3.06 Admission of Patients with an Emerging Infectious Disease (EID) to the Hospital

Purpose: To prevent transmission of an EID from patients with an EID or possible EID to admitting/financial personnel.

Audience: Admitting Office personnel, Financial Counselors, and Admitting Staff in the Emergency Department (ED)

Policy Statement:

1. Patients with a potential EID will wait in line outside the ED for triage.
2. While waiting, the patients will be asked to apply an alcohol hand rub to their hands and then complete an abbreviated down time form and a medical consent form.
3. Once at the triage desk, the nurse will ask a variety of epidemiologic questions and complete the nursing triage form. The nurse will collect the abbreviated down time form (A), the medical consent form (B) and the assignment of benefits form (C).
4. If the patient screens positive the patient will be taken inside the negative pressure zone. The triage nurse will place the abbreviated down time form and the assignment of benefits form in the basket on the triage table for the financial counselors. The triage nurses need to call the financial counselors on the cordless phone so they know forms are ready to be picked up. The medical consent form will be taken into the negative pressure zone and placed into the patient's chart.
5. Once the Financial Counselors have the abbreviated down time form they will enter the information into Invision and create arm bands and labels. Each time the Financial Counselors finish working with forms from the triage table, they should apply an alcohol hand rub to their hands. The arm bands, labels and patients copy of the assignment of benefits form will be taken to the negative pressure zone and handed through the first set of double doors in the lobby to a nurse or HUC inside the negative pressure area. The Financial Counselors need not enter the negative pressure zone.
6. If there are financial questions, especially about the assignment of benefits form, the patient may call the Financial Counselors using a cordless phone for additional information at extension 29551.
7. The patient will be balanced billed for the co-pay and any other charges associated with the ED visit.
8. If the patient is going to be admitted to the hospital, the ED personnel will call the Bed Information Center to get a bed assignment. The admitting sheet with the diagnosis of "influenza" and the fact that the patient is being admitted to 9D or a negative pressure room on 10B or

9B will alert the Financial Counselors that they will not visit the patient in the room. The Admitting Financial Counselors will call the patient and obtain any additional financial information over the phone. They will also have 2 employees on the line and will get a verbal consent to treat.

Downtime Registration Form

Form A

UH#:_____ Case#:_____ Patient Location:_____

Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip Code:
Maiden:	Birthdate/Birthplace:	SS#:	Religion:
Marital Status:	Race:	Language:	
Home Phone:	Alternate Phone:	Income:	# of Dependents

Employer Name:	Employer Phone:	Occupation:	
Employer Address:	City:	State:	Zip Code:

Emergency Contact:			Home Phone:
Address:			Work Phone:
City:	State:	Zip Code:	Relationship:

Nearest Relative:			Home Phone:
Address:			Work Phone
City:	State:	Zip Code:	Relationship:

Primary Care Physician:		Referring Physician:
Name of Insurance Plan:	Name of Insured:	ID#:
Guarantor Name:		Verification Phone Number: Verified Yes No

***Is this a work related injury: Yes_____ or No_____**

PHG____ HPPI____ Forms____ Information Loaded____ Information QA'd____

Form B

AGREEMENTS AND AUTHORIZATIONS

I. CONSENT FOR DIAGNOSIS AND TREATMENT: Knowing that I am suffering from a condition requiring hospital and physician care, I voluntarily consent to such hospital and physician care which includes diagnostic procedures and medical treatment by my physician, his or her assistants, or his or her designees, as may be necessary in his or her judgment. If I receive a psychiatric consultation, anything I say or do may be used in a court proceeding for detention or treatment.

II. CONSENT FOR NECESSARY TESTS IN THE EVENT OF ACCIDENTAL EXPOSURE TO BLOOD AND/OR BODY FLUIDS: I understand that while I am receiving care, physicians and other health care workers may inadvertently be exposed to my blood and body fluids and that such exposure may potentially transmit infectious diseases, including hepatitis and Acquired Immune Deficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infections. I acknowledge that the law provides for testing of my blood for evidence of these communicable diseases in the event of an accidental exposure and I agree to have my blood drawn and tested if such exposure occurs.

III. PERSONAL PROPERTY: I understand that the hospital provides a safe in the Business Office for the safekeeping of valuables, and that UTMB assumes no responsibility for items that remain in my possession.

IV. CONSENT FOR TREATMENT ON A PSYCHIATRIC UNIT: Additional consent is required to be treated on a Psychiatric Unit. Prior to admission I have had reviewed with me in a language that I can understand the following document(s): (Check)

☐ Introductory Statement including access to the patient complaint process and the Adult Patient Bill of Rights.

