Patient Registration Form

Patient's Rights and Notice of Privacy Practices: I have been informed of and received copies of the "Patient's Rights and Responsibilities," "Notice to Patients Concerning Complaints / Grievances," "Notice of Privacy Practices" for Baylor Surgical Hospital at Fort Worth, and "Spiritual Options."

Patients Notification of Data Collection Acknowledgement: I have been informed of and received a copy of the "Notification of Data Collection." PURSUANT TO: 84TH TEXAS LEGISLATIVE REGULAR SESSION, HB 764 SECTION 108.0095. NOTIFICATION OF DATA COLLECTION which states: A provider shall provide to a patient whose data is being collected under this chapter written notice on a form prescribed by the department of the collection of the patient's data for health care purposes. The Texas Department of State Health Services, Texas Healthcare Information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is upheld to the highest standard and is not subject to public release. For further information regarding the data collected, and to send inquiries to please see your copy of the "Notification of Data Collection."

Disclosure of Physician Ownership: As a prospective partner of Baylor Surgical Hospital at Fort Worth, we are pleased to inform you of the following:

- Baylor Surgical at Fort Worth is partly owned by physicians and meets the federal definition of physician owned hospital as specified in 42 CFR 489.3. A list of the hospital's physician owners is available upon request.
- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Baylor Surgical Hospital at Fort Worth.
- You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of Baylor Surgical Hospital at Fort Worth. We welcome you as a patient and value our relationship with you.

I acknowledge that I have read and understand the foregoing Notice of Patients regarding physician ownership.

Facility-Based Physician Disclosure: We are committed to providing clinical excellence in a safe, attractive environment for you and your family members. We welcome you as a patient and value our relationship with you. In connection with your visit at Baylor Surgical Hospital at Fort Worth, please be aware of the following:

- Certain anesthesiologists, pathologists, radiologists, or emergency department physicians (facility-based physician) who may provide medical services to you while at Baylor Surgical Hospital at Fort Worth may not be participating with your health insurance plan.
- You may receive a bill from Allied Health and/or Bridge Orthopedic, who may provide medical services to you while at Baylor Surgical Hospital at Fort Worth these providers may not be participating with your health insurance plan.
- You may request a list of facility-based physicians who have been granted medical staff privileges at Baylor Surgical Hospital at Fort Worth.
- You may request information from a facility-based physician as to whether the physician is a participating provider with your health insurance plan and under what circumstances you may be responsible to pay amounts not covered by your insurance.

Insurance Acknowledgement: It is our mission to provide clear understanding of our billing process for your visit. All services rendered by Baylor Surgical Hospital at Fort Worth are charged directly to the patient. As a courtesy, we will file your primary and secondary (if applicable) insurance(s) and credit their payments to your account. Whether we are contracted or non-contracted with your insurance carrier, all unmet deductibles and/or coinsurance or copayment amounts are due upon the date of service. If you have no insurance, all fees are due upon the date of service as well, unless previous arrangements have been made with hospital administration.

Insurance Disclosure: Should you have insurance that will be filed for your visit; we will do so within 7-10 business days from your date of service. If we are contracted with your insurance carrier, we will accept assignment, and all applicable adjustments will be applied to your account according to allowable amounts determined by our contract with your insurance carrier. Please note that benefits quoted by your insurance carrier are merely a quote, and final reimbursement determination will not be known until your carrier processes your claim. Should any services ultimately be denied for any reason, you will be responsible for the final balance.

If you have insurance, we will not know the exact out of pocket amount until your insurance carrier has processed your claim. If you do not have insurance, this amount is only an estimate, based upon the procedure that has been scheduled. All fees will not be determined until all of your charges have been applied to your account. Any amount over and above the estimated quote will be billed directly to you.
Should you have any questions once you receive your final billing information, you may contact our facility at (682)703-5712, and for extension 5712 or 5713 (Patient Accounts Department)

Account Billing Information: If you have insurance for your visit, based upon the information provided, we are:

_____ IN-NETWORK _____ OUT OF NETWORK

Based on this information the following estimated portion of the bill that you are responsible for is:

The estimated patient portion for your visit is: $_____

Please remember this is only an estimate.

Benefit Estimation: We have made every attempt to estimate your portion based upon benefit information quoted by your insurance carrier. In doing so, we need to inform you once again, that this amount is only an **estimate**. We calculate this amount based upon the procedure your physician has scheduled, as well as the anticipated length of operating room time he has estimated you will require.

