

COMO PACIENTE INTERNO, USTED TIENE EL DERECHO A:

- Recibir servicios cubiertos por Medicare. Esto incluye servicios de hospital necesarios desde el punto de vista médico y servicios que podría necesitar después de la salida (dado de alta), si son ordenados por el médico. Tiene el derecho a estar informado sobre estos servicios, quién pagará y dónde obtenerlos.
- Participar en toda decisión sobre la estadía en el hospital y saber quién la pagará.
- Notificar toda preocupación que tenga sobre la calidad de la atención recibida a la Organización para el Mejoramiento de la Calidad (QIO) mencionada aquí **TMF Health Quality Institute 1−800−725−8339 (TTY 1−877−486−2048)** .

SUS DERECHOS DE MEDICARE PARA SALIR DEL HOSPITAL

Planificación para su salida (dado de alta): Durante la estadía en el hospital, el personal cooperará con usted para prepararlo para que su salida no presente riesgos y organizar los servicios que usted podría necesitar después de salir del hospital. Cuando ya no necesite recibir la atención de hospital como paciente interno, el médico o el personal del hospital le informarán la fecha de su salida.

Si piensa que su salida es muy apresurada:

- Puede hablar con el personal del hospital, su médico y la administración de su plan de cuidado de la salud (si pertenece a uno de ellos) sobre sus preocupaciones.
- También tiene el derecho de apelar, es decir, pedir una revisión de su caso por una Organización para el Mejoramiento de la Calidad (QIO, por sus siglas en inglés). El QIO es un organización externa contratada por Medicare para revisar el caso a fin de decidir si usted está listo para salir del hospital.
  - **Si desea apelar, debe comunicarse con el QIO antes de la fecha de su salida (dado de alta) planificada y antes de salir del hospital.**
  - En tal caso, no tendrá que pagar los servicios que reciba durante el proceso de apelación (con excepción de los cargos como copagos y deducibles).
- Si no apela la decisión, pero decide permanecer en el hospital más allá de la fecha de salida (dado de alta) planificada, tal vez tenga que pagar el costo de los servicios que reciba después de esa fecha.
- ***La página 2 incluye instrucciones paso por paso para comunicarse con el QIO y presentar una apelación.***

Si desea hablar con alguien en el hospital sobre este aviso, llame al 361−761−1518.

Favor de firmar y escribir la fecha para mostrar que recibió este aviso y que entiende sus derechos.

_____ _____

Firma del paciente o representante Fecha

CMS-R-193-SP(aprobado 5/07)

DOB: MR#

EADMF3042 NWERRP50 14:55 06−07−07

PASOS PARA APELAR UNA SALIDA

- ***PASO 1:*** Debe comunicarse con el QIO antes de la fecha de su salida (dado de alta) planificada y antes de salir del hospital. En tal caso, no tendrá que pagar los servicios que reciba durante la apelación (con excepción de los cargos como copagos y deducibles).
    - Esta es la información para comunicarse con el QIO:

      TMF Health Quality Institute
      Instructions on Filing an Appeal:
      1−800−725−8339 (TTY 1−877−486−2048)
    - Puede presentar una solicitud de apelación cualquier día de la semana. **Una vez que hable con alguien o deje un mensaje, ha comenzado la apelación.**
    - Puede pedir ayuda al hospital para comunicarse con el QIO si fuera necesario.
    - El nombre de este hospital es Corpus Christi Medical Center 45−0788
- ***PASO 2:*** Recibirá un aviso detallado del hospital o del plan Medicare Advantage u otro plan de cuidado de salud administrado de Medicare (si pertenece a uno de ellos) que explica las razones por las que consideran que usted está listo para ser dado de alta.
- ***PASO 3:*** El QIO le solicitará su opinión. Usted o su representante necesitan estar disponibles para hablar con el QIO, si se solicita. Usted o su representante pueden presentar al QIO una declaración escrita, pero no se le exige que así lo haga.
- ***PASO 4:*** El QIO revisará su historial médico y otra información importante sobre su caso.
- ***PASO 5:*** El QIO le notificará sobre su decisión en el lapso de 1 día después de recibir toda la información necesaria.
    - Si el QIO determina que usted no está listo para ser dado de alta, Medicare continuará cubriendo el costo de los servicios de hospital.
    - Si el QIO determina que usted está listo para ser dado de alta, Medicare continuará pagando sus servicios hasta el mediodía del día después que el QIO le notifique a usted su decisión.

SI NO CUMPLE CON LA FECHA LÍMITE PARA LA APELACIÓN, USTED TIENE OTROS DERECHOS DE APELACIÓN:

- Todavía puede solicitar al QIO o a su plan (si pertenece a uno de ellos) que revisen su caso:
    - Si tiene Medicare Original: Llame al QIO mencionado arriba.
    - Si pertenece al plan Medicare Advantage o a otro plan de cuidado de salud administrado de Medicare: Llame a su plan.
- Si usted se queda en el hospital, el hospital puede cobrarle el costo de los servicios que reciba después de la fecha de su salida (dado de alta) planificada.

Si desea más información, llame GRATIS al 1−800−MEDICARE (1−800−633−4227)
o TTY: 1−877−486−2048.

Información adicional:

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT
You have the right, to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "DRG's" or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and for any post−hospital services.

You have the right to request a review by a TRICARE Regional Review Authority (RRA) of any written Notice of Non−coverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. RRA's employ groups of doctors under contract by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of the RRA for your area are:

Humana Military Healthcare Services, Inc.
Utilization Management
P.O. Box 740044
Louisville, KY 40201−9973
1−800−658−1405

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL
You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post−hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON
Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Non−coverage." You must have this Notice of Non−coverage if you wish to exercise your right to request a review by the RRA. The Notice of Non−coverage will state either that your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care. If the hospital and your doctor agree, the RRA does not review your case before a Notice of Non−coverage is issued. But the RRA will respond to your request for a review of your Notice of Non−coverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision if you request the review by noon of the first workday after you receive the Notice of Non−coverage. If the hospital and your doctor disagree, the hospital may request the RRA to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation, the RRA must agree with the hospital or the hospital cannot issue a Notice of Non−coverage. You may request that the RRA reconsider your case after you receive a Notice of Non−coverage but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW. THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING THE DAY FOLLOWING THE DAY OF RECEIPT OF THE HOSPITAL NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the Notice of Non−coverage states that your physician agrees with the hospital's decision:
?· Call the RRA 1−800−334−5612 by noon of the first work day after you receive the notice of noncoverage and request a review.
· The RRA must ask for your views about your case before making its decision. The RRA will inform you by phone and in writing of its decision on the review.
· If the RRA agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the RRA's decision.
· Thus, you will not be responsible for the cost of hospital care before you receive the RRA's decision.

If the Notice of Noncoverage states that the RRA agrees with the hospital's decision:
· You should make your request for reconsideration to the RRA immediately upon receipt of the Notice of Noncoverage by contacting the RRA in writing.
· The RRA can take up to three working days from receipt of your request to complete the review. The RRA will inform you in writing of its decision on the review.
· Since the RRA has already reviewed your case once, prior to issuance of the Notice of Non−coverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Non−coverage even if the RRA has not completed its review.
· Thus, if the RRA continues to agree with the Notice of Non−coverage, you may have to pay for least one day of hospital care.

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of the TRICARE decision to no longer pay for your Care at any point during your hospital stay or after you leave the hospital. The Notice of Non−coverage tells you how to request this review.

POST−HOSPITAL CARE
When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Tricare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, health benefits advisor, patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions. Questions involving billing or specific benefit coverage issues should be addressed to your TRICARE claims processor:

Palmetto Government Benefits Administrators (PGBA) Correspondence
P.O. Box 7032
Camden, SC 29020−7032
(800) 403−3950

ACKNOWLEDGMENT OF RECEIPT
My signature only acknowledges my receipt of this Message from HCA and does not waive any of my rights to request a review or make me liable for any payment.

Signature of beneficiary or person acting on behalf of beneficiary:

CHART COPY

Corpus Christi Medical Center
An Important Message from Tricare

DOB: MR#

EADMF3052 NWERRP50 14:55 06−07−07

CORPUS CHRISTI MEDICAL CENTER

WRITTEN NOTICE OF MEDICARE/TRICARE BENEFICIARY'S FINANCIAL OBLIGATION

Dear Medicare/TRICARE Patient:

This department, _____, is a hospital outpatient department of **CORPUS CHRISTI MEDICAL CENTER** (the "Provider"). Because it is a hospital−baseddepartment that is located off the hospital campus, Medicare/TRICARE requires us to inform you that you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital−basedand to provide you with a notice of your potential financial liability for the hospital service(s).

At this time, we can provide you with the following information on the estimated amount of your coinsurance liability.

- Based upon current information regarding the type and extent of the services scheduled, your coinsurance liability for the hospital service(s) is **estimated** to be $_____; or,

- Since we do not know the exact type and extent of services that you may need, we are unable to provide you with an estimate of your liability at this time. However, the typical charge incurred by a beneficiary based on all visits to this department or facility normally ranges from $_____ to $_____.

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and also subject to final determination by the Medicare/TRICARE program.

If you are enrolled in a state medical assistance program such as Medicaid or Medi−Cal,your coinsurance liability may be reduced or eliminated by law.

Your coinsurance liability for hospital services is separate from the Medicare/TRICARE coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

~~*I acknowledge that I have read the foregoing and understand that I will incur a liability to the hospital for Medicare/TRICARE*~~ *coinsurance as permitted by law and that I have received a copy of this notice.*

_____ _____

Patient Signature Date Witness Signature Date

DOB: MR#

EADMF0084 NWERRP50 14:55 06−07−07

CORPUS CHRISTI MEDICAL CENTER

" I understand that, in the opinion of Corpus Christi Medical Center, the services or items that I have requested to be provided to me on _____ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del Corpus Christi Medical Center, es posible que Medicaid no cubra los servicios o las provisiones que solicite _____ por no considerarlos razonables mi medicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad medical de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si después se determina que esos servicios y provisiones no son razonables ni medicamente necesarios para mi salud."

Date/Fecha	
Time/Hora : ☒ A.M. ☐ P.M.	
Patient/Parent/Guardian **X**	If other than patient, indicate relationship **X**
Spouse (if Married/Available) **X**	Witness (to Signature only) **X**

CHART COPY

Corpus Christi Medical Center
Client Acknowledgement Statement

DOB: MR#

Date: _____

PATIENT NAME	ACCOUNT NUMBER

This document is intended to help provide uninsured patients with an understanding of the financial aspects of their healthcare. Patients covered by automobile, third party liability or other reimbursement that may be billed for these services, will not qualify for the uninsured discount.

This document also provides options available to assist you in resolving your account. In an effort to assist uninsured patients, HCA will apply a discount to your account and then will work with you to resolve your remaining account balance.

The following information is an outline of how an uninsured account will be processed and the discount options that may be available to you. If you have received an elective cosmetic or flat rate procedure, these discounts do not apply. Otherwise, HCA discounts all uninsured bills. The discounted balance due on the account is expected to be paid in full at the time of service.

- Total charges for services provided are applied to the account
- Uninsured discount is applied to total charges, thereby reducing the account balance
- If you are unable to pay the discounted account balance in full, we will work with you to establish monthly payment arrangements.
- If you cannot establish monthly payment arrangements, we will assist you with applying for Medicaid assistance
- If you obtain Medicaid we will bill them and you will only be responsible for any non-covered charges
- If you do not qualify for Medicaid, you may complete the Financial Assistance Application, provide supporting documentation as needed and have this visit reviewed for a potential Charity discount
- If you qualify for a Charity discount based upon Federal Poverty Guidelines, your account will be considered paid in full. If you do not meet the required Federal Poverty Guidelines, you will need to make arrangements to resolve your bill immediately.

HCA provides a 100% discount on approved charity accounts. All other uninsured accounts will receive a partial discount.

Patient/Responsible Party Signature	Date
Witness Signature	Date

Corpus Christi Medical Center
Uninsured Patient Information Document

DOB: MR#

Date: _____

NOMBRE DE PACIENTE	NUMERO DE CUENTA

La intención de este documento es para proveer a pacientes sin aseguranza información sobre sus aspectos financieros de la salud. Los pacientes cubrieron en coche u otra cobertura de seguros que puede ser facturada para estos servicios no recibirÆ el descuento proporcionado a pacientes sin aseguranza.

Este documento tambiØn provee opciones de asistencia para resolver su cuenta. En nuestro esfuerzo por asistir a pacientes sin aseguranza, HCA proveerÆ un descuento y asistencia para resolver el balance de su cuenta.

La siguiente información es una descripción de como las cuentas sin aseguranza serÆn procesadas. Si usted recibe un procedimiento cosmØtico electivo o se le a dado un precio con descuenta incluido, estos descuentos no se aplicaran. Unos de los descuentos de HCA se aplicaran a todas las demÆs cuentas de pacientes sin aseguranza. Se requiere que el balance restante en la cuenta con descuento, se pague completamente al momento de recibir sus servicios.

- Cargos totales por los servicios proveídos se aplicaran a la cuenta
- Un descuento se aplicara a los cargos totales de la cuenta, de esa manera el balance se reducirÆ
- Si usted no puede pagar todo el balance despuØs de su descuento, nosotros trabajaremos con usted para establecer arreglos para pagos mensuales.
- Si usted no puede establecer pagos mensuales, lo asistiremos para aplicar para el programa de Medicaid.
- Si usted califica para Medicaid nosotros le cobraremos al programa y usted solamente serÆ responsable por los cargos no cubiertos por Medicaid.
- Si usted no califica para Medicaid podrÆ llenar una aplicación para ayuda financiera, usted tendrÆ que proveer documentación necesaria y revisaremos su caso para posible descuento total de Caridad.
- Si usted califica para descuento de Caridad basado en el ˝ndice de Pobreza Federal, su cuenta se considerara pagada en total.
- • Si usted califica para descuento de Caridad basado en el ˝ndice de Pobreza Federal, su cuenta se considerara pagada en total.

HCA provee un descuento de 100% en las cuentas aprobadas para Caridad. Todas las demÆs cuentas sin aseguranza recibirÆn un descuento parcial.

Firma de Paciente / Responsable de la cuenta	Fecha
Firma Testigo	Fecha

Corpus Christi Medical Center
Uninsured Patient Information Document

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Please Initial:

Authorization to Opt Out of Hospital Directory

☐ I hereby request that my name, general conditions, religious affiliation, and location not be included in the Hospital Directory.

☐ By invoking this patient right I understand that people inquiring by phone and visitors will be told "I have no information about this patient."

☐ No deliveries, including cards or flowers, will be forwarded to me.

☐ Electing to Opt Out of the Directory after Registration
By invoking this right after the initial registration process, I acknowledge that certain information may have already been disseminated. Therefore, can not guarantee my confidentiality status as it relates to information already disclosed.

Print Name: _____ Date: _____ Time: _____

Signature: _____

Witness printed Name/Title: _____

Witness Signature: _____

Please Initial:

Authorization to Opt Back into the Hospital Directory

☐ I hereby request that my name, general conditions, religious affiliation, and location be placed in the Hospital Directory. I no longer wish to "Opt Out" as previously indicated.

Print Name: _____ Date: _____ Time: _____

Signature: _____

Witness printed Name/Title: _____

Witness Signature: _____

Facility Use Only Below This Line

Form to be forwarded to Admission Supervisor.
Status change request processed by: _____
Received by Facility Privacy Officer (or designee): _____

To be filed in permanent medical record

Corpus Christi Medical Center
Directory Disclosure and
Status Change Request

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Por favor Inicial:

La autorizaci?ón para Optar Fuera de Guía de Hospital

☐ Yo por la presente solicito que mi nombre, las condiciones generales, la afiliaci?ón religiosa, y la ubicación no sea incluida en la Guía del Hospital.

☐ Invocando este derecho paciente yo entiendo esa gente que pregunta por tel?éfono y visitantes será dicha "Tengo no informaci?ón acerca de este paciente."

☐ Ningunas entregas, inclusive tarjetas ni flores, ser?án adelantadas a mí.

☐ Elegir a Optar Fuera de la Gu?ía después de Matrícula
Invocando este derecho despu?és que el proceso inicial de matrícula, yo reconozco que esa cierta información se puede haber difundido ya. Por lo tanto, Tejas el Hospital Ortopédico no puede garantizar mi posición de confidencialidad como está relacionado con información ya revelado.