And if for treatment of a minor: ☐ Adolescent Bill of Rights ☐ Child: Wilbur, the Little Dinosaur Booklet.

And: ☐ UTMB Patient Rights and Responsibilities Statement.

Signature of Patient/Legal Representative X_____ **Signature of Witness** _____

V. COMPLAINTS ABOUT LICENSEES AND REGISTRANTS OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS: I acknowledge that complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attention: Investigations
P.O. Box 2018 Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353

VI. A photocopy of this document shall be considered as effective and valid as the original.

VII. The terms and consequences of this document have been fully explained to me to my understanding, and I have signed it freely and without inducement other than the rendition of services by UTMB and physicians.

VIII. AGREEMENT TO THE ABOVE TERMS AND CONDITIONS: My signature below acknowledges that I have read, or have had read to me, the information contained in the paragraphs above, and that I agree to the terms and conditions expressed above.

SIGNATURE _____ **RELATION TO PATIENT** _____

SIGNATURE OF WITNESS _____ DATE _____

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

EMERGENCY SERVICES

Agreements and Authorizations

Medical Record Form 2001-101-Rev. 11/01

The University of Texas Medical Branch Hospitals
Galveston, Texas

Original—Medical Record

Form C – Page 1

AGREEMENTS, AUTHORIZATIONS, AND IRREVOCABLE ASSIGNMENTS

I. ***CONSENT FOR DIAGNOSIS AND TREATMENT:*** Knowing that I am suffering from a condition requiring hospital and physician care, I voluntarily consent to such hospital and physician care which includes diagnostic procedures and medical treatment by my physician, his or her assistants, or his or her designees, as may be necessary in his or her judgment. If I receive a psychiatric consultation, anything I say or do may be used in a court proceeding for detention or treatment.

CONSENT FOR TREATMENT ON A PSYCHIATRIC UNIT: ***See Reverse Side.***

I understand that I am being admitted to a teaching hospital and, therefore, I may be visited and attended by students or residents of various disciplines.

I acknowledge that no guarantees have been made as to the results of treatment or examination that I will receive.

II. ***CONSENT FOR NECESSARY TESTS IN THE EVENT OF ACCIDENTAL EXPOSURE TO BLOOD AND/OR BODY FLUIDS:*** I understand that while I am receiving care, physicians and other health care workers may inadvertently be exposed to my blood and body fluids and that such exposure may potentially transmit infectious diseases including, hepatitis and Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infections. I acknowledge that the law provides for testing of my blood for evidence of these communicable diseases in the event of an accidental exposure and I agree to have by blood drawn and tested if such exposure occurs.

I understand that the tests will be done at the expense of UTMB and will not be charged to my account nor billed to my insurance carrier. I understand that the results of these tests may be released to the affected physician or other health care worker and as otherwise provided in the Communicable Disease Prevention and Control Act.

III. ***PERSONAL PROPERTY:*** I understand that the hospital provides a safe in the Business Office for the safekeeping of valuables, and that UTMB assumes no responsibility for items that remain in my possession.

IV. ***FINANCIAL RESPONSIBILITY:*** I hereby promise to pay The University of Texas Medical Branch at Galveston and its Physicians' Billing Service (hereinafter referred to as "UTMB") for any and all services rendered to me as a patient. In addition, I will be financially responsible for my child/children that is/are born or treated here.

If my account is referred to an attorney or collection agency, I agree to pay actual attorneys' fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

V. ***MEDICARE PATIENTS:*** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf. I have been advised, however, that Medicare may not cover the hospital charges related to this admission. I understand that I will be responsible for all charges should Medicare not pay.

VI. ***ASSIGNMENT OF INTEREST IN INSURANCE CLAIMS:*** For value received, and in consideration of the hospital and/or physician care and services rendered during the hospitalization and any and all subsequent hospitalization and/or treatment periods, I hereby irrevocably assign, and transfer absolutely to UTMB and/or physicians all my rights, title and interest in medical or disability insurance benefits payable under any plan or policy of insurance and all claims or causes of action relating to my hospitalization, treatments, and physicians' services rendered. I understand that I am responsible for any room rate difference not paid by my insurance company. THIS ASSIGNMENT SHALL NOT BE CONSTRUED AS RELEASING ME FROM HOSPITAL AND/OR PHYSICIANS' BILLS INCURRED, EXCEPT TO THE EXTENT SUCH BILLS MAY BE ACTUALLY COLLECTED UNDER ANY INSURANCE POLICIES OR PLAN.

