New Patient Registration Form

Acct #

HEALTHTEXAS PROVIDER NETWORK

Patient Information

Patient Name: Last	First	Middle	(Maiden)	
Address: (Street or Box)		City	State	Zip
Home Phone #	Work Phone #		Cell Phone #	
Sex (check one) Male Female	Date of Birth	Age	Social Security #	Driver's License #
Marital Status (check one) Single Married Divorced Widowed			Spouse's Name (If Applicable)	
Employer			Employer Address	
Primary Care Physician	Phone #		Referring Physician	Phone #

Responsible Party

Complete only if the patient is a minor

Responsible Party: Last	First	Middle	(Maiden)	
Address: (Street or Box)		City	State	Zip
Home Phone #	Work Phone #		Cell Phone #	
Sex (check one) Male Female	Date of Birth	Age	Social Security #	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company		Effective Date	**Secondary** Insurance Company		Effective Date
Claims Mailing Address			Claims Mailing Address		
City	State	Zip	City	State	Zip
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber (policy holder)	Date of Birth		Subscriber (policy holder)	Date of Birth	
Subscriber's Social Security #	Relationship to Patient		Subscriber's Social Security #	Relationship to Patient	
Subscriber's Employer	Work Phone #		Subscriber's Employer	Work Phone #	
Subscriber's Employer Address			Subscriber's Employer Address		
City	State	Zip	City	State	Zip

_____ _____

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

Consent to Treat & Financial Responsibility

Acct #

HEALTHTEXAS PROVIDER NETWORK

Consent to Treat

I hereby authorize employees and agents of HealthTexas Provider Network, including physicians, physician assistants and nurse practitioners and other employees and staff members, to render medical evaluations and care to the patient indicated below. 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.

_____

Patient Name (please print)

_____ _____

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

Only if patient is a minor:

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

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

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's 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 the patient's insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand that 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**

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 physicians[1] 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 your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out-of-pocket and in-full.;
- 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;
- Subject to certain exceptions under the law, provide notice of any unauthorized acquisition, access, use or disclosure of your protected health information to the extent it was not otherwise secured;
- 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 upon your 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

[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.*

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, business associates are also required 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 b enefits 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 at 866-245-0815 or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: MAY 20, 2010
VERSION: 3

Acknowledgement of The Receipt of HealthTexas Provider Network (HTPN) Notice of Health Information Practices

HEALTHTEXAS PROVIDER NETWORK

Acct #

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 physicians[1] 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, Parent, or Legal Guardian **Date**

_____

Effective Date of Notice

[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.*

Patient Secure Messaging

Acct #

HEALTHTEXAS PROVIDER NETWORK

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

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 emails to patients. Currently, HTPN is not able to accept patient emails through the Baylor Office EHR.
- 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.

_____ _____

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

Race, Ethnicity & Language Form

Acct #

HEALTHTEXAS PROVIDER NETWORK

HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. **The purpose of collecting this information is to ensure that all patients receive high-quality care.**

We would like for you to provide us with your race and ethnic background. **We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.**

First, do you consider yourself Hispanic/Latino?
Of the following choices, please choose the one that best describes your ethnicity.

Yes No Decline

Which category best describes your race?
Of the following choices, please choose the one that best describes your race. Race definitions can be found at the bottom of this page.

American Indian or Alaska Native

Black or African American

White

Asian (includes Pakistan or Indian origins)

Native Hawaiian or Other Pacific Islander

Multiracial

Decline

What language do you feel most comfortable speaking with your doctor or nurse?
Of the following choices please choose the one that best fits you.

English
Spanish
Vietnamese
Chinese
Tagalog
Hindi
Italian
Korean
Unknown
Decline
Other _____
Sign Language or other Auxiliary Aid or Service

_____ _____

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

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial**: A person having more than one or a combination of the above origins

Patient Preferences Regarding Communication of Patient Health Information

(PCP Office)

Acct #

HEALTHTEXAS PROVIDER NETWORK

Approved HIPAA Contacts

DO NOT disclose or discuss any information related to my billing account information with anyone other than myself.

I hereby give permission to disclose and discuss any information related to my **billing account information** with the following family members, relatives, and other persons:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

DO NOT disclose or discuss any information related to my medical condition(s) with anyone other than myself.

I hereby give permission to disclose and discuss any information related to my **medical condition(s)** with the following family members, relatives, and other persons:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Preferred Method of Contact

I request that communication regarding my medical condition(s) to occur ONLY when I am in the clinic. Please only print and hand me information when I am in the clinic. I DO NOT wish to be notified by any other communication method regarding my medical condition(s).

Please communicate with me regarding my **medical condition(s)** using the method I've indicated below:

Home Phone	Work Phone	Cell Phone
Mailed Letter	Guardian	Other: _____

If the above method of contact is by phone, please check the appropriate box below:

OK to leave a message with detailed information.
Please leave a message with a call-back number only.

Please note that you are responsible for any charges occurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

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

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

Name of Legal Guardian _____ **Relationship to Patient** _____

Patient Preferences Regarding Communication of Patient Health Information

(Guardianship)

HEALTHTEXAS PROVIDER NETWORK

Acct #

Patient Guardianship

Guardian Information (Complete only if patient has a Legal Guardian)

Name of Legal Guardian	Relationship to Patient
Guardian Home Phone	Guardian Cell Phone
Guardian Work Phone	Guardian Email Address

Healthcare Decision Maker

NOTE: Please provide legal documentation.

Mother Father Mother & Father Other: _____

Please document any guardianship or custody issues:

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

Signature of Patient, Parent, or Legal Guardian	**Date**
Name of Legal Guardian	**Relationship to Patient**

Authorization for Release of Information (To HTPN)

HEALTHTEXAS PROVIDER NETWORK

I hereby authorize _____ _____
Entity or Person **from** whom records are requested Address

_____ _____ _____ _____ _____
Telephone Fax City State Zip

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____
Patient Name (please print) Date of Birth Social Security Number

_____ _____
Patient Address (City, State and Zip) Phone Number

_____
Specific Date(s) of Service (if known) All Dates of Service

Information to be released: (Check all that apply)

Complete Medical Records	Radiology Reports & Films	Registration Records	Billing Records
Visits & Encounters	Laboratory Reports	Consultation Reports	Emergency Room
Laboratory Reports	Operative Records	Other: _____	

_____
Description of the purpose of the use and/or disclosure:

The health information described herein shall be **released to**:

Category: Hospital Physician Insurance Company Attorney Patient Other_____

_____ _____
Name of Person or Entity (please print) Phone Number

_____ _____
Address (City, State, and Zip) Fax Number

Delivery Method: Mailing Address Fax Pick-Up Records

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

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

_____
Printed Name of Patient, Parent, or Legal Guardian

_____ _____
Relationship to Patient **or** **Legal Authority** (Attach Supporting Documentation)