KINGWOOD PINES HOSPITAL

CONDITIONS OF ADMISSION & CONSENT FOR TREATMENT

1. GENERAL DUTY NURSING: The hospital provides the patient with general nursing care. It is agreed that such must be arranged by the patient, legal representatives, or his/her physician.
   MEDICAL/PSYCHIATRIC: The patient is under care of his/her attending physicians. The undersigned consents to any x-ray examination, laboratory procedures, anesthesia, psychiatric, medical or hospital services rendered the patient under the general and special instructions of the physician. The undersigned realizes that all doctors of medicine furnishing services to the patient including the radiologist, pathologist, anesthesiologist and the like may be independent contractors and not employees or agents of the hospital. I, the undersigned, understand that if the patient appears to be dangerous to him/her or to others, the staff will exercise the necessary restraints and/or seclusion in order to protect the patient or others. The undersigned understands that a physician is not staffed on the premises 24-hours a day, but a physician is on-call and may be reached 24-hours a day by hospital staff.
2. MEDICAL EMERGENCIES: It is my understanding that during hospitalization at Kingwood Pines Hospital medical emergencies may arise which would be best treated at a general facility. For this reason, I am authorizing a general care facility to treat the named patient for any condition that might occur.
3. PERSONAL VALUABLES: The hospital maintains a safe for the safekeeping of money and valuables. The hospital shall not be liable for the loss or damage to money, clothing, jewelry, dentures, or any other articles of value unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping.
4. CONTRABAND ITEMS: The undersigned agrees and understands that drugs, alcohol, weapons, or other articles specified as contraband by the Hospital may not be brought onto the premises, and that failure to abide by this rule could result in immediate discharge from the hospital.
5. PHOTOGRAPHS: The undersigned hereby consents to the taking of a photograph for the purpose of identification. The photograph may be permanently retained in the patient's medical records. I understand that a patient identification wrist band may be used in lieu of a photograph. I understand the photograph will be used only for the purpose described, and will not be otherwise released without my express permission. Further, the undersigned acknowledges and is hereby informed that the hospital uses real-time video surveillance and recording equipment on its program units. This equipment is used solely for monitoring the patient areas for safety. Video surveillance and recording equipment is used in common areas and is never used in a patient's bedroom or bathroom.
6. VIOLENCE – ZERO TOLERANCE POLICY: I understand that Kingwood Pines Hospital enforces a Zero-Tolerance policy regarding violence (verbal or physical), and has the right to pursue legal action against any patient who engages in such violence against staff members, patients, visitors, or others while on hospital premises.
7. DISCHARGE AGAINST MEDICAL ADVICE: This certifies that the patient assumes full responsibility for being discharged against the advice of the attending physician and the hospital administration, and hereby releases the attending physician and Kingwood Pines Hospital from all responsibility for any ill effects which may result from this action.
8. PROPERTY DAMAGE: Any damage to hospital property, caused by the patient, will be billed to the patient's account for the cost of repair or replacement, and must be paid in full on or before discharge.
9. NON-DENOMINATIONAL CHURCH SERVICES: The undersigned consents for patient to attend non-denominational services provided by Kingwood Pines Hospital.
10. ***Kingwood Pines Hospital is committed to prevent, reduce, and strive to eliminate the use of restraint and seclusion.*** The use of seclusion and restraint is limited to emergency safety interventions only in situations where there is an imminent risk of self-harm, or harm to others. In the adult program with your consent, your family will be involved in your treatment; this will include notification, with the patient's permission, of a restraint or seclusion episode (parents/guardians will always be notified for children and adolescents).
11. ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: In consideration of the services rendered, I hereby transfer and assign Kingwood Pines Hospital all rights, titles, and interest in any payment due me for said services as provided by any and all policies of the insurance or other health care covered contract in which the patient is covered beneficiary. I further assign all right to payment due to medical services under said policies to the patient's attending practitioner and all consulting practitioners. I do hereby assign and transfer any and all Medicare/Medicaid benefits payable for hospital and practitioner services relating to this hospital admission to Kingwood Pines Hospital and the patient's attending and consulting practitioners, and hereby authorize the hospital and said practitioners or practitioner organizations to submit claims directly to Medicare/Medicaid for payment on behalf of the undersigned patient.
    I hereby authorize the above named hospital to release any information requested by said insurance company(s) its representatives, third party payers, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third party reimbursement. Nevertheless, each of the undersigned do hereby release and hold Kingwood Pines Hospital all agents and treating practitioners harmless of and from any and all costs, loss, damage or liability resulting from any such disclosure(s).
12. FINANCIAL AGREEMENT: The undersigned understands and agrees that Kingwood Pines Hospital is not responsible for collecting insurance, or for resolving any disputed insurance or other third party payer claim, and promises unconditionally to pay Kingwood Pines all costs and charges incurred in connection with the patient's hospitalization pursuant to this admission. It is agreed that if full payment is not made by insurance or other third party payers within thirty (30) days, the undersigned shall make payment in full. The undersigned acknowledged that failure to pay the hospital account may result in referral of said account to a commercial collection agency and/or credit bureau. Should the account be referred to any agency or attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
13. PHYSICIAN/PROFESSIONAL SERVICES: Physicians will bill separately for their services. You may incur bills for specialized services provided by physicians in the hospital other than your attending physician. Acceptable payment arrangements must be made with their business office. Physician offices encourage communication so that you will have a clear understanding of their billing and collection policies. ANY QUESTIONS OR CONCERNS REGARDING BILLING, INSURANCE, OR PAYMENT ARRANGEMENTS SHOULD BE DISCUSSED WITH OUR PATIENT ACCOUNT REPRESENTATIVES IN THE BUSINESS OFFICE AT 281-404-1001.
14. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) The undersigned acknowledges receipt and understanding of the facility HIPAA Guidelines, privacy practices, and commitment to compliance of such.
15. ADVANCE DIRECTIVES The undersigned acknowledges receipt of information about my rights to formulate medical and mental health advance directive. Patients are not required to have an advance directive in order to receive treatment at Kingwood Pines Hospital.
    _____ I HAVE executed an Advance Directive and will provide the facility with a copy _____ I HAVE NOT executed an Advance Directive, and information was provided
    _____ I HAVE executed a Declaration for Mental Health and will provide a copy _____ I HAVE NOT executed a Declaration for Mental Health Treatment
16. POST DISCHARGE WELLNESS CALL Undersigned acknowledges and consents to receive post discharge follow-up call
17. CONSENT TO TREATMENT The undersigned acknowledges and accepts treatment(s) ordered by my physician and consulting physicians. I will not be given treatment against my wishes and may discuss my refusal with my attending physician. I hereby consent to admission and treatment at Kingwood Pines Hospital until which time I am discharged from the facility. I acknowledge and understand the Conditions of Admission as stipulated above on this document.
    The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or parent/legal guardian if the patient is a minor, or is duly authorized by the patient as the patient's general agent to execute its terms.

PRINT NAME PATIENT/GUARDIAN	✍ SIGNATURE	DATE/TIME
PRINT NAME OF ADMISSIONS STAFF	✍ SIGNATURE	DATE/TIME