VII. ***ASSIGNMENT OF THIRD PARTY CLAIMS, CRIME VICTIMS COMPENSATION:*** I hereby irrevocably assign to UTMB all right, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions of the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover. I further authorize UTMB to pursue on my behalf, any claim I may be entitled to pursue before the Crime Victims Compensation Division Of The Texas Industrial Accident Board in the event my hospitalization is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of UTMB. I understand that this agreement in no way restricts my or my dependents' independent rights to pursue any such claim before the Crime Victims Compensation Division Of The Texas Industrial Accident Board in the event I am entitled to file. I understand that if UTMB is not paid in full by proceeds of any insurance policies then this assignment does not release my obligation and liability to UTMB for payment of the services and items provided to me by UTMB. I agree to pay UTMB for all charges incurred or, alternatively, for all charges in excess of the sums actually paid pursuant to said policies.

VIII. ***CREDIT EVALUATION:*** I hereby authorize UTMB to make necessary investigation of my credit transactions by appropriate inquiry.

IF PT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

AGREEMENTS, AUTHORIZATIONS AND IRREVOCABLE ASSIGNEMENTS
Medical Record Form 2001-Rev. 08/03
Department of Admitting
301 University Blvd.
The University of Texas Medical Branch Hospitals
Galveston, Texas 77555-0209

PATIENT COPY

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68539

Form C - Continued

IX. ***CONSENT FOR RELEASE OF PATIENT INFORMATION FOR REIMBURSEMENT AND CONTINUITY OF CARE:*** I authorize UTMB and/or its physicians to release any information (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, including Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus Infection) for the period of my hospitalization 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 UTMB;
- individuals, agencies, or facilities, working with UTMB's staff 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.
- I further authorize UTMB to disclose patient-identifiable information about me for the purposes of seeking reimbursement assistance or for enrolling me in pharmaceutical patient assistance programs that may provide certain products free of charge or at a reduced rate. I understand that, in order to obtain reimbursement assistance or to determine my eligibility to participate in patient assistance programs, certain information about me, including, without limitation, the type and date of my medical diagnosis and treatment, my family income and my health insurance will need to be provided by UTMB to the pharmaceutical manufacturer(s) or their agent(s) for the product(s) prescribed to treat my condition. I understand this information will not be used for any other purposes than that as described above.

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

X. ***CONSENT FOR TREATMENT ON A PSYCHIATRIC UNIT:*** Additional consent is required to be treated on a Psychiatric Unit. Prior to admission I have had reviewed with me in a language that I can understand the following document(s): (Check)

☐ Introductory Statement including access to the patient complaint process and the Adult Patient Bill of Rights.

And if for treatment of a minor: ☐ Adolescent Bill of Rights ☐ Child: Wilbur, the Little Dinosaur Booklet.

And: ☐ UTMB Patient Rights and Responsibilities Statement. **Signature of Patient/Legal Representative X**_____

XI. ***COMPLAINTS ABOUT LICENSEES AND REGISTRANTS OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS:*** I acknowledge that complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attention: Investigations
P.O. Box 2018 Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353.

XII. A photocopy of this document shall be considered as effective and valid as the original.

XIII. The terms and consequences of this document have been fully explained to me to my understanding, and I have signed it freely and without inducement other than the rendition of services by UTMB and physicians.

The above Agreements, Authorizations, and Irrevocable Assignments pertain to the admission/occasion of service

XIV. ***AGREEMENT TO THE ABOVE TERMS AND CONDITIONS:*** My signature below acknowledges that I have read, or have had read to me, the information contained in the paragraphs above, and that I agree to the terms and conditions expressed above.

SIGNATURE _____ RELATION TO PATIENT _____

SIGNATURE OF WITNESS _____ DATE _____

XV. ***ACKNOWLEDGMENT OF RECIPT:*** My signature only acknowledges my receipt of the Message (An Important Message from Medicare) from the Hospital and does not waive any of my rights to request a review or make me liable for any payment.

SIGNATURE _____ RELATION TO PATIENT _____
(Beneficiary or person acting on behalf of beneficiary)

SIGNATURE OF WITNESS _____ DATE _____

XVI. ***AUTHORIZATION TO RELEASE INFORMATION:*** I hereby authorize The University of Texas medical Branch at Galveston and Physicians' Billing Service (hereinafter referred to as "Hospital") to release any information requested by any insurance company, insurance company designee, self-insured entities, HMO, PPO's, Medicare and/or Medicaid that may be required in order to determine benefits due under the terms of such plan for hospital and physicians' services rendered to the above-named patient.

SIGNATURE _____ RELATION TO PATIENT _____
(Beneficiary or person acting on behalf of beneficiary)

SIGNATURE OF WITNESS _____ DATE _____