Your Provider is a HealthTexas Physician

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

HealthTexas Provider Network is the 2nd largest subsidiary of Baylor Health Care System. We are a large network of close to 800 providers serving patients in almost 200 care sites throughout North Texas and Fort Worth who are dedicated to providing you with outstanding quality and service when it comes to caring for your medical needs.

Having your healthcare needs overseen by a HealthTexas physician means that your care is coordinated across our network and the Baylor Health Care System.

As long as you are seeing a HealthTexas primary or specialty care physician, we will have your completed registration packet and medical record securely stored in our Electronic Health Record system giving any HealthTexas physician access to the information they need to provide you and your family with the best care possible.

Benefits of Belonging to HealthTexas Provider Network:

- **One Time Form Completion**
  The registration forms you are filling out today will only have to be **filled out once.** (Some additional patient information may need to be updated annually)
- **Electronic Health Record (EHR) system**
  The EHR stores your medical records (including any medications, allergies or health issues you may have) and allows physicians easy access to referrals, consultations, and patient education materials.
- **Improved Coordinated Care**
  Our primary care sites are recognized by the National Committee for Quality Assurance (NCQA) as Physician Connections-Patient-Centered Medical Homes (PPC-PCMH) allowing our physicians to coordinate your care seamlessly across our network of specialists, labs, and hospitals in accordance with your specific needs.

We appreciate your trust in us and thank you for choosing a HealthTexas physician to meet and monitor your healthcare needs. You can now find a HealthTexas physician with the touch of a button. Download your HealthTexas physician finder app, free from the App store on your iPhone. You can also check **www.healthtexasdoctors.com**.

Patient-Centered Medical Home
NCQA
RECOGNIZED PRACTICE

Thank you for choosing our practice.

We look forward to providing you with professional health care in a friendly and welcoming environment. In order to best partner with you in your care, we have outlined expectations below which will promote an ideal provider-patient relationship.

We pledge to:

- Treat patients with respect and dignity.
- Learn about the person as well as the condition.
- Partner with our patients in medical decision making.
- Engage, listen and clearly explain issues to our patients so that time spent with us exceeds their expectations.
- Strive to make each patient feel as though he or she is our only patient.
- Make patients feel that we are always on their side because effective care can never be delivered in opposition.
- Aim to return phone calls promptly.
- Strive to be timely and respect our patient's time as much as our own.
- Thank patients for waiting when we are behind schedule.
- Respect patient privacy.
- Earn patient's loyalty through our behavior.

What we need from you:

- Treat others with courtesy, respect and dignity.
- Be patient and understanding.
- Inform our office of any pertinent changes in your contact information, health issues, medications, other healthcare providers, insurance and employment.
- To arrive on time for scheduled appointments.
- Call the office as soon as you are aware you cannot make an appointment or are running late.
- Provide payment for services provided.
- Follow the agreed upon treatment plan and inform your care team of any changes.
- Ask questions if directions and procedures are not understood.

Mission

To deliver the highest value patient experience through quality, safety, accessibility, and cost-effectiveness, enhanced by medical education and research in collaboration with Baylor Scott & White Health.

Vision

To improve the health and well-being of those we serve.

Values

Integrity	Teamwork	Innovation
Servanthood	Excellence	Stewardship

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Patient Demographics & Insurance

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	Mobile Phone ☐ Primary Number ☐ Yes, you can communicate information via SMS text for appointment reminders.	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the physician you are seeing today? ☐ Billboard ☐ Community Event/Health Fair ☐ Digital/Web Advertising ☐ Friend or Family Member ☐ Mailer/Postcard ☐ New Neighbors Program ☐ News Story/Broadcast ☐ Newspaper/Magazine Ad ☐ Physician Referral ☐ Radio Commercial ☐ TV Commercial

Responsible Party

Complete this section only if the patient above is a minor

Responsible Party Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone	Work Phone	Mobile Phone	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	

Insurance & Subscriber Information

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

Consent to Treat & Financial Responsibility

Acct #

BaylorScott&White 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)

SIGNED ELECTRONICALLY AT THE PRACTICE.

