USMD HOSPITAL AT FORT WORTH

UNIVERSAL CONSENT FOR TREATMENT

General Consent:

I understand that my health condition requires inpatient or outpatient admission to USMD Hospital at Fort Worth. I consent to and authorize testing, treatment and hospital care by USMD Hospital at Fort Worth nurses, employees and others as ordered by my doctor and his/her consultants, associates, and assistants. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand that persons in professional training programs may be among the individuals who provide care to me. If I am to receive obstetrical care, this consent is also given for any child(ren) born to me during this hospitalization. I understand that in connection with my treatment, photos or videos may be taken. Any tissue or body parts removed from my body may be retained or disposed of by the Hospital at its sole discretion.

Communicable Disease Testing:

I acknowledge that Texas Law provides the following for any health care worker who is exposed to my blood or other bodily fluid. The Hospital may perform tests, without my consent, on my blood or other bodily fluid to determine the presence of hepatitis B and C and HIV. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at the Hospital. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my hospital patient record.

Independent Physicians:

I acknowledge that the physicians taking part in my care do not work for the Hospital. They are engaged in the private practice of medicine and are not employees, servants or agents of the Hospital. In addition to my attending doctor, other doctors who may take part in my care may include but are not limited to surgeons, radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, physician assistants, emergency physicians and other specialists. I acknowledge that the Hospital is not responsible for the judgment or conduct of doctors who treat or provide a professional service to me.

No Guarantee:

I acknowledge that no guarantees or warranties have been made to me with respect to treatment provided at this Hospital. I understand that all supplies, medical devices, and other goods sold or furnished to me by the Hospital are sold and furnished by the Hospital are warranties with respect to them. With respect to specific supplies and devices, manufacturer warranty may apply, and I may request manufacturer's warranty information concerning such supplies and/or devices.

I have read and understand this information:

_____	_____	_____
Signature of patient or of an authorized representative	**Relationship to patient**	**Date**

If the person signing this form is not the patient, please give your full name, address and phone number

_____

_____	_____	_____
Witness	**Title**	**Date**

* For the purpose of this form only, a legally authorized representative is:
1) A legal guardian
2) An agent authorized in a medical power of attorney or directive to physicians
3) An attorney appointed by the court,
4) An attorney retained by the patient or patient's legally authorized representative
5) A parent or legal guardian of a minor, or
6) A person authorized under the Texas Consent to Medical Treatment act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy