Baylor Scott & White | MEDICAL CENTER UPTOWN

Joint ownership with physicians

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

LAST NAME: _____ FIRST NAME: _____ MI: _____

SSN#: _____ DOB: _____ GENDER: M ☐ F ☐

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ MOBILE #: _____

MARITAL STATUS: _____MARRIED _____SINGLE _____DIVORCED _____OTHER

RELIGIOUS PREFERENCE: _____ PREFERREDLANGUAGE: _____

EMPLOYER: _____ EMPLOYMENT STATUS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

EMAIL ADDRESS: (E-Survey purpose only) _____

INSURANCE INFORMATION

PRIMARY INS: _____ POLICY #: _____ GRP#: _____

POLICY HOLDER: _____ DOB: _____ SSN #: _____

REL TO PATIENT: _____ EMPLOYER: _____

SECONDARY: _____ POLICY: _____ GRP #: _____

POLICY HOLDER: _____ DOB: _____ SSN #: _____

REL TO PATIENT: _____ EMPLOYER: _____

WORKERS COMP CARRIER: _____ CLAIM#: _____

ADJUSTER: _____ PHONE #: _____

PLEASE BRING YOUR DRIVERS LICENSE AND ALL INSURANCE CARDS ON YOUR DATE OF SERVICE THANK YOU

BaylorScott&White | MEDICAL CENTER UPTOWN

Joint ownership with physicians

Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Privacy Notice for Baylor Medical Center at Uptown, Baylor Medical Center Imaging, and Baylor Medical Center for Physical Medicine.

Privacy Notice Revision Date: October 28, 2015

_____ _____

Patient or Personal Representative Signature **Date**

_____

Personal Representative's Relation to Patient

ABOVE - Patient or Personal Representative Use Only

BELOW - Provider Use Only

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

☐ Patient refused to sign the Privacy Notice Acknowledgement

☐ Patient was unable to sign because:

_____

☐ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

☐ Other reason, described below:

_____

_____

_____ _____

Employee Signature **Date**

PATIENT LABEL:

BaylorScott&White | MEDICAL CENTER UPTOWN

Joint ownership with physicians

Patient's Communication Preferences Regarding their PHI

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.

Place Patient Identification Label Here

_____ I agree if an email address has been provided, Baylor Scott & White Medical Center - Uptown, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

_____ I agree if a telephone number is provided, Baylor Scott & White Medical Center - Uptown, its legal agents, or affiliates may use the numbers to 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.

_____ I agree if a mobile number is provided, Baylor Scott & White Medical Center - Uptown, its legal agents, or affiliates may use the number provided to send a text notification. Text messaging is not a completely secure means of communication because messages can be accessed improperly while in storage or intercepted during transmission. Text messages may contain personal information.

_____ I agree if my Primary Care Provider (PCP) information is provided below, Baylor Scott & White Medical Center – Uptown will fax my discharge information to my PCP regarding today's date of service in the event my surgeon requests for an overnight stay.

Telephone Communication Preferences

Home # _____ Work # _____ Mobile # _____

Email Address: _____

Primary Care Physician Communication Preferences

PCP Name: _____ PCP Phone #: _____

PCP Address: _____ PCP City/St/Zip Code: _____

PCP Fax #: _____ PCP email: _____

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

	Name	Telephone
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

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**

BaylorScott&White | MEDICAL CENTER UPTOWN
joint ownership with physicians

Advance Directive Acknowledgment

An ADVANCE DIRECTIVE is a legal document designed to help you communicate your wishes about future medical treatment when you are unable to make your wishes known because of illness or injury. You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician.