Imprima el Nombre: _____ Fecha: _____ Hora: _____

La firma: _____

El testigo imprimi?ó el Nombre/el Título: _____

Presencie Firma: _____

Por favor Inicial:

La autorizaci?ón para Optar Espalda en la Guía del Hospital

☐ Yo por la presente solicito que mi nombre, las condiciones generales, la afiliaci?ón religiosa, y la ubicación sean colocados en la Guía del Hospital. Yo no deseo más largo "Optar Fuera" como previamente indicado.

Imprima el Nombre: _____ Fecha: _____ Hora: _____

La firma: _____

El testigo imprimi?ó el Nombre/el Título: _____

Presencie Firma: _____

El Uso de la facilidad S?ólo Debajo de Esta Línea

Form to be forwarded to Admission Supervisor.

Status change request processed by: _____

Received by Facility Privacy Officer (or designee): _____

To be filed in permanent medical record

Corpus Christi Medical Center
La Revelaciï¿½n de la guï¿½a y el Pedido del Cambio de la Posiciï¿½n

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Advance Directives Act

(see 166.163, Health and Safety Code)

Before signing this document, you should know these important facts.

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life−sustaining treatment.

Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician. Your agent\'s authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had. It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you. This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility;
- or a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

Corpus Christi Medical Center
Disclosure for Medical Power of Attorney

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Medical Power Of Attorney

Advance Directives Act (see ?§166.164, Health and Safety Code)

Designation of Health Care Agent:

I, _____ (insert your name) appoint:

_____
Name & Phone Number

_____
Address, City, State, Zip Code

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician. Limitations On The Decision Making Authority Of My Agent Are As Follows:

Designation of an Alternate Agent:
(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.) If the person designated as my agent is unable or unwilling to make health care decisions for me, designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number

Second Alternate Agent

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number

The original of this document is kept at:

_____
Name

_____
Address, City. State, Zip Code

The following individuals or institutions have signed copies:

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number

Duration
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself. (If Applicable) This power of attorney ends on the following date:

Prior Designations Revoked
I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.
Continued on next page.

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

You Must Date and Sign this Power of Attorney
Advance Directives Act (see §166.164, Health and Safety Code)

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____
City & State

_____
Signature, Print Name

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

_____
Signature

_____
Printed Name & Date

_____
City, State, Zip Code

_____
Signature

_____
Printed Name & Date

_____
City, State, Zip Code

Corpus Christi Medical Center
Medical Power of Attorney 2/2

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Ley de Directivas Anticipadas

((ver ?§166.163, del Código de Salud y Seguridad)

saber esta informaci?ón importante:

Salvo los límites que usted imponga, este documento le da a la persona que usted nombre como su agente la autoridad de tomar, en su nombre, y cuando usted ya no esté en capacidad de tomarlas por su propia cuenta, todas y cada una de las decisiones referentes a la atención médica conforme con sus deseos y teniendo en cuenta sus creencias morales y religiosas. Puesto que "atención médica" se refiere a cualquier tratamiento, servicio o procedimiento para controlar, diagnosticar o tratar cualquier padecimiento físico o mental, su agente tiene el poder de tomar, en su nombre, decisiones sobre una amplia gama de opciones médicas. Su agente puede dar consentimiento, negar consentimiento o retirar el consentimiento para recibir tratamiento médico y puede decidir si suspender o no dar tratamiento para prolongar la vida. Su agente no puede autorizar su ingreso voluntario a un hospital para recibir servicios de salud mental, ni que le den tratamiento convulsivo, psicocirugía o un aborto. El doctor deberá seguir las instrucciones de su agente o permitir que se le cambie a usted de doctor. La autoridad de su agente comenzará cuando su doctor certifique que usted no está en capacidad de tomar decisiones de carácter médico. Su agente tiene la obligación de seguir sus instrucciones cuando tome decisiones en su nombre. A menos que usted especifique lo contrario, su agente tiene la misma autoridad que usted tendría para tomar decisiones sobre su atención médica. Antes de firmar este documento, es muy importante que hable sobre éste con el doctor o con cualquier proveedor médico para asegurarse de que entienda la naturaleza y los límites de las decisiones que se tomarán en su nombre. Si no tiene un doctor, debe hablar con alguien más que sepa de estos asuntos y pueda contestar sus preguntas. No necesita la ayuda de un abogado para hacer este documento, pero si hay algo en este documento que usted no entienda, debe pedírle a un abogado que se lo explique. La persona que usted nombre como su agente debe ser alguien conocido y de su confianza. Debe ser mayor de 18 años, o puede ser menor de 18 años si se le ha retirado la incapacidad de minoría de edad. Si usted nombra al proveedor de atención médica o terapeuta (por ejemplo, su doctor o un empleado del centro de salud, hospital, casa para convalecientes o centro de tratamiento terapéutico, que no sea un pariente) esa persona tiene que escoger entre ser su agente o ser su proveedor de atención médica o terapeuta; conforme con la ley, una misma persona no puede desempeñar las dos funciones a la vez.

Debe informarle a la persona que usted escoja que quiere que ella sea su agente de atenci?ón médica. Usted debe hablar sobre este documento con su agente y con su doctor y darle a cada uno de ellos una copia firmada. Usted debe escribir en el documento el nombre de las personas e instituciones a quienes ha dado copias firmadas. Su agente no puede ser enjuiciado por las decisiones sobre atención médica tomadas de buena fe en su nombre. Aun después de firmar este documento, usted tiene el derecho de tomar decisiones de atención médica mientras esté en capacidad de hacerlo y no se le puede administrar o detener un tratamiento si usted se opone. Tiene derecho de revocar la autoridad otorgada a su agente informándole a su agente o a su proveedor de atención médica o terapeuta, oralmente o por escrito, y firmando un nuevo poder médico. A menos que indique lo contrario, el nombramiento de su cónyuge como su agente se disuelve en el caso de que usted se divorcie. Este documento no se puede modificar o cambiar. Si quiere hacer algún cambio, tiene que hacer un documento nuevo. Es aconsejable que nombre a un tercer agente en caso de que su agente no quiera, no pueda o esté incapacitado para actuar como su agente. Cualquier agente alterno que usted nombre tendrá la misma autoridad de tomar decisiones de atención médica en su nombre. Este poder no tiene validez a menos que se firme en presencia de dos testigos adultos hábiles. Las siguientes personas no pueden actuar como UNO de los testigos:

- la persona que usted ha nombrado como su agente;
- una persona que es su pariente por sangre o matrimonio;
- una persona que, despu?és de su muerte, tenga derecho a cualquier porción de su sucesión de acuerdo con su testamento o con una adición a su testamento firmado por usted o que tenga derecho a ésta por efecto legal;
- el doctor que lo atiende; un empleado del doctor que lo atiende;
- un empleado de un centro de atenci?ón médica del cual usted es paciente si el empleado le está prestando servicios directamente a usted o es un funcionario, director, socio o empleado de las oficinas del centro de atención médica o de cualquier organización matriz del centro de atención médica; o
- una persona que, en el momento de firmar este poder, pueda reclamar cualquier porci?ón de su sucesión después de su muerte.

Corpus Christi Medical Center
Declaraciï¿½n referente al poder mï¿½dico

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Ley de Directivas Anticipadas (ver ?§166. 164, del Código de Salud y Seguridad)

Yo, _____ (escriba su nombre) nombro a:

Name & Phone Number

Address, City, State, Zip Code

como mi agente para que tome todas y cada una de las decisiones sobre atenci?ón médica por mí, a menos que yo diga lo contrario en este documento. Este poder médico entra en vigor si yo no tengo capacidad para tomar mis propias decisiones sobre la atención médica y mi doctor certifica este hecho por escrito.

Nombramiento de un agente alterno:

(Usted no tiene que nombrar a un agente alterno, pero si quiere puede hacerlo. Un agente alterno puede tomar las mismas decisiones m?édicas que tomaría el agente designado si el agente designado no puede o no quiere hacer las veces de agente. Si el agente designado es su cónyuge, el nombramiento se revoca automáticamente por ley si su matrimonio se disuelve). Si la persona designada como mi agente no es capaz o no está dispuesta a tomar decisiones médicas por mi, nombro a las siguientes personas, para que hagan las veces de agente para tomar decisiones de tipo médico conforme yo las autorice por medio de este documento. Lo harán en el siguiente orden:

Nombre:	*Nombre:*
Direcci?ón:	*Direcci?ón*
Direcci?ón:	*Direcci?ón*
Tel?Øfono:	*Tel?Øfono:*

El original de este documento se mantendr?á en:

Nombre:

Direcci?ón:

Las siguientes personas o instituciones tienen copias firmadas:

Nombre:	*Nombre:*
Direcci?ón:	*Direcci?ón*

Comprendo que este poder existir?á indefinidamente a partir de la fecha en que se firma el documento a menos que yo establezca un término más corto o lo revoque. Si no estoy en capacidad de tomar decisiones médicas por mi propia cuenta cuando este poder se venza, la autoridad que le he dado a mi agente seguirá en vigor hasta que yo pueda volver a tomar decisiones por mí mismo. (Si aplica) Este poder se vencerá en la siguiente fecha: _____.

Revoco cualquier poder m?édico anterior.

Me dieron la declaraci?ón en la que se explica las consecuencias de este documento. La leí y la entiendo.

Continued on next page.

CORPUS CHRISTI MEDICAL CENTER

Tiene que escribir la fecha y firmar este poder

Firmo mi nombre en este poder m?édico el _____ de _____ (mes) de (año) en

_____

(Ciudad y Estado)

_____

Firma / (Nombre en letra de molde)

No soy la persona designada como agente por medio de este documento. No soy pariente del poderante ni por sangre ni por matrimonio. No tendr?é derecho a ninguna parte de la sucesión del poderante después de su fallecimiento. No soy el médico tratante del poderante ni estoy empleado por el médico tratante. No tengo ningún derecho sobre ninguna porción de la sucesión del poderante después de su fallecimiento. Además, si trabajo en el centro de atención médica donde es paciente el poderante, no tengo que ver con el cuidado directo del poderante y no soy funcionario, director, socio, ni empleado de la oficina del centro de atención médica ni de ninguna organización matriz del centro de atención médica.

_____

Firma

_____

Nombre en letra de molde & Fecha

_____

Direcci?ón

_____

Firma

_____

Nombre en letra de molde & Fecha

_____

Direcci?ón

CORPUS CHRISTI MEDICAL CENTER

Directive to Physicians and Family or Surrogates

Advance Directives Act (see ?§166.033, Health and Safety Code)

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences.

Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences. In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out−of− Hospital Do−Not−Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I _____ recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored: If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life−sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life−sustaining treatment. (This selection does not apply to Hospice care.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life−sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life−sustaining treatment. (This selection does not apply to Hospice care.)

Additional Requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life−sustaining treatments.

Continued on Next Page.

CORPUS CHRISTI MEDICAL CENTER

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

Person 1 *Person 2*

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me, following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signature

Printed Name & Date

City, State, Zip Code

Two witnesses must sign in the spaces below.

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness (1) may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 *Witness 2*

DEFINITIONS

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
a. that may be treated, but is never cured;
b. that leaves a person unable to care for or make decisions for the person's own self; and
c. that, without life−sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life−sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life−sustainingtreatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life− sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life−sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

CORPUS CHRISTI MEDICAL CENTER

Ley de Directivas Anticipadas (ver §166.033, del Código de Salud y Seguridad)

Directiva

Yo _____ _____ reconozco que la mejor atenci?ón médica se basa en una relación de confianza y comunicación con mi doctor. Juntos, mi doctor y yo tomaremos las decisiones médicas mientras yo esté en condiciones mentales de hacer conocer mis deseos. Si en algún momento yo no estoy en capacidad de tomar decisiones médicas respecto a mi salud debido a una enfermedad o lesión, ordeno que se respeten las siguientes preferencias respecto al tratamiento:

Si, a juicio de mi doctor, estoy padeciendo de una enfermedad terminal de la que se espera morir?é dentro de los seis meses, incluso con tratamientos disponibles para prolongar la vida, suministrado de acuerdo con las normas actuales de atención médica:

_____ Yo pido que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme c?ómodo, y que mi doctor me deje morir tan dignamente como sea posible; O

_____ Yo pido que me mantengan con vida en esta situaci?ón terminal usando los tratamientos disponibles para prolongar la vida.(Esta preferencia no se aplica al cuidado de hospicio).

Si, a juicio de mi doctor, estoy sufriendo de un padecimiento irreversible, que no permitir?á que me atienda yo mismo ni que tome decisiones por mí mismo y se espera que moriré si no me suministran tratamientos para prolongar la vida de acuerdo con las normas actuales de atención médica:

_____ Yo pido que no me den o me retiren todo tratamiento salvo aquellos necesarios para mantenerme c?ómodo, y que mi doctor me deje morir tan dignamente como sea posible; O

_____ Yo pido que me mantengan con vida en esta situaci?ón irreversible usando tratamientos disponibles para prolongar la vida. (Esta preferencia no se aplica al cuidado de hospicio).

Despu?és de firmar esta directiva, si mi representante o yo elegimos cuidado de hospicio, entiendo y estoy de acuerdo en que me den solamente aquellos tratamientos para mantenerme cómodo y que no me den los tratamientos disponibles para prolongar la vida.

_____

_____

Corpus Christi Medical Center
Directiva a los mï¿½dicos y
a familiares o substitutos 1/2

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

1 2

Si las personas nombradas antes no est?án disponibles, o si no hay un vocero designado, comprendo que se escogerá un vocero para mí, siguiendo las pautas especificadas por la ley de Texas.
Si, a juicio de mi doctor, mi muerte es inminente dentro de minutos u horas, a pesar de que me den todo tratamiento m?édico disponible suministrado dentro de las pautas de atención actuales, autorizo que no me den o que me retiren todo tratamiento salvo aquellos necesarios para mantenerme cómodo. Comprendo que bajo la ley de Texas esta directiva no tiene efecto si se ha diagnosticado que estoy embarazada. Esta directiva seguirá en efecto hasta que yo la revoque.
Nadie m?ás puede hacerlo.

Firmado

Nombre en letra de molde / Fecha

Ciudad, condado y estado de domicilio

Dos testigos tienen que firmar en los espacios siguientes.

Dos testigos adultos h?ábiles tienen que firmar a continuación, reconociendo la firma del declarante. El testigo designado Testigo (1) no puede ser una de las personas designadas para tomar decisiones relacionadas con el tratamiento para el paciente y no puede estar relacionado con el declarante por sangre o por matrimonio. Este testigo no puede tener derecho a ninguna parte de la sucesión y no puede tener un reclamo en contra de la sucesión del paciente. Este testigo no puede ser el médico que lo atiende ni un empleado del médico que lo atiende. Si el testigo es empleado del centro de salud en el cual se cuida al paciente, este testigo no puede estar directamente involucrado en el suministro de atención al paciente. Este testigo no puede ser funcionario, director, socio o empleado de la oficina del centro de atención médica donde se atiende al paciente o de ninguna organización matriz del centro de atención médica.

Testigo 1 *Testigo 2*

Definiciones:

"Nutrici?ón e hidratación artificial" quiere decir el suministro de nutrientes o líquidos mediante una sonda puesta en una vena, bajo la piel en los tejidos subcutáneos o en el estómago (tracto gastrointestinal).

"Padecimiento irreversible" quiere decir un padecimiento, lesi?ón o enfermedad:
a. que se puede tratar, pero que nunca sana;
b. que deja a la persona incapaz de cuidarse o tomar decisiones por ella misma, y
c. que sin el tratamiento para prolongar la vida, suministrado conforme con las normas actuales de atenci?ón médica, podría ser fatal.
Explicaci?ón:muchas enfermedades graves como el cáncer, la insuficiencia de cualquier órgano vital (el riñón, el corazón, el hígado o el pulmón) y una enfermedad del cerebro grave, como la demencia de Alzheimer, se pueden considerar irreversibles desde muy temprano. No hay curación, pero el paciente puede mantenerse con vida por periodos prolongados de tiempo si recibe tratamientos para prolongar la vida. Más tarde durante la misma enfermedad, ésta se puede considerar terminal cuando, incluso con tratamiento, se espera que el paciente muera. Usted deberá considerar qué niveles de tratamiento está dispuesto a soportar para lograr un resultado particular. Ésta es una decisión muy personal que usted deberá discutir con el doctor, la familia u otras personas importantes en su vida.

