Houston Northwest MEDICAL CENTER

Consent for Treatment

1. Consent to Medical and Surgical Procedures

I, the patient identified below or the patient's legally authorized representative, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, including testing of blood or other bodily fluid to determine the presence of any communicable disease such as, to the extent allowed by law, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS), x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of my/the patient's physician or surgeon. I further consent to my/the patient's physician or surgeon or his/her designees including other practitioners and hospital personnel, which may include health care professionals in training, performing or administering all tests, services or treatments indicated as previously described.

2. Consent to Vaccine

I consent to administration of pneumococcal (pneumonia) vaccine and influenza vaccine(Oct-March) as determined by nursing screening and medical staff protocol.

3. Consent to Photograph

I permit the hospital to photograph as a part of the documentation of my/the patient's medical/surgical condition. These photographs will be maintained as part of my/the patient's permanent medical record. I understand and acknowledge that the hospital is permitted to use cameras to monitor all patients.

4. Nursing Care

I understand and acknowledge that this hospital will provide nursing care to meet my/the patient's needs in accordance with accepted standards of nursing practices. If I/the patient desire sitter services or the services of a private duty nurse to provide personal care needs, I understand that such retention of such services is my responsibility and I agree to notify the hospital if I intend to arrange for additional or private duty nursing. I also understand and acknowledge that the hospital may use cameras or other devices for patient monitoring.

The undersigned certifies that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative, or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____

Date Patient/Patient's Authorized Signature

_____ _____ _____

If other than patient, indicate relationship Witness Witness