

PATIENT REGISTRATION FORM

Baylor Family Medicine at Flower Mound, 1110 Parker Square, Flower Mound, TX 75028

FOR OFFICE USE ONLY

Acct # _____

Today's Date: _____

Patient Information

Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Email Address	
Referred By:	Date of Birth	Age	Sex (check one) Male Female	Social Security # Drivers License #
Occupation	Employer	Employer Address		
Marital Status (check one) Single Married Widowed Divorced Separated	Spouse's Name		Race (check one) American Indian Asian Black Hispanic White Other	
If Student, Indicate School		If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):		
Emergency Contact (not living at same address)			Emergency Contact Phone # ()	

Responsible Party

Guarantor Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Drivers License #	
Date of Birth	Age	Sex (circle one) Male Female	Social Security #	Patient Relationship to Guarantor
Employer	Employer Address			

Insurance Information

Name of Primary Insurance Company			Phone #	Name of Secondary Insurance Company			Phone #
1.			()	2.			()
Mailing Address				Mailing Address			
City		State	Zip	City		State	Zip
Policy Number	Group Number	Effective Dates of Policy		Policy Number	Group Number	Effective Dates of Policy	
		From:				From:	
		To:				To:	
Policy Holder (if other than patient)			Date of Birth	Policy Holder (if other than patient)			Date of Birth
Social Security #		Relationship to Patient		Social Security #		Relationship to Patient	
Policy Holder's Employer		Work Phone # ()		Policy Holder's Employer		Work Phone # ()	
Employer Address				Employer Address			
City		State	Zip	City		State	Zip

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FOR OFFICE USE ONLY

Acct # _____

Patient Name: _____

Accident / Workers Comp

Insurance Company	Phone # ()	
Mailing Address		
City	State	Zip
Effective Dates of Policy From:	Date of Accident / Onset	Due To: (circle one) Auto accident Work injury / illness
To:	Other	
Agent / Adjuster / Case Manager		
If Workers Comp: Claim #	TWCC Claim #	

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian **Date**

HEALTHTEXAS PROVIDER NETWORK NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/ Information

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians¹ with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with

¹ Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

your care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at www.baylorhealth.edu; and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial,

administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 02/01/06
VERSION: 2

Patient Name: _____ Patient Identifier: _____



**ACKNOWLEDGMENT OF THE RECEIPT OF
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION
PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians¹ may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

(Signature of Patient or Legal Representative)

(Date)

February 1, 2006
(Effective Date of Notice)

¹Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

Patient Name: _____ Patient Identifier #: _____

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to **Baylor Family Medicine at Flower Mound** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ I do not wish to disclose any information with anyone.

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only

Written Communication

OK to mail to my home address _____

OK to mail to my work/office address _____

OK to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date

Electronic Communications to Patients

Baylor Office EHR is a joint effort of HealthTexas Physician Network physicians and other physicians aligned with Baylor Health Care System to fully support an electronic patient care experience through implementation of a common electronic health record platform. HealthTexas Physician Network (“HTPN”) is pleased to offer Baylor Office EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

Use of Electronic Communication from HTPN to the Patient

Please check the appropriate box below:

Yes, I want HTPN to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

E-mail address: _____.

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

No, I do not want HTPN to use electronic communication as a way to communicate my information to me.

HTPN E-mail Guidelines

- At this time, HTPN can only send e-mails *to* patients. Currently, HTPN is not able to *accept* patient e-mails.
- All e-mail you receive from HTPN is sent under the name and e-mail account of DFW Centricity.
- The patient is responsible to notify HTPN promptly of any changes to his/her e-mail address.
- All of HTPN’s electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- HTPN will not share your e-mail address with anyone unauthorized to view your medical record.

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from HTPN. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

Name

Date

Patient Instructions for Secure Messages

1. You will receive an email in your Inbox from BaylorofficeEHR@BaylorHealth.edu or name@BaylorHealth.edu (the name may be the physician or nurse). Note: please make sure you have your email set up to accept emails with the domain BaylorHealth.edu so it will not be discarded as SPAM mail.
2. Open the email and **click** on the link in the message.

BAYLOR Office EHR

Secure Message

You have received a secure message from Marek, Deirdre [DeirdreM@BaylorHealth.edu].

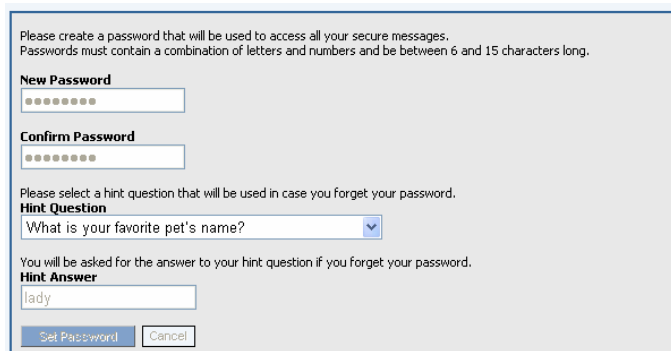
To retrieve this message click on the following link

https://tst.baylorpatient.com/mc10/ViewMessage.aspx?key=4aad7wb8IESUQH_48Q5s75-G5GcnYw

3. A welcome greeting will appear that describes Secure Messaging. **Click** Next



4. On the initial log-in, you will need to create a password. **It is important that you write down your password and put it in a secure location** because this same password will be used with any future messages received from your provider. **Type** in the information and **click** set password



5. If you forget your password and attempt to enter the system, you will get locked out after three bad password attempts to enter your account. You will be locked out for 20 minutes before you can try again. Please make a note of your password and put it in a secure location. If you are still unable to get into the system, please contact [your physician office](#) for help.
6. You will be able to **view the secure message but will not have the option to reply**.



