

**PATIENT REGISTRATION FORM**  
**Health Texas Provider Network**

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	
Referring Physician:	Date of Birth	Age	Sex (circle one) Male Female	Social Security #	Drivers License #
Occupation	Employer		Employer Address		
Marital Status (circle one) Single Married Widowed Divorced Separated			Spouse's Name		
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 # ( )		

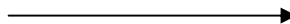
**Responsible Party**

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 <b>Primary</b> Insurance Company			Phone # ( )	Name of <b>Secondary</b> Insurance Company			Phone # ( )
<b>1.</b>				<b>2.</b>			
Mailing Address				Mailing Address			
City		State	Zip	City		State	Zip
Policy Number	Group Number	Effective Dates of Policy From: To:		Policy Number	Group Number	Effective Dates of Policy From: 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

(COMPLETE BACK OF FORM)



**PATIENT REGISTRATION FORM**  
**Health Texas Provider Network**

FOR OFFICE USE ONLY  
Acct # \_\_\_\_\_

Patient Name: \_\_\_\_\_

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 Provider Network (hereinafter "HTPN") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my 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 HTPN. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HTPN, 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 HTPN and that of its physicians<sup>1</sup> 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;

<sup>1</sup> 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.

- 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 Practice Administrator.

#### 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](http://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: 04/14/03**

**VERSION: 1**

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.

**Health Texas Provider Network** is furnishing you with the attached notice, which provides information about how HTPN and its physicians<sup>1</sup> 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)

April 14, 2003  
(Effective Date of Notice)

<sup>1</sup>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.

# **AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize \_\_\_\_\_  
Entity/Person from whom records are requested; Include full name

\_\_\_\_\_  
Complete address,

\_\_\_\_\_  
City, State, ZIP, Telephone and Fax.

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.

Print Patient Name \_\_\_\_\_

Date of Birth 

MM	MM	DD	DD	YY	YY	YY	YY

 Social Security Number 

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Patient Address \_\_\_\_\_ Phone Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_\_

Date(s) of Service (if known) \_\_\_\_\_

Description of information to be released: ( Check  all that apply )

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission / Registration | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records                  | _____                                 |
| <input type="checkbox"/> Nurse's Notes      | <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Laboratory Reports       | _____                                 |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records          | _____                                 |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Films      |   |                                       |

Description of the purpose of the use and / or disclosure: \_\_\_\_\_

The health information described herein shall be released to: ( Check  the appropriate category )

Hospital     Physician     Insurance Company     Attorney     Patient     Other

( Check  the appropriate delivery method )

Name \_\_\_\_\_  Mail     Fax

Address \_\_\_\_\_  Pick-up Records

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  Other \_\_\_\_\_

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 or Patient's Representative Date

\_\_\_\_\_  
Printed Name of Patient's Representative

PATIENT IDENTIFICATION NO. \_\_\_\_\_

PATIENT \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

**Health Texas Provider Network**  
3600 Gaston Avenue  
Barnett Ste 600  
Dallas, TX 75246

**AUTHORIZATION FOR RELEASE  
OF INFORMATION** (Rev. 9/04)

Patient Name: \_\_\_\_\_ Patient Identifier #: \_\_\_\_\_

## Patient Preference Regarding Communication of Health Information

### I. Who to Contact

I hereby give permission to (*Insert Group Name*) 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

# Health Texas Provider Network Patient History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

What health condition brought you to see the doctor?  
\_\_\_\_\_  
\_\_\_\_\_

## Treatment Summary/ Other Medical Problems

Date	<u>Reason for Hospitalization/ Surgeries/Biopsies/Fiducial Placements</u>	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had Chemotherapy? Please circle Y or N,  
If yes where and when? \_\_\_\_\_

Have you had radiation? Please circle Y or N, If yes Where? \_\_\_\_\_ When? \_\_\_\_\_  
What Type? \_\_\_\_\_

Last MRI \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Last CT scan \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Last PET scan \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Name of Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

## MEDICATION LOG

Name	Dosage	Frequency
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____

## ALLERGIES

1) _____	4) _____
2) _____	5) _____
3) _____	6) _____