"Tratamiento para prolongar la vida" quiere decir un tratamiento que, a juicio m?édico, preserva la vida de un paciente y sin el cual el paciente moriría. El término se refiere a medicamentos para preservar la vida y a medios artificiales para mantener la vida como los respiradores mecánicos, el tratamiento de diálisis del riñón, la hidratación y la nutrición artificial. El término no se refiere a la administración de medicamentos para el dolor, la ejecución de un procedimiento quirúrgico necesario para suministrar comodidad ni ningún otro servicio médico ofrecido para aliviar el dolor del paciente.

"Padecimiento terminal" quiere decir una enfermedad incurable causada por lesi?ón, enfermedad o dolencia que a juicio médico produciría la muerte dentro de unos seis meses, incluso con el tratamiento disponible para prolongar la vida suministrado de acuerdo con las normas de atención médica actuales.
Explicaci?ón: muchas enfermedades graves se pueden considerar irreversibles desde muy temprano en la evolución de la enfermedad, pero no se considera terminal hasta que la enfermedad ha avanzado bastante. Al pensar en una enfermedad terminal y su tratamiento, deberá considerar los beneficios y las dificultades relacionados con el tratamiento y discutirlos con el doctor, la familia u otras personas importantes en su vida.

CORPUS CHRISTI MEDICAL CENTER

PATIENT RIGHTS

EVERY PATIENT SHALL HAVE THE RIGHT TO:
+ Reasonable access to care
+ Receive considerate and respectful care
+ Visitors
+ Know the name of his / her physician
+ Be informed of his / her health condition, including unanticipated outcomes
+ Information concerning:
  - Diagnosis
  - Treatment
  - Prognosis
+ Be involved in care planning and treatment
+ Formulate advance directives and appoint a surrogate to make health care decisions on his / her behalf to the extent permitted by law
  - Have the hospital staff and practitioners comply with those directives including withholding resuscitative services, forgoing or withdrawal of life sustaining treatment
+ Have a family member or representative of choice and his / her own physician notified promptly of admission to the hospital
+ Accept or refuse treatment and be informed of the medical consequences of such refusal
+ Make informed decisions regarding participation in clinical research
+ Personal respect, privacy and confidentiality
+ Access to information contained in his / her clinical or medical records within a reasonable timeframe
+ Confidentiality of clinical and medical records
+ Social, religious, and psychological well being
+ Reasonable response to requests for service including ethical issues
+ A qualified interpreter if needed
+ Be informed of hospital rules, regulations, and complaint resolution
+ Be informed of the reason for transfer to another facility
+ Knowledge concerning the professional status of caregivers
+ Access protective services
+ Appropriate assessment and management of pain
+ To receive treatment and care in the least restrictive environment
+ Receive care in a safe setting and be free from abuse or harassment
+ Explanation of his / her hospital bill and access to financial counsel

PATIENT RESPONSIBILITIES

EVERY PATIENT IS RESPONSIBLE FOR:
+ Communicating honestly and directly
+ Cooperating with the health care team
+ Understanding his / her health issues
+ Participating in his / her medical plan
+ Consequences resulting from non-compliance
+ Following hospital rules and regulations
+ Being respectful of others and hospital property
+ Informing the hospital of a violation of patient rights
+ Fulfilling his / her financial obligations for health care
+ Communicating any safety concerns including perceived risks in his / her care, and unexpected change(s) in their condition

COMPLAINTS AND GRIEVANCES
If you have a concern regarding any aspect of your care, please ask to speak with the manager responsible for the area of concern. If you feel that your concern was not adequately addressed, please call our Customer Feedback Hotline at 361-761-4357 during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday, excluding holiday). For all other hours, please contact the Nursing Supervisor by calling "0". If your complaint continues to be unresolved, you may also call the Department of State Health Services (DSHS)at 888-973-0022 or write to Health Facility Licensing and Compliance Complaints, Department of State Health Services (DSHS), 1100 West 49th Street, Austin, Texas 78756-3199.

OUR MISSION
The mission of Corpus Christi Medical Center is to show its commitment to the care and improvement of human life by striving to deliver high quality, cost-effective health care services to our community.

VISION
Our vision at Corpus Christi Medical Center is to be the provider of a full continuum of integrated health services that provide the highest quality medical care in a cost effective manner to benefit our community.

Concerns regarding safety and quality of care issues that cannot be resolved at the hospital level may be reported to the Joint Commission on Accreditation for Healthcare Organization:
Mail: Joint Commission on Accreditation of Health care Organizations, Office of Quality Monitoring, One Renaissance Blvd. Oak brook Terrace, IL 60181, Fax: (630) 792-5636, E-mail complaint@ jcaho.org, 1(800) 994-6610 (for questions about how to file a complaint).

Corpus Christi Medical Center
Patient Rights and Responsibilities

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

DERECHOS DEL PACIENTE

TODO PACIENTE SER?Á RESPONSABLE DE:
- Obtener un acceso razonable al cuidado
- Recibir un cuidado atento y respetuoso
- Recibir visitas
- Conocer el nombre de su m?édico
- Ser informado sobre su estado de salud, lo cual incluye resultados imprevistos
- Recibir informaci?ón relativa a:
  - Diagn?óstico
  - Tratamiento
  - Pron?óstico
- Participar en la planificaci?ón de su cuidado y tratamiento
- Formular instrucciones anticipadas y designar a un reemplazante para que tome decisiones sobre cuidado de la salud en su nombre seg?ún el grado en que la ley lo permita
  - Hacer que el personal y los profesionales del hospital cumplan con esas instrucciones, lo cual incluye servicios de reanimaci?ón y enuncia a tratamiento de soporte vital o retiro del mismo
- Hacer que un familiar o representante de su elecci?ón, así como su propio médico, sean notificados a la brevedad respecto a su internación en el hospital
- Aceptar o rechazar tratamiento y ser informado sobre las consecuencias m?édicas de dicho rechazo
- Tomar decisiones informadas respecto a su participaci?ón en investigaciones clínicas
- Recibir respeto, privacidad y confidencialidad respecto a su persona
- Acceder a la informaci?ón contenida en sus registros clínicos o médicos en un plazo razonable
- Obtener confidencialidad respecto a sus registros cl?ínicos y médicos
- Recibir servicios de bienestar social, religioso y psicol?ógico
- Recibir una respuesta razonable a sus solicitudes de servicio, lo cual incluye cuestiones ?éticas
- Si es necesario, obtener un int?érprete calificado
- Ser informado sobre las normas, reglamentaciones y proceso de resoluci?ón de quejas del hospital
- Ser informado sobre la raz?ón de su transferencia a otro establecimiento
- Obtener conocimiento respecto a la categor?ía profesional del personal que brinda el cuida
- Acceder a servicios de protecci?ón
- Obtener una evaluaci?ón adecuada y tratamiento del dolor
- Recibir tratamiento y cuidado en un entorno con las menores restricciones posibles
- Recibir cuidado en un entorno seguro y estar libre de todo abuso o acoso
- Recibir una explicaci?ón de su factura hospitalaria y acceder a asesoramiento financiero

RESPONSABILIDADES DEL PACIENTE

TODO PACIENTE SER?Á RESPONSABLE DE:
- Comunicarse en forma honesta y directa
- Cooperar con el equipo de cuidado de la salud
- Comprender toda cuesti?ón relacionada con su salud
- Participar en su plan m?édico
- Aceptar las consecuencias que resulten de su falta de cumplimiento
- Seguir las normas y reglamentaciones del hospital
- Ser respetuoso hacia los dem?ás y los bienes del hospital
- Informar al hospital sobre toda violaci?ón a los derechos del paciente
- Cumplir con sus obligaciones financieras respecto a cuidado de la salud
- Comunicar toda inquietud relativa a seguridad, lo cual incluye todo riesgo que perciba en su cuidado, as?í como cambios imprevistos en su condición

QUEJAS Y AGRAVIOS

Si usted tiene alguna inquietud sobre alg?ún aspecto de su cuidado, solicite hablar con el administrador responsable del área en cuestión. Si usted considera que su inquietud no recibió el trato adecuado, llame a nuestra Línea de Urgencia para Opiniones de Clientes al 361−761−4357 durante el horario de atención regular (lunes a viernes de 9:00 a.m. a 5:00 p.m., excluidos feriados). En otros horarios, comuníquese con el Supervisor de Enfermería llamando al "0" o a la extensión 7474. Si su queja continúa sin resolverse, también puede llamar al Departamento de Salud de Texas al 888−973−0022 o bien escribir a Health Facility Licensing and Compliance Complaints, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756−3199.

NUESTRA MISI?ÓN

La misi?ón de Corpus Christi Medical Center es demostrar su compromiso hacia el cuidado y el mejoramiento de la vida humana esforzándose por ofrecer a nuestra comunidad servicios de cuidado de la salud de alta calidad y económicamente eficientes.

VISI?ÓN

La visi?ón de Corpus Christi Medical Center es proveer un conjunto integral de servicios de la salud que ofrezca cuidado médico de óptima calidad en forma económicamente eficiente para beneficio de nuestra comunidad.

DOB: MR#

NOTICE OF PRIVACY PRACTICES

Effective Date: 02/17/2010

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

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may

disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- To contact you as part of fundraising efforts, unless you elect not to receive any such communications;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment,

payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

  We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL **Kellie Barnett**
Telephone Number: **361-761-3728**

AVISO SOBRE LAS PRACTICAS DE PRIVACIDAD

Fecha de Vigencia: March 21, 2003

ESTE AVISO DESCRIBE LA FORMA EN QUE PUEDE UTILIZARSE Y REVELARSE LA INFORMACIÓN SOBRE SU SALUD Y LA MANERA EN QUE USTED PUEDE TENER ACCESO A ESTA INFORMACIÓN

SEA USTED TAN AMABLE DE REVISARLO CUIDADOSAMENTE.

Si tiene usted alguna pregunta o duda sobre este aviso, sea tan amable de ponerse en contacto con el Funcionario de Privacidad del Hospital marcando el n?úmero telefónico principal del hospital.

Cada vez que usted realice una visita a un hospital, un m?édico o a otro proveedor de la salud, se lleva a cabo un registro sobre su visita en su expediente personal. Lo típico es que dichos registros indiquen sus síntomas, los resultados de su exploración física y análisis, los diagnósticos, el tratamiento, un plan para atención o tratamiento futuros e información relacionada con la facturación. El presente aviso se aplica a todos los registros de su atención generados por el hospital, ya sea que los hayan llevado a cabo los miembros del personal del hospital, sus representantes o su médico personal quien tal vez tenga diferentes políticas o avisos referentes al uso y revelación de su expediente creado en el consultorio del médico o en la clínica.

Nuestras Responsabilidades La ley exige que mantengamos la privacidad de la información sobre su salud y le hagamos entrega de una descripción sobre nuestras prácticas de privacidad. Puede usted tener la seguridad de que nos regiremos por los términos y condiciones del presente aviso.

Usos y Revelaciones De qué manera podemos emplear y revelar la Información de su Expediente

Las siguientes categorías describen ejemplos de la forma en que utilizamos y revelamos información de los expedientes:

Para el tratamiento: Es posible que utilicemos información de su expediente para darle algún tratamiento o prestarle nuestros servicios. Tal vez revelemos información de su expediente a otros médicos, las enfermeras, los técnicos, estudiantes de medicina u otros miembros del personal del hospital que participen en su atención en el hospital; por ejemplo: un médico que lo esté tratando por una pierna rota tal vez necesite saber si sufre usted de diabetes debido a que esta enfermedad puede hacer más lento el proceso de curación; por otra parte, diferentes departamentos del hospital tal vez compartan la información sobre su salud para coordinar las diferentes medidas que usted puede llegar a necesitar como serían recetas de medicamentos, análisis de laboratorio, comidas y radiografías.

De igual modo, le podemos ofrecer a su médico o a otro proveedor de la salud posterior, copias de diferentes informes que puedan ayudarle a tratarlo una vez que sea usted egresado de este hospital.

Parael Pago: Es posible que empleemos y revelemos información sobre su salud relacionada con su tratamiento y los servicios que debemos facturar y cobrarle a usted, su aseguradora o a cualquier tercero que pague los gastos; por ejemplo: tal vez necesitemos darle a su aseguradora información sobre su cirugía para que ellos nos paguen o le reembolsen a usted el tratamiento y quizás tengamos que avisarle a su plan de salud en qué consiste el tratamiento que usted deba recibir para determinar si su plan de salud lo cubre o no.

Para las Operaciones de Atención de la Salud: Miembros del personal médico y/o del equipo de mejora de la calidad pueden emplear los registros de su expediente para valorar la atención y resultados de su caso así como de otros casos similares al suyo. Los resultados tendrán que ser utilizados entonces para mejorar continuamente la calidad de la atención de todos los pacientes a los que atendemos; por ejemplo: es posible que combinemos información sobre la salud de varios pacientes con el objeto de valorar la necesidad de nuevos servicios o tratamientos o tal vez revelemos información a los médicos, enfermeras y otros estudiantes para propósitos de educación; es posible que combinemos la información sobre la salud que tenemos a nuestra disposición con la de otros hospitales para ver si podemos mejorar o posiblemente eliminemos de esta serie de datos sobre la salud, información que le identifique con el objeto de proteger su información médica.

También es posible que empleemos y revelemos información sobre la salud:

- A colaboradores que hayamos contratado para llevar a cabo algún servicio y para facturarlo;
- Para recordarle que tiene usted una cita para recibir atención médica
- Para valorar su satisfacción con nuestros servicios
- Para indicarle algunas alternativas de tratamiento
- Para señalarle los beneficios o servicios relacionados con su salud
- Para informar a los Directivos de Funerarias de acuerdo con las leyes pertinentes
- Para llevar a cabo actividades poblacionales que sirvan para mejorar la salud o reducir los costos de atención de la salud y
- Para llevar a cabo programas o revisar la competencia de los profesionales de salud.

Al revelar la información, los recordatorios principalmente de citas y los esfuerzos de facturación/cobranzas, es posible que le dejemos algunos mensajes en su contestador telefónico/correo de voz.

En el caso de colaboradores: En nuestro hospital existen algunos servicios que se prestan a través de contratos con colaboradores en el mismo medio. Ejemplos de ellos incluyen servicios de médicos en el departamento de urgencias y radiología, algunas pruebas de laboratorio y un servicio de copiado que utilizamos cuando hacemos copias de su expediente. Cuando estos servicios son contratados, hay la posibilidad de que redactemos información médica a nuestros colaboradores para que ellos puedan ejercer su trabajo y asimismo facturarle a usted o a su aseguradora por los servicios proporcionados. Nosotros exhortamos a nuestros colaboradores de que practiquen medidas de seguridad para proteger su información médica.

Directorio: Tal vez tengamos que incluir información limitada sobre usted en el directorio del hospital mientras esté usted hospitalizado; dicha información puede incluir su nombre, ubicación en el hospital, su condición en términos generales (por ejemplo: buena, regular) y sus creencias religiosas; esta información puede ser entregada a miembros del clero y, con la salvedad de las creencias religiosas, a otras personas que pregunten por usted, dando su nombre. Si desea usted que no se le incluya en el directorio del hospital, por favor pida una Forma de No Inclusión en el Directorio (Opt Out Form en inglés) al personal de admisiones o al Funcionario de Privacidad del Hospital.

Personas que Participan en su Atención o que Pagan por su Atención: Es posible que le revelemos información sobre su salud a un amigo o familiar que participen en su atención médica o que le ayuden a pagar por dicha atención; además, tal vez revelemos información de su expediente a alguna entidad que esté asistiendo en un esfuerzo de alivio de desastres para poder notificar a sus familiares sobre su condición,
estado y ubicación.

Investigación: Tal vez revelemos información de su expediente a investigadores cuando el consejo institucional de revisión lleve a cabo una revisión de las propuestas de investigación y protocolos establecidos con el objeto de asegurar que se haya aprobado la privacidad de la información sobre su salud en la investigación y que se haya otorgado una renuncia al requisito de autorización.

Comunicaciones Futuras: Es posible que nos comuniquemos con usted a través de boletines, envíos por correo u otros medios relacionados con alternativas relacionadas con la salud, programas para el manejo de enfermedades, programas de bienestar u otras iniciativas o actividades comunitarias en las cuales participa nuestro hospital.