If you have an Advance Directive, complete Questions 1 - 5

1. Do you have any of the following ADVANCE DIRECTIVES? (Check all that apply)
   ☐ Medical Power of Attorney ☐ Living Will ☐ Out of Hospital Do Not Resuscitate ☐ Mental Health Directive
2. If you have any of these documents and do not have a copy with you, where is it located? _____
3. Can someone bring a copy to the hospital? ☐ Yes ☐ No
4. If you have an Advance Directive, but a copy is not available at this time, what are your treatment wishes if you become terminally or irreversibly ill and are unable to make your wishes known? _____
   _____
5. If you are unable to make your wishes known, indicate your designated representative that may make decisions for you:
   _____
   Name *Relationship* *Telephone Number*

If you DO NOT have an Advance Directive, complete Questions 1 – 3

1. If you do **NOT** have an Advance Directive and **wish to complete one**, we will provide the proper forms and other information needed to complete the directive:
   ☐ Communicating Your Health Care Choices ☐ Personal Choices ☐ Decline any information
2. ☐ I do NOT wish to make an Advance Directive at this time.
   I am aware that if I become unable to make decisions for myself and I have not completed an Advance Directive, state law will require that my physicians turn to the persons in the order listed for medical decision-making: my spouse, my reasonably available children, my parents, or my nearest living relative. If none of those persons are available or willing to act on my behalf, I am aware that state law allows my doctors to turn to the Hospital's Ethics Committee or to a court of law for medical decision-making. This information will be available from your doctor. However, if you have questions or wish to discuss this further with him/her, please let us know. You may rescind any portion of these Directives at any time during your hospitalization by notifying any member of the health care team.
3. If you are unable to make your wishes known, indicate your designated representative that may make decisions for you:
   _____
   Name *Relationship* *Telephone Number*

Patient Signature: _____ **Date/Time:** _____

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

For Hospital Staff use only- Please date the following when completed (if applicable):

_____ Patient unable to discuss (re-assess daily). Information given to family/surrogate.
_____ Advance Directive placed in medical record.
_____ Advance Directive sticker placed in physician notes.
_____ Patient desired more information – referred to Case Management Representative.

Staff Signature: _____ **Date/Time:** _____

Patient Sticker

Revised March, 2017

BaylorScott&White | MEDICAL CENTER UPTOWN
joint ownership with physicians

PATIENT'S CONSENT ON ADMISSION TO BAYLOR SCOTT & WHITE CENTER UPTOWN

Consent to Medical and Surgical Procedures: I give my consent to all the medical procedures which may be performed upon me by the Hospital, on either an inpatient or outpatient basis, which are ordered or prescribed for me by my attending physicians. This may include but are not limited to: laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician. Diagnostic results may include requirements for disclosure of information regarding cases of HIV, tuberculosis, viral meningitis, and other disease that are reported to organizations such as the health departments or the Centers for Disease Control and Prevention.

Consent to Draw Blood / Emergency Procedures: I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the Hospital has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to medical treatment from a licensed physician in the event of a highly urgent or emergency event in which the patient, a family member, or other responsible party cannot reasonably be reached to authorize treatment.

_____ **Financial Agreement:** The undersigned agree(s), whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Hospital for services rendered to the patient accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay attorney's fees and collection expenses actually incurred. I further acknowledge that all physicians furnishing services eluding but not limited to ER physicians, radiologist, pathologist, anesthesiologist, consultants and assistants to the physician are independent contractors and not employees of the hospital. I understand that I may receive separate billing from each of these providers for service rendered, and these providers may not participate with my insurance carrier meaning the claim will processes out of network.

Assignment of Insurance Benefit: I hereby authorize payment directly to Baylor Scott & White Medical Center Uptown and all attending physicians of the insurance benefits specified and otherwise payable to me but not to exceed the Hospital's regular charges for these services. I understand that I am financially responsible to the Hospital for charges not covered or disallowed by this assignment.

Estimated Financial Responsibility: I understand that Baylor Scott & White Medical Center Uptown has confirmed my benefit coverage. Benefits are estimated, and not guaranteed, until the claim has been paid. If actual coverage differs from the quote given by the insurance company, or the surgery differs from the procedures scheduled, I am responsible for actual charges

My estimated financial responsibility is: _____

Release of Information: I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or maybe 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 the Hospital to release any information from my medical records to my employer and/or its designee.

