Baylor Scott & White MEDICAL CENTER UPTOWN
Joint ownership with physicians

Radiology Department
Patient Registration

Patient Label

Please provide your driver's license or photo ID and insurance card at time of registration.

Patient Last Name | First Name | MI | Date of Birth (MM / DD / YYYY)

Social Security Number (- -) | Gender (M ☐ F ☐) | Email Address (to access your records and for satisfaction survey)

Responsible Party | Relationship to Patient | Patient's Mobile Phone ( ) - | Call ☐ Msg ☐

Address | Apartment # | Patient's Home Phone ( ) - ☐ ☐

City | State | ZIP | Work or Other Phone ( ) - ☐ ☐

Emergency Contact | Emergency Contact Phone 1 ( ) - | Emergency Contact Phone 2 ( ) -

May we send mail to your home address? Yes ☐ / No ☐ If not, please provide an alternate mailing address:

street or p. o. box apt. # city state zip

Insurance | Subscriber Name | Subscriber DOB (MM / DD / YYYY) | Group Number | Policy Number

If Accident: Date (MM / DD / YYYY) | Time | Accident Details

Work Related? Yes ☐ No ☐ | Employer | Employers Phone ( ) -

Religious Preference | Preferred Language

Other than you, your insurance company and healthcare providers involved in your care, with whom can we share your healthcare information? (Please enter all that apply.)

Name	Phone Number	Relationship
	( ) -	
	( ) -	
	( ) -	
	( ) -	

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I hereby verify the above information is true and correct.

Patient or Legal Guardian Signature | Date / / | Time

Witness Signature | Date / / | Time

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CONSENT FOR TREATMENT: I, the undersigned, request and authorize ***Baylor Scott & White - Uptown***, and all its physicians, surgeons, technicians, nurses, and other qualified personnel, whether employed directly by the hospital or brought in on a consulting basis, to provide any medical/surgical treatment, diagnostic tests and hospital care which the attending physician or designee(s) may deem necessary or beneficial for my health. **Initial** ☐

FINANCIAL AGREEMENT: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines, however, the responsibility for the balance of this account falls on you. **Initial** ☐

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to ***Baylor Scott & White - Uptown*** and any physicians, including, but not limited to ER physicians, radiologists, etc. of the insurance benefits specified and otherwise payable to me, but not to exceed the Hospital's regular charges for these services. **Initial** ☐

RELEASE OF INFORMATION: I authorize ***Baylor Scott & White - Uptown*** and any physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this emergency department visit to any organization which is, or may be liable or responsible for payment of charges associated with my care, and for all other purposes of benefit payment. If my injury is work-related, I authorize ***Baylor Scott & White - Uptown*** to release any information from my medical records to my employer and/or its designee.
Initial ☐

PHYSICIANS SERVICES: Emergency Department physicians, radiologists, pathologists, surgeons, etc. are independent contractors, and are not employees of ***Baylor Scott & White - Uptown*** . Physicians' services are billed separately.
Initial ☐

PERSONAL ITEMS and MEDICATIONS: I understand that ***Baylor Scott & White - Uptown*** is not responsible for lost or stolen personal or valuable items or medications. **Initial** ☐

PATIENT RIGHTS: I have received a copy of the **PRIVACY NOTICE, PATIENT RIGHTS and GRIEVANCE POLICY.**
Initial ☐

SENSORY OR PHYSICAL IMPAIRMENTS: I understand ***Baylor Scott & White - Uptown*** has resources to meet most special needs for patients with sensory or physical impairments. **I do ☐ / do not ☐** have special needs. **Initial** ☐

Identified needs:

Patient or Legal Guardian Signature **Date** / / **Time**

Witness Signature **Date** / / **Time**

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Texas law requires healthcare facilities to ask patients to identify their own race and ethnic background. If the patient fails or refuses to identify their own race and ethnic background, facility staff will use its best judgment in making the identification.

Race:

- ☐ American Indian, Eskimo or Aleut
- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other: (including multi-racial, mixed) _____
- ☐ Prefer Not to Answer

Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Prefer Not to Answer

Patient or Legal Guardian Signature _____ **Date** / / **Time** _____

Witness Signature _____ **Date** / / **Time** _____

Access to Health Records Online

If you would like to have access to your records for this radiology visit online, please provide your email address below. You should receive an email invitation to join ***myHealth*** from ***United Surgical Partners*** ***[mailto:noreply@iqhealth.com]*** Please check your SPAM folder if you don't find it in your inbox.

Patient Satisfaction Survey

We would like you to have a voice in our quality improvement. With your permission, we will email you a survey to allow you to give us feedback about your experience as a patient at ***Baylor Scott & White - Uptown.*** Your email address will be kept confidential, and not used for any other purpose.

Please enter your email address here: _____

Disclosure of Physician Ownership

Baylor Scott & White - Uptown meets the Federal definition of a physician-owned hospital, and a list of the hospital's owners that are physicians (or their immediate family members) is available upon request. Radiologists are independent contractors, not owners or employees of ***Baylor Scott & White - Uptown*** .

Baylor Scott & White - Uptown is committed to providing clinical excellence in a safe, attractive environment for you and your family members. We are proud that many of the physicians who practice here have chosen to have ownership in this hospital. Their ownership enables them to have a voice in the administration and policies of our hospital. This involvement helps to ensure the highest quality of care for you.

If you have any questions concerning this notice, please feel free to ask your physician or the Chief Executive Officer at ***Baylor Scott & White - Uptown .***

Baylor Scott & White
MEDICAL CENTER
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Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Place Patient Identification Label Here

Home # _____

Work # _____

Mobile # _____

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Baylor Scott & White - Uptown or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Baylor Scott & White - Uptown or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

_____

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

_____

_____

Other than you, your Insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	**Telephone**
☐Spouse	_____	_____
☐Caretaker	_____	_____
☐Child	_____	_____
☐Parent	_____	_____

☐Other _____ _____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**