Arreglo Organizado para la Atención de la Salud: Este hospital y los miembros de su personal m?édico se han organizado y someten a su atención el presente documento como una notificación conjunta. La información será compartida en la medida necesaria para llevar a cabo el tratamiento, las operaciones de pago y atención de la salud. Los médicos y profesionales de la salud pueden tener acceso a información médica que exista en sus consultorios para auxiliar en la revisión de tratamientos anteriores que tal vez puedan afectar el tratamiento que se dé en ese momento.

Entidad de Cobertura Afiliada: Toda informaci?ón médica se pondrá a disposición del personal del hospital en los hospitales afiliados cuando sea necesario para dar algún tratamiento, efectuar un pago y para las operaciones de atención de la salud. Los profesionales de la salud de otras unidades pueden tener acceso a la información médica en sus lugares de trabajo para ayudar en la revisión de la información sobre tratamientos anteriores que pudieran afectar el tratamiento en ese momento. Si desea mayor información sobre los sitios específicos incluidos en esta entidad, favor de ponerse en contacto con el Funcionario de Privacidad del Hospital. La ley requiere que empleemos y revelemos también información sobre los expediente a los siguiente tipos de entidades que incluyen, sin limitarse a lo siguiente:

- La Administración de Alimentos y Medicamentos (FDA por sus siglas en inglés)
- Las Autoridades Legales o de Salud Pública encargadas de prevenir o controlar las enfermedades, lesiones o discapacidades
- Las Instituciones de Rehabilitación Social
- Los Representantes de los Trabajadores en Materia de Compensaciones
- Las Organizaciones para la Donación de Órganos y Tejidos
- Las Autoridades de Comando Militar
- Los Organismos Que Vigilan la Salud
- Los Directivos de Funerarias, Médicos Forenses y Examinadores Médicos
- Los Organismos de Seguridad Nacional e Inteligencia
- Los Servicios de Protección para el Presidente y Otros Terceros

Procedimientos Legales/Para Hacer Valer la Ley: Tal vez revelemos información sobre la salud para propósitos de hacer cumplir la ley de acuerdo con lo que ésta requiere o en respuesta a un citatorio válido.

Requisitos Espec?íficos del Estado: Muchos estados tienen requisitos de notificación que incluyen actividades poblacionales que se relacionan con mejorar la salud o reducir los costos de atención de la salud. Algunos estados tienen leyes separadas referentes a la privacidad que pueden aplicarse a requisitos legales adicionales. Si las leyes de privacidad del estado son más estrictas que las leyes federales, las leyes estatales son las que regirán por encima de las leyes federales.

Sus Derechos a Recibir Información Sobre su Salud

Aun cuando su expediente médico es propiedad del hospital que lo recopiló, usted tiene derecho a:

• Inspeccionar y Copiar: Usted tiene derecho a inspeccionar y obtener una copia de su expediente que puede utilizarse para tomar decisiones sobre su salud que por lo general incluye registros médicos y de facturación pero no abarca notas sobre psicoterapia. Es posible que nos neguemos a permitirle que inspeccione y copie la información bajo ciertas circunstancias limitadas. Si le llegaran a negar acceso a la información sobre su salud, puede usted solicitar que se revise la negativa en cuyo caso, el hospital elegirá a otro profesional de la salud para revisar su solicitud y la negativa de manera que la persona que lleve a cabo la revisión no sea la misma que se negara a aceptar su solicitud y acataremos los resultados de dicha revisión.

• Enmiendas: Si piensa usted que la informaci?ón sobre su salud es incorrecta o está incompleta, puede pedirnos que enmendemos dicha información. Usted tiene derecho a solicitar una enmienda durante todo el tiempo que la información se encuentre en poder del hospital o a su disposición. Tal vez nos neguemos a aceptar su solicitud de una enmienda en cuyo caso, le notificaremos la razón de dicha negativa.

• Una Contabilización de las Revelaciones: Tiene usted derecho a solicitar que le den cuenta sobre las diferentes revelaciones o sea una lista de las revelaciones que lleguemos tratamientos anteriores que tal vez puedan afectar el tratamiento que se dé en ese momento. a hacer acerca de la información sobre su salud para propósitos distintos al tratamiento, pago u operaciones de atención de la salud cuando no se requiera de una autorización.

• Restricciones de Solicitud: Tiene usted el derecho a solicitar una restricción o limitación a la información de su salud que empleemos o revelemos con referencia a su tratamiento, el pago o las operaciones de atención de la salud. También tiene usted el derecho a solicitar que se limite la información de su expediente que podamos revelar a alguien que participe en su atención o el pago de su tratamiento como sería un familiar o amigo; por ejemplo: puede usted pedir que no empleemos o revelemos información acerca de la cirugía que se le practicó. No tenemos la obligación de cumplir con su petición. Sin embargo, si estamos de acuerdo, acataremos su solicitud a menos que la información se necesite para darle algún tratamiento de urgencia.

• Solicitar Comunicaciones Confidenciales: Tiene usted derecho a solicitar que nos comuniquemos con usted en materia de asuntos médicos en cierta forma o en cierto lugar; por ejemplo: es posible que usted nos pida que le llamemos a su lugar de trabajo en lugar de su casa. El hospital cumplirá con las solicitudes razonables respecto a comunicaciones confidenciales enviadas a un lugar alternativo y/o a través de medios alternativos sólo en el caso de que la solicitud se presente por escrito e incluya un domicilio en el cual la persona reciba sus facturas por los servicios prestados por el hospital y que se relacionen con correspondencia referente al pago de los servicios. Le rogamos que se percate de que nos reservamos el derecho de ponernos en contacto con usted a través de otros medios y en otros lugares si usted no responde a nuestras comunicaciones requiriendo una respuesta pero antes de intentar ponernos en contacto con usted a través de otros medios o en otro lugar, le enviaremos la notificación correspondiente de acuerdo con su solicitud original.

• Una Copia Impresa del Presente Aviso: Tiene usted derecho a recibir una copia impresa del presente aviso que puede usted solicitar en cualquier momento aunque haya usted aceptado que se lo enviemos por medios electrónicos.

Si el hospital cuenta con una página de Internet, puede usted imprimir o consultar una copia del aviso haciendo clic en el enlace "Notice of Privacy Practices" (Aviso Sobre las Prácticas de Privacidad).

Para ejercer cualquiera de sus derechos, favor de obtener las formas necesarias del Funcionario de Privacidad y presentar su solicitud por escrito.

CAMBIOS AL PRESENTE AVISO

Nos reservamos el derecho de modificar el presente aviso y el aviso revisado o modificado entrará en vigor en lo tocante a información que ya tengamos sobre usted así como información que recabemos en el futuro. El presente aviso se colocará en carteles en toda la unidad e incluirá la fecha de vigencia. Además, cada vez que usted se registre o sea admitido al hospital para servicios de tratamiento o atención de la salud en calidad de paciente interno o externo, le ofreceremos una copia del aviso que esté en vigor en ese momento.

QUEJAS

Si cree usted que se han violado sus derechos a la privacidad, puede presentar una queja ante el hospital siguiendo el proceso detallado en la documentaci?ón de Patient Rights del hospital. También puede procesar su queja ante la Secretaria del Departamento de Salud y Servicios Humanos. Todas las quejas deberán presentarse por escrito.

No se le penalizará por presentar una queja.

OTROS USOS DE LA INFORMACIÓN SOBRE SU SALUD

Si llegara a ser necesario que revelemos o hagamos usos de la información sobre su salud, que no estén cubiertos bajo el presente aviso o las leyes pertinentes, lo haremos sólo con su autorización por escrito. Si usted nos da autorización para emplear o revelar información sobre su salud, puede revocar dicha autorización, por escrito, en cualquier momento, en cuyo caso, ya no podremos hacer uso o revelar la información sobre su salud para las razones incluidas en su autorización por escrito. Se entiende que usted no podrá negar ninguna revelación que ya hayamos hecho con su autorización y que debemos conservar en nuestros archivos la información sobre la atención que le hayamos prestado.

FUNCIONARIO DE PRIVACIDAD DEL HOSPITAL:

Kellie Barnett
Telephone Number:361−761−3728

CORPUS CHRISTI MEDICAL CENTER

Patent Name: _____

Admission/Registration Date: _____

Account Number: _____

I understand that my protected healthcare information may be disclosed to my family members and others as designated by me. I will provide those individuals with a passcode or other verification means specified by the hospital for this purpose.

The password for this visit is:

The passcode is a verification tool to determine the individual's relationship to the patient and to permit the release of protected health information relevant to such individual's involvement with the patient's healthcare or payment.

The passcode does not replace or substitute the patient's authorization to obtain a copy of or access to the patient's medical and/or billing record.

Please Note: This notice contains protected health information which is privileged and confidential and is intended for use only by the above named patient.

If you are not the intended recipient of this document please be advised that you have received this document in error and that any use, dissemination, distribution or copying is strictly prohibited. If you have received this document in error, please promptly return it to an employee of the hospital so that it may be properly disposed.

PATIENT COPY –SIGNATURE ON FILE

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Paciente Nombre: _____

Admisi?ón/Matrícula Fecha: _____

D?é cuenta el Número: _____

Entiendo que mi ha informaci?ón protegida de asistencia sanitaria puede ser revelada a mis miembros de la familia y otros como designado por mí. Proporcionaré esos individuos con un passcode u otra comprobación significan especificado por el hospital para este propósito.

La se?ña para esta visita es:

El passcode es un instrumento de comprobaci?ón de determinar la relación del individuo al paciente y para permitir la liberación de información protegida de salud pertinente a tal envolvimiento del individuo con la asistencia sanitaria de paciente o pago.

El passcode no reemplaza ni substituye la autorizaci?ón de paciente para obtener una copia de ni del acceso al registro médico y/o facturando del paciente.

Favor de notar: Esta nota contiene informaci?ón protegida de salud que se privilegia y confidencial y es pensado para el uso sólo por el encima de paciente denominado.

Si usted no es el recipiente destinado de este documento sea avisado por favor que usted ha recibido este documento en el error y que ning?ún uso, la diseminación, la distribución ni copiar se prohiben estrictamente. Si usted ha recibido este documento en el error, por favor inmediatamente lo vuelve a un empleado del hospital para que lo se pueda disponer apropiadamente.

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

Separate Billing For Professional Services

This information is provided to help you understand which charges are for hospital services and which charges are for professional associates who are independent contractors at Corpus Christi Medical Center.

ER Services −Patients who are seen in the Hospital's Emergency Department or Patients having studies done at the Hospital Laboratory, Radiology, EEG/EKG, Radiation Therapy or Anesthesia will also receive a SEPARATE bill from the physician/specialist rendering services or interpreting studies.

Bay Area, Doctors	**GHEP−CCPLLC** **3765 S. Alameda, Corpus Christi** **281−784−1111**
NorthWest	**The Schumacher Group** **4849 Greenville Ave, Dallas Tx 75206** **866−816−2822**

Anesthesia −For the services of an anesthesiologist to stand by or administer anesthesia during a surgical or invasive procedure, or to assist in an emergency care situation, call

Bay Area, Doctors	**Premier Anesthesia Group** **3650 Mancell Rd. Suite 310, Alpharetta, GA 3002** **800.562−8663**
Bay Area, Doctors	**Bay Area Anesthesia Group** **4444 Corona St, Suite 232, Corpus Christi, TX 78411** **361−857−8525**

Pathology −For professional service rendered in the clinical laboratory by a physician specializing in clinical laboratory and pathological interpretation. These services including laboratory test results, microscopic examination and medical management. Please contact:

Bay Area, Doctors	**Pathology Associates** **PO Box 3758, Corpus Christi, TX 78463−3703** **361−992−4040**

Radiology −For interpretations of all X−Raystudies, fluoroscopic and special procedures by a physician who is a specialist in the field of radiology, you may receive a bill from:

Bay Area, Doctors, NorthWest	**Radiology Associates** **4444 Corona St, Suite 200, Corpus Christi, TX 78411** **361−561−3100**

Additionally, some of the physicians may be out of network with your insurance plan.

I have read and understand that I will receive a SEPARATE bill from the physician/specialist rendering services or interpreting studies as indicated above.

PATIENT COPY −SIGNATURE ON FILE

Corpus Christi Medical Center
Separate Bills for Professional Services

DOB: MR#

EADMF3051 NWERRP50 14:55 06−07−07

SMOKING CESSATION INSTRUCTIONS / GETTING READY FOR DISCHARGE INFORMATION

Quitting takes hard work and a lot of effort, but you can quit Smoking.

Five Keys for Quitting:

1. GET READY.
Set a quit date and stick to it−not even a single puff!

2. GET SUPPORT AND ENCOURAGEMENT.
Tell your family, friends, and co−workersyou are quitting.

3. LEARN NEW SKILLS AND BEHAVIORS.
When you first try to quit, change your routine. Reduce stress.

4. GET MEDICATION AND USE IT CORRECTLY.
Talk with your health care provider about which medication will work best for you.

5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.
Avoid alcohol.
Eat a healthy diet and stay active.

ADDITIONAL RESOURCES:

American Cancer Society Quitline
1−877−YES−QUIT(1−877−937−7848)

American Heart Association
713−610−5000/www.americanheart.org

American Lung Association
www.lungusa.org

CDC−Tobacco Information and Prevention Source
www.cdc.gov/tobacco

PATIENT COPY −SIGNATURE ON FILE

Corpus Christi Medical Center
Smoking Cessation
Getting Ready for Discharge Information

DOB: MR#

Patient Name:

Patient ID Number:

Physician:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938−0692

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: TMF Health Quality Institute 1−800−725−8339 (TTY 1−877−486−2048)

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 the 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 361−761−1518.

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

Signature of Patient or Representative Date

DOB: MR#

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 copays and deductibles).

Here is the contact information for the QIO:

TMF Health Quality Institute
Instructions on Filing an Appeal:
1−800−725−8339 (TTY 1−877−486−2048)

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 Corpus Christi Medical Center

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 case.

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 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 (1−800633−4227), or TTY: 1−877−486−2048.

Additional Information:

DOB: MR#

Nombre del paciente:

Nœmerode identificaci n del paciente:

MØdico:

DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS
Centros de Servicios de Medicare y Medicaid
No de aprobaci n OMB 0938-0692

MENSAJE IMPORTANTE DE MEDICARE SOBRE SUS DERECHOS

COMO PACIENTE INTERNO, USTED TIENE EL DERECHO A:

- Recibir servicios cubiertos por Medicare. Esto incluye servicios de hospital necesarios desde el punto de vista mØdicoy servicios que podr a necesitar despuØsde la salida (dado de alta), si son ordenados por el mØdico.Tiene el derecho a estar informado sobre estos servicios, quiØnpagarÆy d nde obtenerlos.

- Participar en toda decisi n sobre la estad a en el hospital y saber quiØnla pagarÆ.

- Notificar toda preocupaci n que tenga sobre la calidad de la atenci n recibida a la Organizaci n para el Mejoramiento de la Calidad (QIO) mencionada aqu **TMF Health Quality Institute 1−800−725−8339(TTY 1−877−486−2048)**.

SUS DERECHOS DE MEDICARE PARA SALIR DEL HOSPITAL
Planificaci n para su salida (dado de alta): Durante la estad a en el hospital, el personal cooperarÆcon usted para prepararlo para que su salida no presente riesgos y organizar los servicios que usted podr a necesitar despuØsde salir del hospital. Cuando ya no necesite recibir la atenci n de hospital como paciente interno, el mØdicoo el personal del hospital le informarÆnla fecha de su salida.

Si piensa que su salida es muy apresurada:

- Puede hablar con el personal del hospital, su mØdicoy la administraci n de su plan de cuidado de la salud (si pertenece a uno de ellos) sobre sus preocupaciones.

- TambiØntiene el derecho de apelar, es decir, pedir una revisi n de su caso por una Organizaci n para el Mejoramiento de la Calidad (QIO, por sus siglas en inglØs).El QIO es un organizaci n externa contratada por Medicare para revisar el caso a fin de decidir si usted estÆlisto para salir del hospital.

  - **Si desea apelar, debe comunicarse con el QIO antes de la fecha de su salida (dado de alta) planificada y antes de salir del hospital.**

  - En tal caso, no tendrÆque pagar los servicios que reciba durante el proceso de apelaci n (con excepci n de los cargos como copagos y deducibles).

- Si no apela la decisi n, pero decide permanecer en el hospital mÆsallÆde la fecha de salida (dado de alta) planificada, tal vez tenga que pagar el costo de los servicios que reciba despuØsde esa fecha.