Personal Items and Medications: I understand that to Baylor Scott & White Medical Center Uptown is not responsible for lost or stolen personal or valuable items. It is understood and agreed that I will not bring or consume personal medications without the Hospital's notice of written permission from my attending physician and that the hospital will not be liable for any harm incurred thereby.

Physician Ownership Acknowledge (Please Initial)

_____ I acknowledge that one or more of the physicians providing treatment at Baylor Scott & White Medical Center Uptown may have an ownership interest in Baylor Scott & White Medical Center Uptown. I also acknowledge that I have the right to choose the provider of my healthcare services and have chosen Baylor Scott & White Medical Center Uptown. I understand that the physicians participating in my care at Baylor Medical Center at Uptown are not employees or agents of Baylor Scott & White Medical Center 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, or third and fourth year medical students participating in an proved medical education program under the direct supervision of the attending physician. Physicians who may participate in my care in addition to my pending physician include, but are not limited to, radiologists, pathologists, anesthesiologists, cardiologists, pulmonologists, gastroenterologists and nephrologist. The physicians participating in my care may or may not be financial partners in Baylor Scott & White Medical Center Uptown.

_____ **Patient Right:** I have been informed of and received a copy of the "Patient's Right and Responsibilities", a copy of the "Financial Assistance Summary", Financial Assistance Policy" and copy of the "Financial Assistance Application" Baylor Scott & White Medical Center Uptown.

Do you have an ADVANCE DIRECTIVE?

Yes, Yes if where is it located? _____

No

Non-Smoking Policy: In accordance with regulatory agency standards, Baylor Scott & White Medical Center Uptown is non-smoking facility.

Medicare Patients Only (Please Initial)

_____ If this is an admission, which is covered by Medicare, I have received a copy of "An Important Message From Medicare" furnished by Baylor Scott & White Medical Center Uptown.

_____ _____ _____

Signature of Patient or Legally Responsible Person **Date** Witness Signature

BaylorScott&White
MEDICAL CENTER
UPTOWN
Joint ownership with physicians

To: Our Patients

From: Baylor Medical Center at Uptown

Thank you for choosing Baylor Medical Center at Uptown. We are committed to providing clinical excellence in a safe, attractive environment for you and your family members. We welcome you as a patient and value our relationship with you. In connection with your visit to Baylor Medical Center at Uptown, please be aware of the following:

- Certain anesthesiologists, pathologists, radiologists, or emergency department physicians ("facility-based physicians") who may provide medical services to you while at Baylor Medical Center at Uptown may not be participating with your health insurance plan.
- You may receive a bill for medical services from a facility-based physician for the amount unpaid by your insurance policy.
- You may request a list of facility-based physicians who have been granted medical staff privileges at Baylor Medical Center at Uptown.

You may request information from a facility-based physician as to whether the physician is a participating provider with your health plan and under what circumstances you may be responsible to pay amounts not covered by your insurance

_____ I acknowledge that I have been offered a copy of this notice by Baylor Medical Center at Uptown staff.

Patient Signature: _____ **Date / Time:** _____

Witness to Signature: _____ **Date / Time:** _____

State Required Ethnicity and Race Questions

Texas law requires the Texas Health Care Information Council to collect information on the race / ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds.

If patients fail or refuse to identify their own race and ethnic backgrounds, facility staff will use its best judgement in making the identification.

Ethnicity:

- ☐ **Hispanic / Latino**
- ☐ **Not Hispanic / Latino**
- ☐ **Prefer not to answer**

Race:

- ☐ **American Indian / Eskimo / Aleut**
- ☐ **Asian or Pacific Islander**
- ☐ **Black**
- ☐ **White**
- ☐ **Other (*Including multiracial or mixed*):** _____
- ☐ **Prefer not to answer**

Language:

- ☐ **English**
- ☐ **Spanish**
- ☐ **Other:** _____

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