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

Complete this section ONLY if the 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.

SIGNED ELECTRONICALLY AT THE PRACTICE.

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.

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

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 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 and its 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.

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; and
- 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 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.com.

Uses and Disclosures of Medical Information That Do Not Require Your Authorization.

The following categories describe different ways that we may use and disclose medical information without your authorization. For each category of uses or disclosures we will explain what we mean, but not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without your authorization 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

[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.*

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 and disclose your health information as otherwise allowed by law. Examples of those uses and disclosures follow.

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

Individuals involved in your care: Unless you object, we may disclose to a family member, other relative, a close personal friend or other person you identify the health information that is directly relevant to that person's involvement in your health care or payment for your health care. If you are not able to agree or object to such disclosure, we may disclose the information as necessary if we determine it is in your best interest in our professional judgment.

Disaster Relief: We may use or disclose your health information to public or private disaster relief organizations to coordinate your care or to notify your family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to these disclosures when practical.

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, coroners and medical examiners: We may disclose health information to funeral directors, coroners and medical examiners 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 regarding treatment alternatives and appointment reminders: 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. You have the right to opt out of receiving fundraising communications by providing a written request to the BHCS Foundation, 3600 Gaston Avenue, Barnett Tower, Suite 100, Dallas, TX 75246.

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.

Health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure.

Threats to health or safety: We may use or disclose health information as allowed by law if we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or for law enforcement authorities to identify or apprehend an individual involved in a crime.

Special government functions: We may disclose health information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law, or for protective services to the President of the United States or certain other government officials. If you are a member of the military, we may disclose health information to military authorities under some circumstances. If you are an inmate of a jail, prison or other correctional facility or in the custody of law enforcement personnel, we may disclose health information necessary for your health and the health and safety of others.

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.

Electronic Health Information Exchange: HTPN uses a third party to maintain a Health Information Exchange (HIE). HTPN stores electronic health information about you in the HIE. Electronic health information about you from other health care providers or entities that are not part of HTPN who have treated you or who are treating you is also stored in the HIE, and HTPN and these other providers can use the

HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law. HTPN monitors who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.

You may opt out of the HIE by providing a written request to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX 75206. If you opt out, your information will still be stored in the HIE by Baylor, but your information will not be viewable through the HIE. You may opt back in to the HIE at any time. You do not have to participate in the HIE to receive care.

When We Need Your Written Authorization

We will not use or disclose your health information without your written authorization, except as described in this notice. Uses or disclosures that require your written authorization include the following:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures for marketing purposes, unless we speak with you face-to-face or provide a nominal promotional gift.
- Disclosures that constitute a sale of your health information under applicable law.

You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to your HTPN physician's office.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the HealthTexas Provider Network Office of HIPAA Compliance at 877-820-6500.

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.

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

Acct #

Acknowledgement of Receipt

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.**

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

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

Effective Date of this Notice: **09-23-2013**

[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.

Race, Ethnicity & Language

Acct #

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.

Race

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Some Other Race
- ☐ Unknown
- ☐ Patient Declined

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 or Caucasian:** 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.

Ethnicity

Which category best describes your ethnicity?

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

Language

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Chinese
- ☐ Dutch
- ☐ Hindi
- ☐ Other_____

_____ _____

Patient Name (please print) **Date**

Patient Preferences Regarding Communication of PHI. (Patient Health Information)

Acct #

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

- ☐ Home Phone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Mailed Letter
- ☐ Guardian
- ☐ My BSWHealth

If the above method of communication is by phone, please check the appropriate box below **(check one):**

- ☐ Leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred 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.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that HealthTexas is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like HealthTexas to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

1 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

2 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

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

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

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