- ***La pÆgina2 incluye instrucciones paso por paso para comunicarse con el QIO y presentar una apelaci n .***

Si desea hablar con alguien en el hospital sobre este aviso, llame al 361−761−1518.

Favor de firmar y escribir la fecha para mostrar que recibi este aviso y que entiende sus derechos.

_____ _____

Firma del paciente o representante Fecha

DOB: MR#

PASOS PARA APELAR UNA SALIDA

- ***PASO 1:*** Debe comunicarse con el QIO antes de la fecha de su salida (dado de alta) planificada y antes de salir del hospital. En tal caso, no tendrÆque pagar los servicios que reciba durante la apelaci n (con excepci n de los cargos como copagos y deducibles).

  - Esta es la informaci n para comunicarse con el QIO:

    TMF Health Quality Institute
    Instructions on Filing an Appeal:
    1−800−725−8339(TTY 1−877−486−2048)

  - Puede presentar una solicitud de apelaci n cualquier d a de la semana. **Una vez que hable con alguien o deje un mensaje, ha comenzado la apelaci n.**

  - Puede pedir ayuda al hospital para comunicarse con el QIO si fuera necesario.

  - El nombre de este hospital es Corpus Christi Medical Center

- ***PASO 2:*** RecibirÆun aviso detallado del hospital o del plan Medicare Advantage u otro plan de cuidado de salud administrado de Medicare (si pertenece a uno de ellos) que explica las razones por las que consideran que usted estÆlisto para ser dado de alta.

- ***PASO 3:*** El QIO le solicitarÆsu opini n. Usted o su representante necesitan estar disponibles para hablar con el QIO, si se solicita. Usted o su representante pueden presentar al QIO una declaraci n escrita, pero no se le exige que as lo haga.

- ***PASO 4:*** El QIO revisarÆsu historial mØdicoy otra informaci n importante sobre su caso.

- ***PASO 5:*** El QIO le notificarÆsobre su decisi n en el lapso de 1 d a despuØsde recibir toda la informaci n necesaria.

  - Si el QIO determina que usted no estÆlisto para ser dado de alta, Medicare continuarÆ cubriendo el costo de los servicios de hospital.

  - Si el QIO determina que usted estÆlisto para ser dado de alta, Medicare continuarÆ pagando sus servicios hasta el mediod a del d a **despuØs**que el QIO le notifique a usted su decisi n.

SI NO CUMPLE CON LA FECHA L´MITE PARA LA APELACI N, USTED TIENE OTROS DERECHOS DE APELACI N:

- Todav a puede solicitar al QIO o a su plan (si pertenece a uno de ellos) que revisen su caso:
  - Si tiene Medicare Original: Llame al QIO mencionado arriba.
  - Si pertenece al plan Medicare Advantage o a otro plan de cuidado de salud administrado de Medicare: Llame a su plan.
- Si usted se queda en el hospital, el hospital puede cobrarle el costo de los servicios que reciba despuØsde la fecha de su salida (dado de alta) planificada.

Si desea mÆsinformaci n, llame GRATIS al 1-800-MEDICARE (1-800-633-4227) o TTY: 1-877-486-2048.

Informaci n adicional:

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT
You have the right, to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "DRG's" or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and for any post−hospital services.

You have the right to request a review by a TRICARE Regional Review Authority (RRA) of any written Notice of Non−coverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. RRA's employ groups of doctors under contract by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of the RRA for your area are:

Humana Military Healthcare Services, Inc.
Utilization Management
P.O. Box 740044
Louisville, KY 40201−9973
1−800−658−1405

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL
You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post−hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON
Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Non−coverage." You must have this Notice of Non−coverage if you wish to exercise your right to request a review by the RRA. The Notice of Non−coverage will state either that your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care. If the hospital and your doctor agree, the RRA does not review your case before a Notice of Non−coverage is issued. But the RRA will respond to your request for a review of your Notice of Non−coverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision if you request the review by noon of the first workday after you receive the Notice of Non−coverage. If the hospital and your doctor disagree, the hospital may request the RRA to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation, the RRA must agree with the hospital or the hospital cannot issue a Notice of Non−coverage. You may request that the RRA reconsider your case after you receive a Notice of Non−coverage but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW. THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING THE DAY FOLLOWING THE DAY OF RECEIPT OF THE HOSPITAL NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the Notice of Non−coverage states that your physician agrees with the hospital's decision:
?· Call the RRA 1−800−334−5612 by noon of the first work day after you receive the notice of noncoverage and request a review.
· The RRA must ask for your views about your case before making its decision. The RRA will inform you by phone and in writing of its decision on the review.
· If the RRA agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the RRA's decision.
· Thus, you will not be responsible for the cost of hospital care before you receive the RRA's decision.

If the Notice of Noncoverage states that the RRA agrees with the hospital's decision:
· You should make your request for reconsideration to the RRA immediately upon receipt of the Notice of Noncoverage by contacting the RRA in writing.
· The RRA can take up to three working days from receipt of your request to complete the review. The RRA will inform you in writing of its decision on the review.
· Since the RRA has already reviewed your case once, prior to issuance of the Notice of Non−coverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Non−coverage even if the RRA has not completed its review.
· Thus, if the RRA continues to agree with the Notice of Non−coverage, you may have to pay for least one day of hospital care.

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of the TRICARE decision to no longer pay for your Care at any point during your hospital stay or after you leave the hospital. The Notice of Non−coverage tells you how to request this review.

POST−HOSPITAL CARE
When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Tricare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, health benefits advisor, patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions. Questions involving billing or specific benefit coverage issues should be addressed to your TRICARE claims processor:

Palmetto Government Benefits Administrators (PGBA) Correspondence
P.O. Box 7032
Camden, SC 29020−7032
(800) 403−3950

ACKNOWLEDGMENT OF RECEIPT
My signature only acknowledges my receipt of this Message from HCA and does not waive any of my rights to request a review or make me liable for any payment.

PATIENT COPY −SIGNATURE ON FILE

Corpus Christi Medical Center
An Important Message from Tricare

DOB: MR#

EADMF3059 NWERRP50 14:55 06−07−07

CORPUS CHRISTI MEDICAL CENTER

" I understand that, in the opinion of Corpus Christi Medical Center, the services or items that I have requested to be provided to me on _____ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del Corpus Christi Medical Center, es posible que Medicaid no cubra los servicios o las provisiones que solicite _____ por no considerarlos razonables mi medicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad medical de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si después se determina que esos servicios y provisiones no son razonables ni medicamente necesarios para mi salud."

PATIENT COPY −SIGNATURE ON FILE

Corpus Christi Medical Center
Client Acknowledgement Statement

DOB: MR#

Comprehensive Discharge Planning with Your Needs First

- **Your Medications**
- **Diet Instructions**
- **Monitoring Your Weight**
- **Follow Up with your Doctors**
- **Signs and Symptoms You Should Watch For**
- **Quitting Smoking**
- **Vaccinations**
- **Activity**

Your Medications

At Corpus Christi Medical Center, doctors, nurses, and other caregivers are dedicated to providing safe patient care.
Although there are many things we do day to day to keep you safe, you as a patient are important in contributing to your care and safety. It is important that you communicate honestly with your nurses and doctor.

Corpus Christi Medical Center has implemented a process to reconcile your medications across the healthcare continuum. Medication Reconciliation is a process of ensuring that caregivers and pharmacies receive the most up-to-date list of medications you are currently prescribed. This includes name of medication, dosage, frequency and manner in which you are taking the medication (such as by pill or liquid). Modern drugs are very powerful. They are tremendously effective but can also be very dangerous if not taken in the exact dose, considering all possible interactions. It is not uncommon for a patient to bring a paper bag to the hospital full of medications dating back many years. Also, many patients are taking herbal and botanical agents, such as garlic, that may interfere with medications they receive in the hospital. A thorough review of your medications to identify all the medications and herbal agents you are taking can eliminate potential problems.

We will ask you about all the medications, over-the-counter drugs, herbals and botanical agents that you are taking at home. Your doctor, the pharmacist and your nurse will work together to reconcile your medications and make sure you are taking the appropriate medications, the right dosage, frequency and the way you are taking them so that you are safe from reactions and/or side effects when you are admitted to Corpus Christi Medical Center. If you transfer from one floor to another and upon discharge, we will again review all your medications and reconcile them each time to ensure your medication safety.

Diet Instructions

It is recommended for many conditions and health problems, such as having surgery, diabetes, heart failure and many others, that patients pay special attention to the foods they eat, and even avoid certain kinds of foods or food additives altogether. When you are admitted to hospital at Corpus Christi Medical Center, your nurse will ask you a series of questions about your current diet, weight, and/or weight loss. Your accurate answers to these questions are very important because they will help us help you access the expertise of our clinical dieticians if you are at high risk. Patients with heart disease and diabetes in particular should be careful to follow the diet their doctor prescribes, and limit their intake of salt and high fat foods.

Monitoring Your Weight

Monitoring changes in your weight is a good health practice for everyone. For some of our patients, especially patients with heart failure, kidney disease, diabetes and those who are pregnant, careful weight monitoring is essential. Progressive gain of a pound or two over a period of only a few days can be a critical warning that something is wrong and you should call your doctor.

Signs and Symptoms that Your Condition is Worsening

Many pressures exist in the healthcare industry today to get patients home as fast as possible. Some are to save you money, but also, because we know that once the acute phase of an illness is passed, the vast majority of patients do much better completing recovery at home among caring family and familiar surroundings. For this reason, it is critical that you know what signs and symptoms to watch for and immediately report to your doctor. Some of the signs and symptoms every patient should watch for during the weeks following discharge include: increasing fatigue, pain that gets worse instead of better with time, leg pain or chest pain with and without activity, shortness of breath, fever, or development of a rash. Some patients who have chronic health conditions such as kidney disease, heart failure and diabetes should continuously monitor for these signs and report them any time they become troublesome.

Following Up With Your Doctors

While in the hospital you will be seen by the doctor who ordered your admission. In some cases you may also be seen by specialists that your doctor has asked to consult on your case. When you are discharged, it is important that you know what instructions your doctor and each specialist has left for you to follow. Some specialists may not wish to see you in their offices after you go home, others will. In most cases, on the day of discharge, your nurse will give you a list of your appointments with office telephone numbers. It is important that you ask to be sure you have all of the instructions intended for you.

Quitting Smoking:

In addition to this brochure, we have included a separate information sheet complete with phone numbers and websites that you can use if you are a smoker and wish to follow your doctor's advice to quit.

If you are not a smoker, we encourage you to share that information sheet with friends or family members who are.

Quitting smoking is one of the single most important things you can do to reduce your risk of many illnesses including, many types of cancer, lung diseases, heart disease, and stroke, just to name a few.

Vaccinations

When you are admitted to the hospital, your nurse will ask you about your vaccination status. In the state of Texas it is now the law that every hospital offer two critical vaccinations to patients 65 years of age and older who are admitted for 24 hours or longer. Barring supply shortages that sometimes occur, the Pneumococcal vaccination is available year round, and the Influenza vaccine is available during flu season.

Ask your nurse or your doctor about giving you these vaccinations. Patients over 65 in particular can significantly reduce their risk of pneumonia by keeping up to date with these two important vaccinations.

Activity

Check with your physician before you do any type of exercise. If it is okay with your physician for you to exercise, start slowly. Walking is excellent excercise, ask your physician for details.

CORPUS CHRISTI MEDICAL CENTER

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Corpus Christi, Texas 78412
(361) 761-1200
www.ccmedicalcenter.com

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Comprehensive Discharge Planning with Your Needs First

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- **Diet Instructions**
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Plan Comprensivo de Salida

Poniendo sus necesidades primero

- **Sus Medicamentos**
- **Instrucciones Sobre su Dieta**
- **Controlando su Peso**
- **Seguimiento con su Doctor**
- **Se?æales y Sintomas de Advertencia**
- **Dejar de Fumar**
- **Vacunas**

Sus Medicamentos

En Corpus Christi Medical Center, los doctores, enfermeros y otros proveedores de servicios m?édicos están dedicados a proveer cuidado suguro a los pacientes. Aunque hay muchas cosas que hacemos día con día para mantenerlo seguro, es muy importante que usted se comuniqué con honestidad con sus enfermeros y doctores. Corpus Christi Medical Center ha implementado un procesó de "reconciliación" de medicamentos a través de toda la red medica. La Reconciliación de Medicamentos es el proceso de asegurar que los proveedores de servicios médicos y farmacéuticos *reciban la lista de medicinas más actualizada que a usted se le ha recetado. Esto incluye el nombre del medicamento, dosis, frecuencia y modo de empleo (ya sea píldora o liquidó). Las medicinas modernas son muy fuertes. Son grandemente efectivas pero pueden también ser muy peligrosas si no se toma la dosis exacta considerando todas las posibles interacciones. Es muy común que un paciente traiga al hospital una bolsa de papel llena de medicinas con fecha de caducidad vencida. También, muchos pacientes toman agentes botánicos y hierbas tales como el ajo, que interfieren con el medicamento que recibe en el hospital. Una evaluación rígida de todos sus medicamentos para identificar todas las medicinas y agentes herbales que usted esta tomando eliminara problemas potenciales.
Le preguntaremos sobre todo su medicamento, medicamentos sin receta m?édica, agentes botánicos y hierbas que toma en casa. Su doctor, farmacéutico y su enfermera trabajaran juntos para reconciliar sus medicamentos y asegurarse que este tomando el medicamento apropiado, la dosis correcta, frecuencia y la forma en la que se esta tomando para así evitar efectos secundarios o reacciones cuando sea admitido a CCMC. Si la cambian de un piso a otro o a la hora de salida del hospital, revisaremos su medicamento de nuevo para asegurarnos que este bien.

Instrucciones sobre su Dieta

Es recomendado por muchas condiciones y problemas de salud, como cirug?ías, diabetes, problemas de corazón y muchos más, que los pacientes presten atención especial a ciertas comidas que consume, y tratar de evitar ciertas comidas y preservativos. Cuando es admitida al hospital, su enfermera le preguntara una serie de preguntas sobre su dieta, peso, yo p?érdida de peso. El que conteste con certeza es muy importante para ayudarle a que le ayudamos obtener lo mejor de nuestros dietistas expertos para reconocer si esta en alto riesgo. Los pacientes con problemas del corazón y diabetes en particular deben tener cuidado en seguir a dieta prescrita por su medico, y limitar la sal y comidas grasosas.

Controlando su Peso

Controlar cambios en su peso es una buena pr?áctica de salud para todos. Para algunos de nuestros pacientes, especialmente los pacientes con problemas de coraz?ón, riñón, diabetes y las embarazadas, control de peso es esencial. El aumento progresivo de una a dos libras en unos cuantos d?ías puede ser una alerta critica que algo anda mal y debe llamar a su doctor.

Se?ñales y Síntomas de que su Condición esta Empeorando

Hoy en d?ía, existen muchas presiones dentro de la industria médica, en mandar al paciente a casa lo antes posible. Algunas veces para ahorrar dinero, pero también, porque sabemos que pasando la etapa mas critica de la enfermedad, la mayoría de los pacientes terminan la etapa de recuperación mejor a lado de sus familiares. Por esta razón, es crítico que usted este consiente de cuales son las señales y síntomas a conocer para que de inmediatamente llame a su doctor. Algunas de las señales y síntomas todos los pacientes deben cuidar después de su salida del hospital incluyen: Cansancio, dolor que aumenta y no mejora, dolor en la pierna o pecho con o sin actividad, respiración corta, fiebre, o sarpullido. Pacientes con condiciones crónicas como enfermedades del riñón, problemas del corazón y diabetes deben considerar continuamente estas señales y síntomas y repórtalas cada vez que sea necesario.

Seguimiento con Su Doctor

Mientras este en el hospital el doctor que dio la orden de admisi?ón es el doctor que lo visitara. En algunos casos podrá ser visitado por especialistas el cual su doctor le pidió una ínter consulta. Cuando salga del hospital, es importante que usted conozca las instrucciones a seguir de su doctor o especialista. Algunos especialistas desearan no verlo en su oficina después que salio del hospital, algunos si. En muchos casos, en el día de salida, su enfermero le dará una lista de citas y números de teléfonos. Es importante
que pregunte si las instrucciones recibidas son de usted.

