UT STUDENT REGISTRATION FORM

NAME_____

LOCAL/MAILING ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____

RACE_____

(CIRCLE THE BEST NUMBER OUR STAFF CAN REACH YOU BY)

MOBILE NUMBER_____ **HOME NUMBER**_____

SOCIAL SECURITY #_____ **BIRTHDATE**___/___/_____ **SEX: M F**

UT STUDENT I.D. # (5000 OR 600) _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWER/WIDOWED

NEXT OF KIN-BLOOD RELATIVE

NAME_____**RELATIONSHIP TO YOU**_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____

HOME/MOBILE#_____**WORK#**_____

PERSON TO NOTIFY IF DIFFERENT

NAME_____**RELATIONSHIP TO YOU**_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____

HOME/MOBILE#_____**WORK#**_____

AGREEMENTS, AUTHORIZATIONS AND ASSIGNMENTS

1. CONSENT FOR ADMISSION AND TREATMENT:

I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician, and/or his/her assistants or designees. I understand that these procedures and services may include but are not limited to emergency treatment or services, laboratory procedures, imaging services, medical or surgical treatment or procedures, anesthesia or hospital services. I understand that other conditions may be diagnosed which may require additional treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of any treatment or examinations provided by The University of Texas Health Science Center at Tyler also known as UT Health Northeast ("UTHSCT").

2. AGREEMENTS AND UNDERSTANDINGS:

a. I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic courses of treatment.

b. I understand that the physicians participating in my care, including my physician, may be either employees of UTHSCT or independent contractors who are not employees or agents of UTHSCT. I understand that the physicians participating in my care have been granted the privilege of using UTHSCT facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. As a teaching institution, UTHSCT welcomes medical residents and students in other disciplines, including nursing and UTHSCT approved observers engaged in an educational purpose, all of whom are under the direct supervision of a privileged provider or staff member.

c. I understand that regardless of my assigned insurance benefits, I AM RESPONSIBLE FOR AND DO HEREBY EXPRESSLY ASSUME FINANCIAL RESPONSIBILTY FOR the total charges for hospital, physician, medical and other services rendered.

d. I understand that UTHSCT has the right to pursue full collection efforts, including credit checks, and litigation.

3. AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION:

a. _____I understand that as part of my health care, UTHSCT personnel and my physician create and maintain a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by UTHSCT to me, as described in the Notice of Privacy Practices.

b. _____I **authorize UTHSCT and/or its physicians to release my information** (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, not including Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus Infection) for the period of my hospitalization and/or outpatient care to the following:

- My insurance carrier(s), the Social Security Administration, its intermediaries or carriers, or any party that is or may be liable for all or part of the hospital and/or physician charges as may be necessary to enable the insurance carrier(s), the Social Security Administration, or any other third party payor to determine the benefits available to me for the services rendered by UTHSCT;
- Individuals, agencies, or facilities working with UTHSCT as may be necessary to assist me with discharge planning;
- The Social Security Administration and/or the Texas Rehabilitation Commission, if applicable, for use in determining my eligibility for disability benefits.

c. _____I understand and acknowledge that as part of receiving my healthcare at UTHSCT, my physician and other personnel engaged in my care may electronically request my prescription medication history from participating pharmacies, pharmacy benefit managers, or payers, and that such prescription medication history may become part of my medical record.

d. _____I understand that I may withdraw this authorization for release of patient information at any time, but that I must do so in writing.

e. _____ I authorize UTHSCT to contact me via automated communications via electronic mail or telephone calls on my cellular phone, other phone(s). and other communication devices, including autodialed calls, pre-recorded messages from the hospital, its affiliates, successors, assigns, agents, and servicers. I understand these calls may regard my hospital visit(s) or financial obligations related to my visit(s). Consent may be revoked at any time by providing verbal or written notice to the Hospital Business Office.

