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.***

Informed Consent for MRI Scan With or Without Contrast Injection

PATIENT'S NAME: _____ MEDICAL RECORD NUMBER: _____

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

Inform center personnel at once if you are pregnant, or think you may be pregnant.

Inform the technologist if you have heart valves, a pacemaker, aneurysm clips or other implanted metallic or electrical devices.

CONSENT TO IMAGING PROCEDURE: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as Magnetic Resonance Imaging (MRI) to aid in diagnosing and treating your medical condition. MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that requires that you lie still on a padded table that gently glides you into the magnet. As part of your MRI exam, a contrast agent may be injected into your vein in order to produce better images of the part of your body that is being examined. The MRI procedure may be conducted without the injection of the contrast agent, but the images may not be as helpful to the radiologist and your physician. If you wish to refuse the contrast injection, inform the technologist and the MRI will be conducted without the contrast agent.

POTENTIAL RISKS: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. MRI exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important to inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma, or other allergic conditions, any history of anemia, sickle cell anemia, or kidney disorder, are pregnant or breast feeding you must inform the technologist. The safety of contrast for children under the age of two has not been established.

PATIENT SIGNATURE: I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

I understand that the physicians participating in my care at BMC@U are not employees or agents of Baylor Scott & White - Uptown. They are either independent physicians engaged in the private practice of medicine or are licensed physicians participating in the care of patients as part of a post-graduate medical education program. Physicians who may participate in my care in addition to my attending physician include, but are not limited to radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, pulmonologists, gastroenterologists and nephrologists. The physicians participating in my care may or may not be financial partners at Baylor Scott & White - Uptown.

_____ _____

SIGNATURE OF PATIENT OR LEGAL RESPONSIBLE PERSON (STATE RELATIONSHIP) **DATE**

_____ _____

WITNESS TO SIGNATURE DATE

Patient Name: _____ **Date:** _____ **Sex: M F Weight:** _____ **DOB** _____

Referring Physician: _____ **Reason for your exam (MRI) today:** _____

Have you had a previous Imaging relating to this problem? Y N

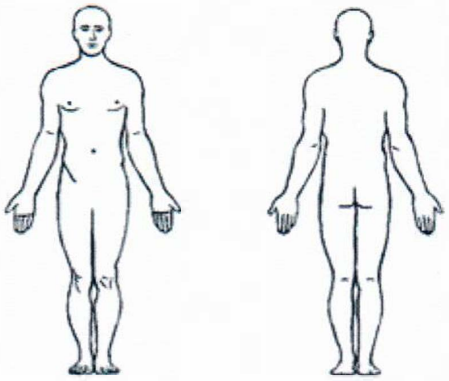
If yes, what type of exam was done and name of the facility that performed the exam:

_____

Please indicate if you have any of the following:

_ Yes _ No Brain/ Aneurysm clip(s)
_ Yes _ No History of Seizures
_ Yes _ No Cardiac pacemaker
_ Yes _ No Implanted cardioverter defibrillator (ICD)
_ Yes _ No Electronic implant or device
_ Yes _ No Heat dispersion disorders
_ Yes _ No Spinal cord stimulator
_ Yes _ No Internal electrodes or wires
_ Yes _ No Bone growth/bone fusion stimulator
_ Yes _ No Ear/ Cochlea Implant/ Hearing Aid
_ Yes _ No Insulin or other infusion pump
_ Yes _ No Implanted drug infusion device
_ Yes _ No Any type of prosthesis (eye, penile, etc.)
_ Yes _ No Heart valve prosthesis
_ Yes _ No Artificial or prosthetic limb
_ Yes _ No Stents/ Filters/ Coils
_ Yes _ No Shunt (spinal or intraventricular)
_ Yes _ No Vascular access port and/or catheter
_ Yes _ No Medication patch (Nicotine, Nitroglycerine)
_ Yes _ No Any metallic fragment or foreign body
_ Yes _ No Surgical staples, clips, or metallic sutures
_ Yes _ No Joint replacement (hip, knee, etc.)
_ Yes _ No Bone/joint pin, screw, nail, wire, plate, etc.
_ Yes _ No Dentures or partial plates
_ Yes _ No Tattoo or permanent makeup
_ Yes _ No Body piercing jewelry
_ Yes _ No Any other metal objects (gun shots, BB's, shrapnel) or implants _____
_ Yes _ No Breathing problem or motion disorder
_ Yes _ No Claustrophobia

Please Mark Area of Pain



IMPORTANT INSTRUCTIONS

*Before entering the MRI scan room, you must remove **ALL metallic objects** including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, wigs, hair extensions, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads.*

List Previous Surgeries: _____

List All Allergies: _____

List All Medical Problems: _____

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding information on this form.

