Texas Tech University Health Sciences Center Ambulatory Clinics **Consent to Treatment/Health Care Agreement**	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

I acknowledge that the "Notice of Privacy Practices" provides more information about how TTUHSC and its workforce may use and/or disclose protected health information (PHI). I understand that my PHI includes some but not all of the following like diagnosis, test results, prescriptions, medical history, treatment, my progress or any other such related information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"). I understand my PHI will only be used or released for treatment, payment or healthcare operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

NOTICE OF PRIVACY PRACTICES:
I have received or reviewed a copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

USE OF CELL PHONE OR EMAIL: I agree TTUHSC, its affiliates and agents may use an automated telephone dialing system, texting, and email to contact the cellular telephone number(s) or email addresses that I provide to TTUHSC for appointment and payment purposes._____ (Patient's Initials)

ADVANCE DIRECTIVE:
Do you have a current, signed Advance Directive? ____ YES ____ NO
Has a signed copy been provided to TTUHSC? ____ YES ____ NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date	**Print Name**	**Signature Patient/ legally authorized person**

Witness/Translator	**Relationship to Patient**