4. **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS:** I hereby assign to UTHSCT, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, Tricare, or any reimbursement from a pre-paid health care plan. This means that UTHSCT and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to UTHSCT any interest in any claims I may have to the extent necessary to fully reimburse UTHSCT for the rendering of services to me. I understand and agree that my account is due in full upon discharge, with allowance made for insurance coverage approved and verified prior to discharge.

5. **VALUABLES:** I understand that UTHSCT provides a safe in the Business Office for safekeeping of valuables and that UTHSCT assumes no responsibility for items that remain in my possession, such as, but not limited to money, jewelry, eyeglasses, dentures or hearing aids.

6. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I received a copy of UTHSCT's Notice of Privacy Practices as part of this visit/admission or during a previous visit/admission. I understand that a copy of the Notice of Privacy Practice is available to me at any time upon my request.

7. **PATIENT RIGHTS AND RESPONSIBILITIES:** UTHSCT acknowledges that I have certain rights as a patient, and I acknowledge I have certain responsibilities as a patient. This information is available to me in writing upon my request.

The patient:

☐	Has an Advance Directive (directive is attached)
☐	Has an Advance Directive filed in his/her UTHSCT medical record
☐	Has an Advance Directive, but the directive is not in his/her UTHSCT medical record. I requested that patient or patient's representative provide a copy to UTHSCT
☐	Does not have an Advance Directive. I have provided the patient (or patient's representative) with an information packet on Advance Directives

The patient:

☐	Is a smoker and has been provided with information on smoking cessation
☐	Is not a smoker
☐	Is or has been exposed to second hand tobacco smoke

_____

Printed name of Patient or Legal Representative Time Date

_____

Signature of Patient or Legal Representative Time Date

THE UNIVERSITY OF TEXAS
HEALTH SCIENCE CENTER AT TYLER
11937 US Highway 271 Tyler, Texas 75708-3154

Patient Name: _____

Patient MRN: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, OTHER RELATIVES, OR FRIENDS INVOLVED IN MY CARE

This authorization may not be used to release or obtain documented information

_____ /_____ /Expires one year from date of signature

Patient Name DOB

AT MY REQUEST, I AUTHORIZE THE UNIVERSITY OF TEXAS HEALTHSCIENCE CENTER AT TYLER TO DISCLOSE INFORMATION INCLUDING, BUT NOT LIMITED TO MY DIAGNOSIS, RESULTS OF EXAMS, LAB RESULTS, DIAGNOSTIC TESTS, OPERATIVE, PATHOLOGY AND RADIOLOGY REPORTS, AND CONSULTATION REPORTS TO THE INDIVIDUALS LISTED BELOW WHO WILL BE DIRECTLY INVOLVED IN MY CARE AND TREATMENT.

This authorization does not permit the disclosure of information relating to HIV test results or treatment for AIDS, my history or treatment of drug or alcohol abuse, or mental health care. I understand that I have the right to further limit the protected health information that is to be released.

NAME	RELATIONSHIP	PHONE NUMBER (Optional)
1.		
2.		
3.		

(Please cross out any unused lines)

- I understand that the information disclosed by this authorization may be subject to re-disclosure by the person that received the information and is no longer protected by state and federal privacy laws.
- I understand that treatment at UTHSCT will not be denied if I do not sign this authorization
- I understand that I can revoke this authorization at any time but I cannot revoke this authorization to the extent that UTHSCT has taken action in reliance on the authorization.
- Unless revoked, this authorization will expire one year from the date of signature.

_____ _____

Patient/Legally Authorized Representative w/ Description of Authority **Date**

_____

Witness **Date**

REVOCATION OF AUTHORIZATION

I,_____, hereby revoke or cancel this authorization effective _____.
Date

_____ _____

Patient/Legally Authorized Representative w/ Description of Authority **Date**

_____ _____ _____ _____

Witness **Date** **Witness** **Date**

Approved by MIMC, Revised 08/04