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Telephone Communication Preferences

Home# _____
Work# _____
Mobile# _____
Other# _____

E-mail Communication Preferences (May we e-mail you?) ☐Yes ☐No

E-mail Address: _____

Mail Communication Preferences (May we send mail to your home address?)

☐Yes ☐No (If no, please provide an alternate mailing address below.)

Mailing Address: _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Baylor Surgical Hospital At Fort Worth, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Baylor Surgical Hospital at Fort Worth when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

Consent to text message: ☐ Yes ☐ No

If an email address has been provided, Baylor Surgical Hospital at Fort Worth, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information?

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

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

☐ **FOR SELF PAY ONLY*: I request that this facility restrict the use and/or disclosure of my protected health information to my insurance company.***

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and have been given the opportunity to request alternative means of communication of my protected health information.

Patient Registration Form

FOR SURGERY PATIENTS ONLY:

In order to verify accurate health and surgical information, we will be asking you various questions in different settings. The Pre-Op and Post-Anesthesia Care areas are locations where you and other patients will be asked questions. You will be in separate bays within these areas, but there is a possibility that you may be seen or overheard by other patients/family members.

Will this be a problem for you? _____

To protect your privacy information while at our hospital, any medical information requested by a family member via phone or in person can only be retrieved by having the patients pass code. This Pass code will be given to you at the time of your registration. (We will not give out any medical information without your pass code.)

SUPPORT PERSON/PATIENT REPRESENTATIVE:

Would you like to designate a support person/patient representative? _____

If yes, list name of designated individual: _____
Name Relationship

I understand that by designating this individual as my support person/patient representative, I am hereby giving permission to share my protected health information with the designated individual.

- Your support person/patient representative may remain with you throughout your hospital stay, with the following exceptions:
  - During a treatment or procedure
  - In a medical emergency, at the physician's discretion
- You also have the right to receive visitors throughout your hospital stay. Baylor Surgical Hospital at Fort Worth's Post-Surgical Unit has an open visitation policy, as long as visitors are not disruptive to other patients. If there is anyone you would like to restrict from visiting you, please let us know.

BAYLOR Surgical Hospital at Fort Worth

Patient Registration Form

Advance Directive Information

Dear Patient: Please complete the following questions. This form will become part of your medical record. Texas and Federal law provides every competent adult and emancipated minor the right to make his/her own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. It is with this in mind that the following questions are asked:

If you have an Advance Directive, complete questions 1-4.

1. Do you have any of the following Advance Directives? (Check all that apply.)

   ☐ Medical Power of Attorney ☐ Living Will ☐ Out of Hospital Do Not Resuscitate ☐ Mental Health Directive

2. If you have any of these documents and do not have a copy with you, where is it located? _____
3. Can someone bring a copy to the Hospital? _____
4. If you have an Advance Directive but a copy is not available at this time, what are your treatment wishes if you become terminally or irreversibly ill and are unable to make your wishes known?

   _____

   _____

If you <u>DO NOT</u> have an Advance Directive, complete questions 5 - 7:

1. If you do **NOT** have an Advance Directive and ***wish to complete one***, we will provide you with the proper forms and other information needed to complete the Directive:

   ☐ Received "Communicating Your Health Care Choices" brochure given to patient/family.

   ☐ Received "Personal Choices" packet given to patient/family.

   ☐ Declined any information.

2. ☐ I do **NOT** wish to make an Advance Directive at this time.

   I am aware that if I become unable to make decisions for myself and I have not completed an Advance Directive, state law will require that my physicians turn to the following persons in the order listed for medical decision-making: my spouse, my reasonably available adult children, my parents, or my nearest living relative. If none of those persons are available or willing to act on my behalf, I am aware that state law allows my doctors to turn to the Hospital's Ethics Committee or to a court of law for medical decision-making.

   This information will be available from your doctor. However, if you have questions or wish to discuss this further with him/her, please let us know. You may rescind any portion of these Directives at any time during your hospitalization by notifying any member of the healthcare team.

3. If I am unable to make my wishes known, I designate the following person to make treatment decisions for me:

   _____

   Name Relationship Telephone Number

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO ALL DISCLOSURES which include Patient Rights, Notice of Privacy Practices, Notification of Data Collection, Physician Ownership, Facility-Based Physician, Financial Disclosures, Communication of PHI, Support Person and Advance Directive Information.

Patient Signature Acknowledgement	_____ Patient or Legal Guardian Signature	_____ Relationship to patient	_____ Date/Time
	_____ Witness Signature	_____ Date/Time	