Dejar de Fumar

Aparte de este folleto, hemos incluido una hoja de informaci?ón que incluye números de teléfono y páginas de Internet que usted puede utilizar en caso de que usted sea fumador y quiera seguir el consejo de su doctor para dejar de fumar.
Si usted no es fumador, le invitamos a que comparta esta hoja de informaci?ón con amigos y familiares que si lo son.

El dejar de fumar es la cosa m?ás importante que usted puede hacer para reducir el riesgo de enfermedades, incluyendo los muchos tipos de cáncer, enfermedades del pulmón, ataques al corazón y otros males relacionados entre otros. .

Vacunas:

Cuando lo admiten al hospital, su enfermera le preguntara sobre el estado de vacunas. En el Estado de Texas es ahora ley que todo hospital ofrezca dos vacunas cr?íticas a pacientes de más de 65 anos de edad y que estén internados por m?ás de 24 horas. Debido a la escasez en las que a veces suelen suceder, la vacuna Pneumococcal es disponible todo el año, y la vacuna en contra de la influenza es disponible durante la temporada de la influenza.
Pregunte a su enfermero o doctor como obtener estas vacunas. Los pacientes de m?ás de 65 anos en particular pueden reducir el riesgo de contraer neumonía permaneciéndose al corriente con estas dos vacunas importantes.

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When you apply for or receive mental health services in the State of Texas, you have many rights. Your most important rights are listed on these four pages. These rights apply to all persons unless otherwise restricted by law or court order. A judge or lawyer will refer to the actual laws. If you want a copy of the laws these rights come from, you can call the Health Facility Licensure and Certification Division of the Texas Department of State Health Services at 1-888-973-0022.

It is the responsibility of this hospital under law to make sure you have been informed of your rights. But just giving you this information does not mean your rights have been protected. This hospital is required to respect and provide for your rights in order to maintain licensure and do business in this state.

Your Right to Know Your Rights

You have the right, under the rules by which this hospital is licensed, to be given a copy of these rights before you are admitted to the hospital as a patient. If you so desire a copy should also be given to the person of your choice. If a guardian has been appointed for you or you are under 18 years of age, a copy will also be given to your guardian, parent, or conservator.

You also have the right to have these rights explained to you aloud in simple Terms in a way you can understand within 24 hours of being admitted to the Hospital to receive services (e.g., in your language if you are not English-speaking, in sign language if you are hearing impaired, in Braille if you are Visually impaired, or other appropriate methods).

Your Right to Make a Complaint

You have the right, to make a complaint and to be told how to contact people who can help you. These people and their addressed and phone numbers are listed below.

You have the right to be told about Advocacy, Inc., when you first enter the hospital and when you leave. Information about how to contact Advocacy, Inc., is also listed below.

If you believe any of your rights have been violated or you have other concerns about your care in this hospital, you may contact one or more of the following:

Health Facility Licensure and Certification Division
Texas Department of State Health Services
1100 W. 49th Street 1-888-973-0022
Austin, Texas 78756

Advocacy, Incorporated 1-800-315-3876
7800 Shoal Creek Blvd., Suite 171E
Austin, Texas 78757

Corpus Christi Medical Center
Department of Psychiatry:
Service Line Director – Jamie Molbert
(361) 767-4400
Clinical Services Director – Lisa Margraves
(361) 767-4400
Director of Nursing – Debra Christensen
(361) 767-4400
Patient Advocate – Jamie Molbert
(361) 767-4400

If you have been involuntarily committed and you believe that your attorney did not prepare your case properly or that your attorney failed to represent your point of view to the judge, you may wish to report the attorney's behavior to the Ethics Committee of the State Bar of Texas by writing:

Disciplinary Council
State Bar of Texas
1414 Colorado
P.O. Box 12487
Austin, Texas 78711-2487

If you are a voluntary patient <u>OR</u> if you have been taken to the hospital against your will, turn to pages three and four for a listing of your special rights under law in Texas. All patients should read pages two and three, which explain the rights that apply to everyone receiving services at this hospital.

STATEMENT THAT YOU HAVE RECEIVED THIS PAMPHLET/IT HAS BEEN EXPLAINED

I certify that:

____ I have received a copy of this four-page document prior to admission
____ Staff have explained its content to me in a language I understand within 24 hours of admission (if involuntarily committed).
____ Staff have explained its content to me in a language I understand prior to admission (if voluntarily committed).

Name: _____ Witness: _____

Date : _____ Date : _____

Relationship of witness to patient:

_____

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

As a patient in Psychiatric Services at CCMC, you have the right to be told in advance of any charges being made, the cost of services, sources of the programs reimbursement and any limitations placed on your length of stay/services.

Our estimated hospital charge per day for services rendered is $1,400.00 per day.

This charge is a result of the appropriate services provided in the Department of Psychiatry as ordered by your physician(s) for your plan of treatment. This estimated charge may be more or less depending on the services your physician(s) orders.

NOTE:

Verification by a third-party carrier is not a guarantee of coverage and/or payment for this hospitalization. Payment of benefits is subject to any subsequent review(s) of medical information of records, eligibility on the date(s) of service, and any other contractual limitations (including any limitations contained in riders) such as pre-existing conditions, cosmetic procedures, other non-covered services, or failure of the patient to notify the carrier in a timely manner of his hospitalization.

I understand that should my insurance carrier fail to pay for services rendered due to non-coverage, I will be responsible for entire bill.

If you have any questions regarding CCMC billing or financial arrangements, you may contact:

CUSTOMER SERVICE
866-453-5906

On occasion, some of our patients/residents may experience a temporary episode of confusion or behavioral changes that may pose a risk of injury to themselves or others. Conditions that may contribute to confusion or behavioral changes are:

- Medication side effects
- Change in surroundings
- Psychiatric conditions

Employees are highly trained to initiate the procedures in a way that avoids undue physical discomfort or harm and to use only minimal amount of physical force that is reasonable and necessary. Restraint is not used as a punishment, for the purpose of convenience, or as a substitute for effective treatment.

Restraint is initiated only when all other less restrictive non-physical means are not effective. Confusion or dangerous behaviors can prevent you/your family member from accurately assessing physical surroundings that could cause harm. During these temporary episodes, the physician and nurses may identify the need for restraint to safely care for you/your family member. These devices may be in the form of vests, belts, or wristlets. While restraints are in place, you/your family member will be observed frequently by our staff to ensure your privacy, personal dignity, safety and well-being are safeguarded whenever it becomes necessary to physically restrain.

As you/your family member's physical condition improve, and the confusion and dangerous behavior decreases, you/he/she will be assessed for the continued need for a restraint. You/your family member's safety and emotional needs are always a primary concern to us while you/he/she are with us at CCMC.

In the Psychiatry Department, seclusion may be used as an option to provide safety. Again, as mentioned above with restraints, seclusion will be used when less restrictive measures have failed and there is still danger to you/your family member or others. As the dangerous behavior decreases, you/he/she will be evaluated for the continued need for seclusion. Following seclusion, you/your family member will be debriefed to make sure emotional needs are met and that the transition back into the unit is smooth and safe.

I/We give my permission for the use of physical restraint(s).

I/We understand the possible complications that can occur with the use of restraints include but are not limited to: reduced range of motion, neurovascular injury, decreased ability to ambulate, symptoms of withdrawal or depression, and reduced social contact.

I/We understand that the restrained body part will be examined and observed by licensed medical personnel and each restraint will be removed at least every two (2) hours to allow range of motion exercises, repositioning for comfort, and assistance with any personal needs. The nurses' call light will be left within the patient's reach at all times and the patient will be observed closely. Furthermore, the physical restraint will be terminated as soon as possible as the need is eliminated.

My signature below constitutes acknowledgement that I have read and agree to the foregoing.

Patient/Legal Representative Signature _____ Date: _____ Time: _____

Staff Witness/Provider of Explanation: _____ Date: _____ Time: _____

Second Witness Signature: _____ Date: _____ Time: _____
(for phone consent)

Organization Philosophy Regarding Restraints and Seclusion/Consent

CORPUS CHRISTI MEDICAL CENTER

DOB: MR#

The items checked below indicate that an explanation was given:

_____Welcome Packet _____Cost of Services

_____Complaint Procedure _____Rules and Regulations

I UNDERSTAND:

1. I agree that Dr. _____ will be the attending physician.

2. I understand that I am expected to participate in my treatment plan.

_____
Patient Signature or Person Authorized to Sign for Patient

_____
Witness

_____
Date

I _____ (Charge Nurse or Supervisor), as the facility administrator designee, accept this patient for admission.

_____
Signature

_____
Date

I _____ hereby apply to be admitted as a voluntary patient to the Department of Psychiatry of Corpus Christi Medical Center in Nueces County, Texas. The admission to our Psychiatric Inpatient Program is for diagnosis, observation, care, and treatment until discharge or until a request for discharge from the hospital is made. I understand that verbal statements of the desire to be discharged will be treated as written requests for release and will be recorded by staff if necessary.

I understand that I have the right to be discharged from the facility within four (4) hours of requesting discharge. There are only three (3) reasons why I would not be able to be discharged:

1. If I change my mind and want to stay, I can sign a paper that says I do not wish to leave, or I can tell a staff member that I do not want to leave, and the staff member has to write it down for me.
2. If the patient is under 16 years old, and the person who admitted the patient (parents, guardian, or conservator) does not want the patient to leave, the patient may not be able to leave. If the patient requests release, the staff must explain to the patient whether or not the patient can sign himself/herself out and why. The facility must notify the person who does have the authority to sign the patient out and tell that person that the patient wants to leave. That person must talk to the patient's doctor, and the patient's doctor must document the date, time, and outcome of the conversation in the patient's medical record.
3. The patient may be detained longer than four (4) hours if the patient's doctor has reasons to believe that the patient might meet the criteria for court-ordered services or emergency detention because:
   a. The patient is likely to cause harm to himself/herself;
   b. The patient is likely to cause serious harm to others; or
   c. The patient's condition will continue to deteriorate and the patient is unable to make an informed decision as to whether or not to stay for treatment. Patient and guarantor agree that this written agreement shall constitute a contract by and between the patient and the facility.

Patient and guarantor agree that this written agreement shall constitute a contract by and between the patient and the facility.

Signed the _____ day of _____, 20 _____, in Corpus Christi, Nueces County, Texas.

_____
Patient Signature or Person Authorized to Sign for Patient

_____
Guardian or Other Responsible Party

_____
Facility Witness

_____
Date

I hereby authorize CORPUS CHRISTI MEDICAL CENTER to release any and all information from the records maintained by Corpus Christi Medical Center of Corpus Christi, Texas for the admissions of _____, including information related to psychiatric treatment, treatment for chemical dependency, and test results, to the following persons or organizations:

_____

_____

_____

Purpose/need for disclosure:

INSURANCE PURPOSES

Extent or nature of information to be disclosed:

ALL MEDICAL RECORDS INCLUDING ANY RELATED TO PSYCHOLOGICAL, SUBSTANCE ABUSE, AND HIV TREATMENT

I also release Corpus Christi Medical Center from all legal responsibility or liability that may arise from the release of information I have authorized by my signature below:

_____

Patient Signature or Person Authorized to Sign for Patient

_____

Witness

_____

Date

This consent may be revoked by the person giving authorization by signing and dating the revocation statement below or through written notice except to the extent that action has been taken in reliance hereon. If not earlier revoked, this consent shall terminate 90 days from the date of consent without express revocation.

On this day, _____, 20_____, I revoke this consent.

_____

Patient Signature or Person Authorized to Sign for Patient

_____

Witness

_____

Date

Psychiatric Services (Inpatient Psychiatric Treatment)

The Psychiatric Services Program at CCMC provides specialized psychiatric treatment for adults.
Your treatment occurs in an inpatient setting under the daily supervision of a psychiatrist.

When you are admitted to Psychiatric Services you will have a team supporting you that consists of the following:

- A psychiatrist will be the leader of your team and will conduct an evaluation to determine what your needs are and how you should be treated.
- All of the resources of the general hospital are available to you and the psychiatrist may also consult a physician with a specialty from the hospital.
- A registered nurse will conduct a nurse evaluation, provide care and education, and monitor your progress 24 hours a day.
- A counselor will perform a psychosocial assessment, conduct therapy sessions and function as your case manager.
- A social worker will provide supervision of social services and can be consulted if you have social service needs.

Our program has a number of scheduled activities which include the following:

- The nurse may provide education classes, individually or in a group, about medication, stress, depression, and other topics to assist you in improving your emotional health.
- The counselor will provide group therapy during which you will sit down with peers and share problems and solutions. Your counselor is also available to provide individual and/or family therapy if needed.
- The Activity and Leisure Education Department will provide activity therapy.

If you have any questions, please call (361) 767-4400.

SCHEDULE	
8:00 a.m.	Breakfast
9:00 a.m.	Goals Group/Meditation
10:00 a.m.	Group Therapy
11:00 a.m.	Activity Group
12:30 p.m.	Lunch
1:30 p.m.	Clinical Education Group
2:30 p.m.	Recreational and Leisure Group
4:00 p.m.	Nursing Group
5:30 p.m.	Dinner
7:00 p.m. – 8:00 p.m.	Recreational Group/Open AA and NA meetings
8:00 p.m. – 9:00 p.m.	Goals Group/Wrap Up Group
9:00 p.m.	Wrap Up/Goals Group/Relaxation Group

Visitation Hours
Tuesday, Thursday, Saturday and Sunday 4:00 p.m. to 5:30 p.m.
from 6:00 p.m. to 7:30 p.m.

Smoke Breaks
8:30 a.m., 1:00 p.m., 3:30 p.m., 5:45 p.m., and 10:00 p.m.

Phone Time
7:00 a.m. - 7:50 a.m., 12:00 p.m. - 1:20 p.m., 6:00 p.m. - 9:00 p.m.

When you apply for or receive mental health services in the State of Texas, you have many rights. Your most important rights are listed on these four pages. These rights apply to all persons unless otherwise restricted by law or court order. A judge or lawyer will refer to the actual laws. If you want a copy of the laws these rights come from, you can call the Health Facility Licensure and Certification Division of the Texas Department of State Health Services at 1-888-973-0022.

It is the responsibility of this hospital under law to make sure you have been informed of your rights. But just giving you this information does not mean your rights have been protected. This hospital is required to respect and provide for your rights in order to maintain licensure and do business in this state.

Your Right to Know Your Rights

You have the right, under the rules by which this hospital is licensed, to be given a copy of these rights before you are admitted to the hospital as a patient. If you so desire a copy should also be given to the person of your choice. If a guardian has been appointed for you or you are under 18 years of age, a copy will also be given to your guardian, parent, or conservator.

You also have the right to have these rights explained to you aloud in simple Terms in a way you can understand within 24 hours of being admitted to the Hospital to receive services (e.g., in your language if you are not English-speaking, in sign language if you are hearing impaired, in Braille if you are Visually impaired, or other appropriate methods).

Your Right to Make a Complaint

You have the right, to make a complaint and to be told how to contact people who can help you. These people and their addressed and phone numbers are listed below.

You have the right to be told about Advocacy, Inc., when you first enter the hospital and when you leave. Information about how to contact Advocacy, Inc., is also listed below.

If you believe any of your rights have been violated or you have other concerns about your care in this hospital, you may contact one or more of the following:

Health Facility Licensure and Certification Division
Texas Department of State Health Services
1100 W. 49th Street 1-888-973-0022
Austin, Texas 78756

Advocacy, Incorporated 1-800-315-3876
7800 Shoal Creek Blvd., Suite 171E
Austin, Texas 78757

Corpus Christi Medical Center
Department of Psychiatry:
Service Line Director – Jamie Molbert
(361) 767-4400
Clinical Services Director – Lisa Margraves
(361) 767-4400
Director of Nursing – Debra Christensen
(361) 767-4400
Patient Advocate – Jamie Molbert
(361) 767-4400

If you have been involuntarily committed and you believe that your attorney did not prepare your case properly or that your attorney failed to represent your point of view to the judge, you may wish to report the attorney's behavior to the Ethics Committee of the State Bar of Texas by writing:

Disciplinary Council
State Bar of Texas
1414 Colorado
P.O. Box 12487
Austin, Texas 78711-2487

If you are a voluntary patient OR if you have been taken to the hospital against your will, turn to pages three and four for a listing of your special rights under law in Texas. All patients should read pages two and three, which explain the rights that apply to everyone receiving services at this hospital.