Signature of Person Completing Form: _____ **Date** ____/____/____

Form Completed By: ___ Patient ___ Relative ___ Nurse (Print name of person completing form) _____

Form Information Reviewed By: _____

___MRI Technologist ___ Nurse ___ Radiologist ___ Other _____

Technologist Notes: _____

Revised: 06/19/14

Comunicación preferencias con respecto a del paciente su PHI

Preferencias de comunicación telefónica

Etiqueta de identificación del paciente lugar aquí

Home # _____

Work # _____

Mobile # _____

Preferencias de comunicación de correo electrónico

Correo electrónico Address___

Con el fin de servir mejor a nuestros pacientes y comunicarse con respecto a sus servicios y obligaciones financieras utilizaremos todos los medios de comunicación para acelerar esas necesidades. Proporcionando la información anterior estoy de acuerdo que Baylor Scott & White - Uptown o uno de sus agentes legales puede utilizar los números de teléfono proporcionado me envíe una notificación de texto, mediante un mensaje de voz pre-recorded artificial mediante el uso de un servicio de marcación automática o dejar un mensaje en un contestador. Si se ha proporcionado una dirección de correo electrónico, Baylor Scott & White - Uptown o uno de sus agentes legales puede comunicarse conmigo con una notificación por correo electrónico con respecto a mi cuidado, nuestros servicios o mi obligación financiera.

_____

Preferencias de comunicación de correo

¿Podemos enviar correo a tu domicilio? ***(Si no, proporcione una dirección de correo alternativa más abajo).***

_____

_____

¿Aparte de usted, su compañía de seguros y proveedores de salud involucrados en su atención, quien hablamos con su información de salud? (Marque todas las que apliquen)

Nombre **Teléfono**

O cónyuge _____ _____

O cuidador _____ _____

O niño _____ _____

Padres o _____ _____

O otros _____ _____

¿Tienes alguna información de salud que le gustaría ser confidencial de cualquier persona o personas? Si es así, describa específicamente la información y la persona o personas más abajo:

_____
_____

Reconozco que ha dado la oportunidad a solicitar restricciones sobre el uso o divulgación de mi información de salud protegida.

Reconozco que he tenido la oportunidad de solicitar medios alternativos de comunicación de mi información de salud protegida.

_____ _____
Paciente o Representante Personal firma Fecha

_____ _____
Imprimir nombre relación al paciente

Formulario de detección de embarazo

(Edades 12 a 55 años)

Patient Name: _____ Age: _____

1.) estás embarazada o crees que puede estar embarazada? _____ Y _____ N
(Si "Sí", por favor notifique a personal inmediatamente).

2.) ha tenido una histerectomía o después de la menopausia son? _____ Y _____ N
(Si "Sí", por favor, firme a continuación).

3.) has tenido un período menstrual durante los últimos 30 días? _____ Y _____ N
(Si no, necesitará tener una prueba de embarazo).

4.) por favor dar la fecha del^{primer} día de su último período menstrual. _____

5.) esta fecha cae en los últimos 10 días? _____ Y _____ N
(Si "Sí", por favor, firme a continuación).

6.) están actualmente practicando alguno de los siguientes anticonceptivos? _____ Y _____ N

A.) ___ la ligadura de trompas
B.) socio vasectomía ___
C.) ___ anticonceptivos orales
D.) ___ condón
E.) ___ diafragma
F.) Foam _____
G.) IUD _____
H.) otros ___

7.) **si no estás practicando todas las medidas de control de la natalidad, ha tenido actividad sexual desde su última menstruación que puede ponerte en riesgo de embarazo?**_____ Y _____ N

He dicho que no estoy embarazada y solicitar el procedimiento ordenado de proyección de imagen de realizarse.

Firma del paciente: ___ Fecha: ___

Firma del testigo: ___ Fecha: ___