BAYLOR FAMILY MEDICINE AT FLOWER MOUND
HEALTH HISTORY

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential. Thank you.

Occupation: _____

Drug Allergies & Reaction: _____

Medications (include vitamins, over-the-counter meds, birth control): _____

Health Habits: Check & describe all that apply.

_____ Caffeine _____	_____ Tobacco _____
_____ Alcohol _____	_____ Drugs _____
_____ Exercise _____	_____ Diet _____

Women: Date of last period _____ Menstrual History _____
Contraceptive Method _____ Any problems? _____

Medical Illnesses (e.g. diabetes, cancer, lung/heart/stomach/kidney/liver disease, nervous or psychiatric disorders):

Surgeries / Hospitalizations (e.g. appendix, tonsils, hysterectomy, vasectomy, etc.):

Family History:

<u>Living?</u>	<u>Age/age at death</u>	<u>Describe any health problem/cause of death</u>
Father _____		
Mother _____		
Brothers / Sisters _____		

Please list any "family" illnesses: _____

Health Maintenance: Please indicate the year you last had any of the following:

TB Skin Test _____	Pap Smear _____	Immunizations: Hepatitis A / B _____
Eye Exam _____	Mammogram _____	Tetanus _____ Pneumovax _____
Proctoscopy _____	Cholesterol _____	Influenza _____ Other _____

Please check symptoms you currently have or suffer from on a chronic basis.

Please check symptoms you currently have or suffer from on a chronic basis.						
	NAME					DATE
X	GENERAL		X	GASTROINTESTINAL		X MEN only
	Chills / Sweats			Poor Appetite		Breast lump
	Depression			Bloating		Erection difficulties
	Dizziness			Bowel changes		Problems with sex life
	Fainting			Constipation		Lump in testicles
	Fever			Diarrhea		Penis discharge
	Forgetfulness / Poor memory			Excessive gas		Sore on penis
	Headache			Excessive thirst		Urinary dribbling
	Difficulty sleeping			Hemorrhoids		Weak urinary flow
	Loss / Gain of weight			Indigestion		
	Nervousness / Anxiety			Nausea / vomiting		WOMEN only
	Fatigue			Black / Bloody Stools		Abnormal pap smear
	Poor Concentration			Stomach pain		Bleeding between periods
	Temperature Intolerance					Breast lump
				CARDIOVASCULAR		Breast pain
	MUSCLE / JOINT / BONE			Chest pain		Menstrual pain
	Pain, weakness, numbness in:			High Blood Pressure		Hot flashes
	Arms / Hands			Irregular Heart Beat		Nipple discharge
	Legs / Feet			Palpitations		Painful intercourse
	Back / Hips			Poor Circulations		Problems with sex life
	Neck / Shoulders			Swelling of ankles		Vaginal discharge
				Varicose veins		Vaginal itching
	SKIN			Exercise intolerance		Premenstrual symptoms
	Bruise easily					
	Hives			PULMONARY		OTHER
	Itching / dryness			Persistent cough		
	Changes in moles			Cough up blood		
	Rash			Shortness of breath		
	Sores that won't heal			Wheezing		
	Nail changes			Night sweats		
	EYE, EAR, NOSE, THROAT			GENITO-URINARY		
	Vision disturbances			Blood in urine		
	Difficulty swallowing			Frequent urination		
	Earache			Lack of bladder control		
	Ear drainage			Painful urination		
	Hay fever / allergies			Frequent infection		
	Hoarseness			Kidney Stone		
	Loss of hearing					
	Nosebleeds					
	Sinus problems					
	Dental problems					
	Bleeding gums					

Baylor Family Medicine at Flower Mound Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this policy. Please read it, ask us any questions you may have, and sign in the space provided at the bottom. A copy will be provided to you upon request.

1. **Insurance** – We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is expected until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and Deductibles** – All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible amounts at each visit.
3. **Non-covered services** – Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by Medicare or of other insurers. You must pay for these services in full at the time of service.
4. **Proof of insurance** – All patients must complete our patient information form before seeing the doctor. We will request a copy of your driver's license and current insurance as identification. If you fail to provide us with the correct information in a timely manner, you may be responsible for payment.
5. **Claims submissions** – We will submit your claims and assist you in any reasonable way to help get your claim paid. You may need to provide your insurance company with information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays the claim. Your insurance benefit is contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes** – If your insurance changes, please notify us before your next visit so that the appropriate changes can be made to help you receive the maximum benefit. If your insurance company does not pay your claim in 45 days, you will receive a bill for the balance due.
7. **Non-payment** – If your account is over 90 days past due, we may refer your account to a collection agency unless payment arrangements are made.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature patient/responsible party

Date