STATEMENT THAT YOU HAVE RECEIVED THIS PAMPHLET/IT HAS BEEN EXPLAINED

I certify that:

____ I have received a copy of this four-page document prior to admission
____ Staff have explained its content to me in a language I understand within 24 hours of admission (if involuntarily committed).
____ Staff have explained its content to me in a language I understand prior to admission (if voluntarily committed).

Name: _____ Witness: _____

Date : _____ Date : _____

Relationship of witness to patient:

_____

CORPUS CHRISTI MEDICAL CENTER

1. You have all the rights of a citizen of the State of Texas and the United States of America, including the right of *habeas corpus* (to ask a judge if it is legal for you to be kept in the hospital), property rights, guardianship rights, family rights, religious freedom, the right to register and vote, the right to sue and be sued, the right to sign contracts, and all the rights relating to licenses, permits, privileges, and benefits under the law.
2. You have the right to be presumed mentally competent unless a court has ruled otherwise.
3. You have the right to a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity.
4. You have the right to appropriate treatment in the least restrictive appropriate setting available. This is a setting that provides you with the highest likelihood for improvement and that is not more restrictive of your physical or social liberties that is necessary for the most effective treatment and for protection against any dangers which you might pose to yourself or others.
5. You have the right to be free from mistreatment, abuse, neglect, and exploitation.
6. You have the right to be told in advance of all estimated charges being made, the cost of services provided by the hospital, sources of the program's reimbursement, and any limitation son length of services known to the hospital. As part of this right, you should have access to a detailed bill of services, the name of an individual at the facility to contact for any billing questions, and information about billing arrangements and available options if insurance benefits are exhausted or denied.
7. You have the right to fair compensation for labor performed for the hospital in accordance with the Fair Labor Standards Act.
8. You have the right to be informed of those hospital rules and regulations concerning your conduct and course of treatment.

Personal Rights

Unless otherwise specified, these personal rights can only be limited by your doctor on an individual basis to the extent that the limitation is necessary to your welfare or to protect another person. The reasons for and duration of the limitation must be written in your medical record, signed, and dated by your doctor, and fully explained to you. The limit on your rights must be reviewed at least <u>every seven days</u> and if renewed, renewed in writing.

9. You have the right to talk and write to people outside the hospital. You have the right to have visitors in private, make private phone calls, and send and receive sealed and uncensored mail. *In no case may your right to contact or be contacted by an attorney, the department, the courts, or the state attorney general be limited.*

   This right includes a prohibition on barriers to communication imposed by a hospital, such as:
   - rigid and restrictive visiting hours;
   - policies that restrict hospitalized mothers and fathers from visiting with their minor children;
   - policies that restrict parents from visiting their hospitalized children
   - limited access to telephone; and
   - failure to provide assistance to patients who wish to mail a letter.
10. You have the right to keep and use your personal possessions, including the right to wear your own clothing and religious or other symbolic items. You have the right to wear suitable clothing which is neat, clean and well fitting.
11. You have the right to have an opportunity for physical exercise and for going outdoors with or without supervision (as clinically indicated) at least daily. *A physicians order limiting this right must be reviewed and renewed at least every three days. The findings of the review must be written in your medical record.*
12. You have the right to have access to appropriate areas of the hospital away from your living unit, with or without supervision (as clinically appropriate), at regular and frequent times.
13. You have the right to religious freedom. However, no one can force you to attend or engage in any religious activity.
14. You have the right to opportunities to socialize with persons of the opposite sex, with or without supervision, as your treatment team considers appropriate for you.
15. You have the right to ask to be moved to another room if another person in your room is disturbing you. The hospital staff must pay attention to your request, and must give you an answer and a reason for the answer as soon as possible.
16. You have the right to receive treatment of any physical problems which affect your treatment. You also have the right to receive treatment of any physical problem that develops while you are in the hospital. If your physician believes treatment of the physical problem is not required for your health, safety, or mental condition, you have the right to seek treatment outside the hospital at your own expense.
17. You have the right not to be unnecessarily searched unless your physician believes there is a potential danger and orders a search. If you are required to remove any item of clothing, a staff member of the same sex must be present and the search must take place in a private place.

Confidentiality

18. You have the right to review the information contained in your medical record. If your doctor says you shouldn't see a part of your record, you have the right at your expense to have another doctor of your choice review that decision. The doctor must also reconsider the decision to restrict your right on a regular basis. The right extends to your parent or conservator if you are a minor (unless you have admitted yourself to services) and to your legal guardian if you have been declared by a court to be legally incompetent.

19. You have the right to have your records kept private and to be told about the conditions under which information about you can be disclosed without your permission, as well as how you can prevent any such disclosures.
20. You have the right to be informed of the current and future use of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies, or photographs.

Consent

21. You have the right to refuse or take part in research without affecting your regular care.
22. You have the right to refuse any of the following:
    - surgical procedures;
    - electroconvulsive therapy (prohibited for minors under the age of 16);
    - unusual medication;
    - behavior therapy
    - hazardous assessment procedures;
    - audiovisual equipment; and
    - other procedures for which your permission is required by law.

    This right extends to your parent or conservator if you are a minor, or your legal guardian when applicable.
23. You have the right to withdraw your permission at any time in matters to which you have previously consented.

Care and Treatment

24. You have the right to be transported to, from, and between private psychiatric hospitals in a way that protects your dignity and safety. You have the right not to be transported in a marked police or sheriff's care or accompanied by a uniformed officer unless other means are not available.
25. You have the right to a treatment plan for your stay in the hospital that is just for you. You have the right to take part in developing that plan, as well as the treatment plan for your care after you leave the hospital. *This right extends to your parent or conservator if you are a minor, or your legal guardian when applicable. You have the right to request that your parent/conservator or legal guardian take part in the development of the treatment plan. You have the right to request that any other person of your choosing, e.g., spouse, friend, relative, etc., take part in the development of the treatment plan. You have a right to expect that your request be reasonably considered and that you will be informed of the reasons for any denial of such a request. Staff must document in your medical record that the parent/guardian, conservator, or other person of your choice was contacted to participate.*
26. You have the right to be told about the care, procedures, and treatment you will be given; the risks, side effects, and benefits of all medications and treatment you will receive, including those that are unusual or experimental, the other treatments that are available, and what may happen if you refuse the treatment.
27. You have the right to receive information about the major types of prescription medications which your doctor orders for you (effective May 1, 1994).
28. You have the right not to be given medication you don't need or too much medication, including the right to refuse medication (this right extends to your parent or conservator if you are a minor, or your legal guardian when applicable). However, you may be given appropriate medication without your consent if:
    - your condition or behavior places you or others in immediate danger; or
    - you have been admitted by the court and your doctor determines that medication is required for your treatment and a judicial order authorizing administration of the medication has been obtained.
29. You have the right to receive a list of medications prescribed for you by your physician, including the name, dosage, and administration schedule, within four hours of the facility administrator or designee receiving such a request in writing.
30. You have the right not to be physically restrained (restriction of movement of parts of the body by person or device or placement in a locked room alone) unless your doctor orders it and writes it in your medical record. In an emergency, you may be restrained for up to one hour before the doctor's order is obtained. If you are restrained, you must be told the reason, how long you will be restrained, and what you have to do to be removed from restraint. The restraint has to be stopped as soon as possible.
31. You have the right to meet with the staff responsible for your care and to be told of their professional discipline, job title, and responsibilities. In addition, you have the right to know about any proposed change in the appointment of professional staff responsible for your care.
32. You have the right to request the opinion of another doctor at your own expense. You have the right to be granted a review of the treatment plan or specific procedure by hospital medical staff. This right extends to your parent or conservator if you are a minor, or your legal guardian, if applicable.
33. You have the right to be told why you are being transferred to any program within or outside the hospital.
34. You have the right to a periodic review to determine the need for continued inpatient treatment.

If you have questions concerning these rights or a complaint about your care, call the Health Facility Licensure and Certification Division for the Texas Department of State Health Services at 1-888-973-0022.

Voluntary Patients – Special Rights

1. You have the right to request discharge from the hospital. If you want to leave, you need to say so in writing or tell a staff person. If you tell a staff person you want to leave, the staff person must write it down for you.
2. You have the right to be discharged from the hospital within four hours of requesting discharge. There are only three reasons why you would not be allowed to go:
   - First, if you change your mind and want to stay at the hospital, you can sign a paper that says you do not wish to leave, or you can tell a staff member that you don't want to leave, and the staff member has to write it down for you.
   - Second, if you are under 16 years old, and the person who admitted you (your parents, guardian, or conservator) doesn't want you to leave, you may not be able to leave. If you request release, staff must explain to you whether or not you can sign yourself out and why. The hospital must notify the person who does have the authority to sign you out and tell that person that you want to leave. That person must talk to your doctor, and your doctor must document the date, time, and outcome of the conversation in your medical record.
   - Third, you may be detained longer than four hours if your doctor has reason to believe that you might meet the criteria for court-ordered services or emergency detention because:
     - ➢ you are likely to cause serious harm to yourself;
     - ➢ you are likely to cause serious harm to others; or
     - ➢ your condition will continue to deteriorate and you are unable to make an informed decision as to whether or not to stay for treatment.

     If your doctor thinks you may meet the criteria for court-ordered services or emergency detention, he or she must examine you in person within 24 hours of your filing the discharge request. You must be allowed to leave the hospital upon completion of the in-person examination unless your doctor confirms that you meet the criteria for court-ordered services and files an application for court-ordered services. The application asks a judge to issue a court order requiring you to stay at the facility for services. The order will only be issued if the judge decides that either:
     - ➢ you are likely to cause serious harm to yourself;
     - ➢ you are likely to cause serious harm to others; or
     - ➢ your condition will continue to deteriorate and you are unable to make an informed decision as to whether or not to stay for treatment.

     Even if an application for court-ordered services is filed, you cannot be detained at the hospital beyond 4:00 p.m. of the first business day following the in-person examination unless the court order for services is obtained.
3. You have the right not to have an application for court ordered services filed while you are receiving voluntary services at the hospital unless your physician determines that you meet the criteria for court-ordered services as outlined in &573.022 of the Texas Health and Safety Code and:
   - you request discharge (see number 2 above);
   - you are absent without authorization;
   - you refuse to consent to necessary and appropriate and necessary treatment; or
   - you refuse to consent to necessary and appropriate treatment recommended by your doctor and your doctor states in the certificate of medical examination that:
     - ➢ there is no reasonable alternative treatment; and
     - ➢ you will not benefit from continued inpatient care without the recommended treatment.
4. Your doctor must note in your medical record and tell you about any plans to file an application for court-ordered treatment or for detaining you for other clinical reasons. If the doctor finds that you are ready to be discharged, you should be discharged without further delay.

Note: The law is written to ensure that people who do not need treatment are not committed. The Texas Health and Safety Code says that any person who intentionally causes or helps another person cause the unjust commitment of a person to a mental hospital is guilty of a crime punishable by a fine of up to $5,000 and/or imprisonment in county jail for up to one year.

Emergency Detention – Special Rights

(people brought to the hospital against their will)

1. You have the right to be told:
   - where you are;
   - why you are being held; and
   - that you might be held for a longer time if a judge decides that you need treatment.
2. You have the right to call a lawyer. The people talking to you must help you call a lawyer if you ask.
3. You have a right to be seen by a doctor. You will not be allowed to leave if the doctor believes that:
   - you may seriously harm yourself or others;
   - the risk of this happening is likely unless you are restrained; and
   - emergency detention is the least restrictive means of restraint. If the doctor decides you don't meet all of these criteria, you must be allowed to leave. A decision concerning whether you must stay must be made within 24 hours, except that on weekends and legal holidays, the decision may be delayed until 4:00 in the afternoon on the first regular workday. The decision may also be delayed in the event of an extreme weather emergency or disaster. If the court is

asked to order you to stay longer, you must be told that you have a right to a hearing within 72 hours (excepting weekends, holidays, or extreme weather, emergencies or disasters).

4. If the doctor decides that you don't need to stay here, the hospital will arrange for you to be taken back to where you were picked up if you want to return, or to your home in Texas, or to another suitable place within reasonable distance.
5. You have the right to be told that anything you say or do may be used in proceedings for further detention.

Order of Protective Custody – Special Rights

1. You have the right to call a lawyer or to have a lawyer appointed to represent you in a hearing to determine whether you must remain in custody until a hearing on court-ordered mental health services is held.
2. Before a probable cause hearing is held, you have the right to be told in writing:
   - that you have been placed under an order of protective custody;
   - why the order was issued; and
   - the time and place of a hearing to determine whether you must remain in custody until a hearing on court-ordered mental health services can be held.
3. You have the right to a hearing within 72 hours of your detention, except that on weekends or legal holidays, the hearing may be delayed until 4:00 in the afternoon on the first regular workday. The hearing may also be delayed in the event of an extreme weather emergency or disaster.
4. You have the right to be released from custody if:
   - 72 hours has passed and a hearing has not taken place (excepting weather emergencies and extensions for weekends and legal holidays);
   - an order for court-ordered mental health services has not been issued within 14 days of the filing of an application (30 days if a delay was granted); or
   - your doctor finds that you no longer need court-ordered mental health services.

Involuntary Patients – Special Rights

Under most circumstances, you or a person who has your permission may, at any time during your commitment, ask the court to ask a physician to reexamine you to determine whether you still meet the criteria for commitment. If the physician determines you no longer meet the criteria for commitment, you must be discharged. If the physician determines you continue to meet the criteria for commitment, the physician must file a Certificate of Medical Examination with the court within 10 days of the filing of your request. If a certificate is filed, or if a certificate has not been filed within 10 days and you have not been discharged, the judge may set a time and place for a hearing on your request.

Dear Patient, Family, or Significant Other:

CCMC-Northwest strives to be an exceptional leader in the community, so we are concerned about the quality of care you receive and your health and safety while you are a patient in our institution. We respect your right to present complaints without compromising your future access to care and have outlined these guidelines so that any complaint can be handled in an efficient and timely manner.

All comments, complaints, and suggestions will be reviewed, evaluated and action taken to prevent and/or improve the care and/or services we provide.

1. A complaint, comment, or suggestion may be stated verbally to any staff member while you are a patient or phoned or written after you are dismissed from the hospital. If you have difficulty reading or writing, you may have assistance. Upon request, phone, pen, paper, envelope and postage will be provided.

2. Written or phoned complaints may be directed to the hospital Administration Office or the Management Team of the Department. Written or phoned complaints may also be directed to the Texas Department of Health or Advocacy, Incorporated. Complaints against licensed physicians may be reported to the State Board of Medical Examiners. (Addresses and phone numbers are listed below.)

3. Complaints regarding nursing should be directed to the Director of Nursing. Complaints concerning clinical services should be directed to the Site Line Director or Director of Clinical Services.

4. While a patient, the following contacts may be made for complaints:

   a. Any staff member, or

   b. Your case manager or charge nurse of the unit you are assigned to, or if not available

   c. The Service Line Director of Directors of Nursing and Clinical Services, or if not available

   d. Administrative Offices

All of these managers are able to handle your concerns courteously, promptly, and efficiently. After your complaint has been investigated, you will be informed of the findings and recommendations. Thank you for helping CCMC to maintain an exceptional standing in the community.

Corpus Christi Medical Center – Northwest 13725 Northwest Boulevard Corpus Christi, TX 78410 Service Line Director (361) 767-4400 Director of Nursing (361) 767-4400 Patient Representative (361) 767-4400	**Health Facility Licensure and Certification Division** Texas Department of State Health Services 1100 W. 49th St. Austin, TX 78711-2688 1-888-973-0022
Texas State Board of Medical Examiners P.O. Box 149134 Austin, Texas 78714-9134 1-800-248-4062	**Advocacy, Inc.** 7800 Shoal Creek Blvd., Suite 171E Austin, Texas 78757 1-800-223-4206

Complaint Policy/Procedure

CORPUS CHRISTI MEDICAL CENTER

As a patient in Psychiatric Services at CCMC, you have the right to be told in advance of any charges being made, the cost of services, sources of the programs reimbursement and any limitations placed on your length of stay/services.

Our estimated hospital charge per day for services rendered is $1,400.00 per day.

This charge is a result of the appropriate services provided in the Department of Psychiatry as ordered by your physician(s) for your plan of treatment. This estimated charge may be more or less depending on the services your physician(s) orders.

