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 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 acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

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 acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC including, but not limited to, 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"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

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.

ADVANCE DIRECTIVE:		
Has an Advance Directive been signed?	____ YES	____ NO
If yes, is it still in effect?	____ YES	____ NO
Has a signed copy been provided to TTUHSC?	____ YES	____ NO

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

I certify that I have read this form or it has been read to me*.

Date	**Print Name**	**Patient/Other legally authorized person**
	Witness/Translator*	**Relationship to Patient**