NOTE:

Verification by a third-party carrier is not a guarantee of coverage and/or payment for this hospitalization. Payment of benefits is subject to any subsequent review(s) of medical information of records, eligibility on the date(s) of service, and any other contractual limitations (including any limitations contained in riders) such as pre-existing conditions, cosmetic procedures, other non-covered services, or failure of the patient to notify the carrier in a timely manner of his hospitalization.

I understand that should my insurance carrier fail to pay for services rendered due to non-coverage, I will be responsible for entire bill.

If you have any questions regarding CCMC billing or financial arrangements, you may contact:

CUSTOMER SERVICE
866-453-5906

On occasion, some of our patients/residents may experience a temporary episode of confusion or behavioral changes that may pose a risk of injury to themselves or others. Conditions that may contribute to confusion or behavioral changes are:

- Medication side effects
- Change in surroundings
- Psychiatric conditions

Employees are highly trained to initiate the procedures in a way that avoids undue physical discomfort or harm and to use only minimal amount of physical force that is reasonable and necessary. Restraint is not used as a punishment, for the purpose of convenience, or as a substitute for effective treatment.

Restraint is initiated only when all other less restrictive non-physical means are not effective. Confusion or dangerous behaviors can prevent you/your family member from accurately assessing physical surroundings that could cause harm. During these temporary episodes, the physician and nurses may identify the need for restraint to safely care for you/your family member. These devices may be in the form of vests, belts, or wristlets. While restraints are in place, you/your family member will be observed frequently by our staff to ensure your privacy, personal dignity, safety and well-being are safeguarded whenever it becomes necessary to physically restrain.

As you/your family member's physical condition improve, and the confusion and dangerous behavior decreases, you/he/she will be assessed for the continued need for a restraint. You/your family member's safety and emotional needs are always a primary concern to us while you/he/she are with us at CCMC.

In the Psychiatry Department, seclusion may be used as an option to provide safety. Again, as mentioned above with restraints, seclusion will be used when less restrictive measures have failed and there is still danger to you/your family member or others. As the dangerous behavior decreases, you/he/she will be evaluated for the continued need for seclusion. Following seclusion, you/your family member will be debriefed to make sure emotional needs are met and that the transition back into the unit is smooth and safe.

I/We give my permission for the use of physical restraint(s).

I/We understand the possible complications that can occur with the use of restraints include but are not limited to: reduced range of motion, neurovascular injury, decreased ability to ambulate, symptoms of withdrawal or depression, and reduced social contact.

I/We understand that the restrained body part will be examined and observed by licensed medical personnel and each restraint will be removed at least every two (2) hours to allow range of motion exercises, repositioning for comfort, and assistance with any personal needs. The nurses' call light will be left within the patient's reach at all times and the patient will be observed closely. Furthermore, the physical restraint will be terminated as soon as possible as the need is eliminated.

My signature below constitutes acknowledgement that I have read and agree to the foregoing.

Patient/Legal Representative Signature _____ Date: _____ Time: _____

Staff Witness/Provider of Explanation: _____ Date: _____ Time: _____

Second Witness Signature: _____ Date: _____ Time: _____
(for phone consent)

Organization Philosophy Regarding Restraints and Seclusion

CORPUS CHRISTI MEDICAL CENTER

Psychiatric Services has a locked entrance. The locked doors are for your protection and confidentiality. You will have scheduled access to the courtyards unless your physician decides to order otherwise.

Upon admission to Psychiatric Services, you will receive full assessments by a nurse, therapist, and physician. You will be expected and encouraged to attend appropriate daily activities assigned by the treatment team, including group, individual, family, and occupational therapy. **For your safety and the safety of others, we please ask that you bring no dangerous objects (e.g., sharps, knives, medication, plastic bags, scissors, razor blades, cigarette lighters, etc.) to the unit. If you have these, please send them home or give them to the staff to be put away.**

You also need to be aware that with your permission staff will conduct a non-intrusive search as follows:

- Routine search of belongings for contraband at the time of admission, return from pass, or transfer.
- Superficial external pat downs by staff of the same sex.
- Search of the person's outer clothing, hair, or mouth, unless the search is resisted.

If you refuse to allow the above, your doctor may write an order to conduct a search as long as he/she feels there is clinical justification. Also if there is clinical justification, your doctor may order staff to search your belongings and to possibly remove dangerous items at times other than at the time of admission, return from pass, or transfer.

While receiving treatment in our therapeutic milieu, certain guidelines regarding behavior are maintained for your comfort and protection. All patients are expected to read and abide by those guidelines which include:

1. No violent or threatening behavior toward other patients, visitors, or staff. **Charges may be pressed if a patient aggresses toward other patients, staff or property.**

2. Patients will usually have roommates – private rooms are not available.

3. Appropriate street dress is expected at all times when in the Day Area.

4. Confidentiality

    a. All patients, visitors and staff are expected to observe strict confidentiality regarding the presence and treatment of all patients on this unit. Staff will only break confidentiality when there is concern about the safety of the patient and/or others. For example, if there is suspected abuse of an adult, the staff is legally obligated to report this to Adult Protective Services.

    b. All visitors are expected to sign the confidentiality book on arrival and each visitation to the unit.

c. Staff will not acknowledge your presence on the unit with visitors/callers unless the caller/visitor has your code number. A code number will be assigned to you which you may share with others.

5. There should be **NO smoking** or use of other tobacco products in the building. The patio door will be opened at designated times for smoking. Consult the schedule for times.

6. Visitation will be limited in number and time. Visiting hours are posted at the entrance to the unit.

7. Radio/tape players, television and telephone use is available after or in between scheduled activities.

8. Cell phones are **not** allowed on the unit. These are valuable and could easily be misplaced or lost. Also, it is important that we protect our patients' confidentiality since some of these phones can take pictures and record.

9. Entertainment and quiet times are available but are limited to assure treatment needs.

10. As personal and milieu cleanliness is expected, a laundry is provided and eating areas are designated. It is expected that each patient be responsible for room/bathroom and living area cleanliness. Infection Control requires food be labeled with patient's name and date opened.

11. Guidelines for all activities are expected to be followed.

12. Bringing contraband to the unit may lead to discharge. Contraband may be turned over to Hospital Security. Valuables must be sent home at admission or turned over to Hospital Security for safekeeping. Patients are given a personal belonging container upon admission that is used for storing containers, substances and items unsafe to be kept in rooms. The nursing staff will delineate which belongings need to be kept in the basket.

UNIT	Psychiatric Services – Adult
VISITING HOURS	**Tuesday, Thursday, Saturday and Sunday** 6:00 p.m. – 7:30 p.m. 4:00 p.m. – 5:30 p.m.
PHONE CALLS	7:00-7:50 a.m. 12:00-1:20 p.m. 6:00-9:00 p.m.

YOUR CODE NUMBER:	

(PLEASE NOTE: Anyone calling you through the Nurse's Station must have your code number before we can acknowledge you are here)

YOUR PHYSICIAN:	

NURSES' STATION: 7-3 Charge Nurse: 3-11 Charge Nurse: 11-7 Charge Nurse: Weekend Charge Nurse:	**Phone/Voice Mail:**
Therapist/Case Manager	**767-4400 ext. 431**

QUESTIONS OR CONCERNS MAY BE REPORTED TO:

Any Staff Member

Jamie Molbert, LPC – Service Line Director
(361) 767-4400
Debra Christiansen, RN – Director of Nursing
(361) 767-4400
Lisa Margraves, LMSW – Director of Clinical Services
(361) 767-4400

CORPUS CHRISTI MEDICAL CENTER

The items checked below indicate that an explanation was given:

_____Welcome Packet _____Cost of Services

_____Complaint Procedure _____Rules and Regulations

I UNDERSTAND:

1. I agree that Dr. _____ will be the attending physician.

2. I understand that I am expected to participate in my treatment plan.

_____
Patient Signature or Person Authorized to Sign for Patient

_____
Witness

_____
Date

I _____ (Charge Nurse or Supervisor), as the facility administrator designee, accept this patient for admission.

_____
Signature

_____
Date

CORPUS CHRISTI MEDICAL CENTER

I _____ hereby apply to be admitted as a voluntary patient to the Department of Psychiatry of Corpus Christi Medical Center in Nueces County, Texas. The admission to our Psychiatric Inpatient Program is for diagnosis, observation, care, and treatment until discharge or until a request for discharge from the hospital is made. I understand that verbal statements of the desire to be discharged will be treated as written requests for release and will be recorded by staff if necessary.

I understand that I have the right to be discharged from the facility within four (4) hours of requesting discharge. There are only three (3) reasons why I would not be able to be discharged:

1. If I change my mind and want to stay, I can sign a paper that says I do not wish to leave, or I can tell a staff member that I do not want to leave, and the staff member has to write it down for me.
2. If the patient is under 16 years old, and the person who admitted the patient (parents, guardian, or conservator) does not want the patient to leave, the patient may not be able to leave. If the patient requests release, the staff must explain to the patient whether or not the patient can sign himself/herself out and why. The facility must notify the person who does have the authority to sign the patient out and tell that person that the patient wants to leave. That person must talk to the patient's doctor, and the patient's doctor must document the date, time, and outcome of the conversation in the patient's medical record.
3. The patient may be detained longer than four (4) hours if the patient's doctor has reasons to believe that the patient might meet the criteria for court-ordered services or emergency detention because:
   a. The patient is likely to cause harm to himself/herself;
   b. The patient is likely to cause serious harm to others; or
   c. The patient's condition will continue to deteriorate and the patient is unable to make an informed decision as to whether or not to stay for treatment. Patient and guarantor agree that this written agreement shall constitute a contract by and between the patient and the facility.

Patient and guarantor agree that this written agreement shall constitute a contract by and between the patient and the facility.

Signed the _____ day of _____, 20 _____, in Corpus Christi, Nueces County, Texas.

_____
Patient Signature or Person Authorized to Sign for Patient

_____
Guardian or Other Responsible Party

_____
Facility Witness

_____
Date

I hereby authorize CORPUS CHRISTI MEDICAL CENTER to release any and all information from the records maintained by Corpus Christi Medical Center of Corpus Christi, Texas for the admissions of _____, including information related to psychiatric treatment, treatment for chemical dependency, and test results, to the following persons or organizations:

_____

_____

_____

Purpose/need for disclosure:

INSURANCE PURPOSES

Extent or nature of information to be disclosed:

ALL MEDICAL RECORDS INCLUDING ANY RELATED TO PSYCHOLOGICAL, SUBSTANCE ABUSE, AND HIV TREATMENT

I also release Corpus Christi Medical Center from all legal responsibility or liability that may arise from the release of information I have authorized by my signature below:

_____

Patient Signature or Person Authorized to Sign for Patient

_____

Witness

_____

Date

This consent may be revoked by the person giving authorization by signing and dating the revocation statement below or through written notice except to the extent that action has been taken in reliance hereon. If not earlier revoked, this consent shall terminate 90 days from the date of consent without express revocation.

On this day, _____, 20_____, I revoke this consent.

_____

Patient Signature or Person Authorized to Sign for Patient

_____

Witness

_____

Date

CORPUS CHRISTI MEDICAL CENTER

WARNING SIGNS OF STROKE

When a stroke happens, every minute counts!
A Stroke is a medical emergency. It is what happens when blood flow to part of the brain is reduced or cut off when a blood vessel gets blocked or bursts. Without blood supply, the brain cells begin to die within minutes. It is important to know the warning signs and get medical help as quickly as possible.

If you notice one or more of these signs, don't wait. Stroke is a medical emergency. Call 9-1-1 or your emergency medical services. Get to a hospital right away!

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

TIAs are emergencies too.

A TIA (transient ischemic attack) is a ministroke. It is a sign that a stroke may be on the way. NEVER ignore a TIA. A TIA has the same warning signs as a stroke but the symptoms generally only last a short time. Get medical help immediately!

Fast treatment helps save lives.

Emergency tests and other procedures can help evaluate and treat a stroke.

Special drugs may break up blockages in the blood vessels, but they must be given within 3 hours of the first symptoms of a stroke.

Be prepared for an emergency.

- Keep a list of emergency rescue service numbers next to the telephone and in your pocket, wallet or purse.
- Find out which area hospitals are primary stroke centers that have 24-hour emergency stroke care.
- Know (in advance) which hospital or medical facility is nearest your home or office.

Take action in an emergency.

- Not all the warning signs occur in every stroke. Don't ignore signs of stroke, even if they go away!
- Check the time. When did the first warning sign or symptom start? You'll be asked this important question later.
- If you have one or more stroke symptoms that last more than a few minutes, don't delay! Immediately call 9-1-1 or the emergency medical service (EMS) number so an ambulance (ideally with advanced life support) can quickly be sent for you.
- If you're with someone who may be having stroke symptoms, immediately call 9-1-1 or the EMS. Expect the person to protest — denial is common. Don't take "no" for an answer. Insist on taking prompt action.

Patient Initials _____Date _____

CHART COPY

DOB: MR#

CORPUS CHRISTI MEDICAL CENTER

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Patient Initials _____Date _____

PATIENT COPY –SIGNATURE ON FILE

DOB: MR#

Understanding Price and Payment

Your hospital bill and payment can be confusing.

Up-Front Payment
Our practice is to collect all known fees when you register at the hospital, including deductibles, co-payments, and co-insurance, based on **estimated** charges. Your final bill may be higher or lower than the estimates we use at registration, since it is based on actual charges for services provided. If it is higher, we may ask for additional payment at discharge; if it is lower, we will promptly refund the amount you overpaid.

Payment by Insurance
If you carry health insurance, we will bill your insurance carrier shortly after your visit and then send you an informational letter (**not** a bill) to let you know about it. Your insurance carrier should pay your bill within 60 days.

Your insurance company may contact you for additional information to process your claim. Please respond as quickly as possible to ensure you receive the maximum benefit from your coverage.

You will not receive further communication from the hospital unless the insurance company has not paid your claim or a balance is due from you (e.g., part not covered by your insurance.)

Payment Without Insurance
Our facility offers a discount for patients without health insurance, unless you receive an elective cosmetic procedure. You may ask for information about our Uninsured Discount Program upon registration or at any time during your visit.

After your discount is applied, we will ask for payment of the balance at the time of service. If you are unable to pay, we will work with you to:

- **Set up a payment plan**
- **Obtain coverage through Medicaid**
- **Apply for a Charity discount**

This pamphlet will help you understand your hospital charges, billing procedures, and payment options.

Other Charges
Your hospital bill contains charges or hospital services only - you will be billed separately for other professional services including:

- **Your physician**
- **ER physicians**
- **Radiologists**
- **Hospitalists**
- **Pathologists**
- **Cardiologists**
- **Neonatologists**
- **Anesthesiologist**

Please call the customer service number on that bill if you have questions about any of these charges.

Online Bill Payment
If you have a balance after discharge, the **Patient Financial Resource** website enables you to pay your bill online with a debit or credit card. Just click the **Patient Pricing & Financial Information** logo from our hospital's home page and then click the **Pay Bill** icon to find and pay your bill. You can call Customer Service at **1-800-361-3974** if you have questions; one of our representatives will be happy to help you.

Knowing your price
can help you prepare.

Knowing your price and understanding your bill

Questions and Answers

What services are included in my hospital bill estimate?
If you are viewing estimates provided on the website, pricing includes estimated room and board (for inpatients), supplies, nursing care, equipment use, nutritional services, and any services handled by the staff of the hospital within the walls of the hospital.

Can I get an exact pricing quote?
Unfortunately, no. We will do our best to provide you with a pricing range based on our hospital's historical pricing for comparable services. Price quotes are not guaranteed since the services used to compute the quote can vary from services you receive due to treatment decisions, unforeseen complications, additional tests or services ordered by your physician, and variation in the clinical needs of each patient.

More Questions? Check out the **Patient Financial Resource** website for a complete set of questions & answers.

Knowing your price
Our facility now offers you access to the ***Patient Financial Resource***, a website that provides pricing estimates for the most frequently used hospital services, online bill payment, and other helpful information such as:

- **Payment options and alternatives for uninsured patients**
- **Guidelines about our billing process**
- **Frequently Asked Questions**

Finding your price

Just click the **Patient Pricing and Financial Information** logo from our hospital's home page to get started.

If you're already in the hospital, can't get to the internet, or wish to speak with one of our friendly Customer Service representatives, you can call the hotline at **1-888-246-3812.**

We are available to answer any questions you may have concerning your hospital bill.

Customer Service:

Look for this icon on the facility website- click it!