

BAYLOR FAMILY MEDICINE AT FORT WORTH
900 West Magnolia Ave, Suite 201
Fort Worth, Texas 76107

FOR OFFICE USE ONLY

Today's Date: _____

Acct # _____

Patient Information

Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()		
Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Social Security #	Drivers License #
Occupation	Employer	Employer Address		
Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Spouse's Name	Race (check one) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> 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 # ()	
How did you hear about the physician you are seeing today? <input type="checkbox"/> Physician Referral Who? _____ <input type="checkbox"/> Other Professional <input type="checkbox"/> Existing Patient <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Baylor Hospital <input type="checkbox"/> Health Plan/Insurance Company <input type="checkbox"/> Emergency Room <input type="checkbox"/> Direct Mail <input type="checkbox"/> 1-800-4-BAYLOR Referral Line <input type="checkbox"/> Website/Internet <input type="checkbox"/> Walk-In <input type="checkbox"/> Newspaper Advertisement <input type="checkbox"/> Radio/TV <input type="checkbox"/> Event <input type="checkbox"/> Location <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Unknown				

Responsible Party/Policy Holder

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #	Patient Relationship to Guarantor
Employer	Employer Address			

Insurance Information

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

BAYLOR FAMILY MEDICINE AT FORT WORTH

900 West Magnolia Ave, Suite 201

Fort Worth, Texas 76107

Patient Name: _____

FOR OFFICE USE ONLY

Acct # _____

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

Baylor Family Medicine @ Fort Worth

Name: _____ DOB: _____ Marital Status: _____
 Occupation: _____ Number of Children: _____

Family History

Drug Allergies: _____		Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
_____	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Disease						
_____	High Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Pressure						
Current Meds: _____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's Age: _____	(convulsions)						
If deceased, age at death & cause: _____	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Disorder						
_____	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Age: _____	Disease						
If deceased, age at death & cause: _____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	disease						
_____	Mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total number of brothers & sisters you have had _____	Illness						
Number living _____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History

<input type="checkbox"/> Headaches	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Depression
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Bowel Irregularity	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Chronic Rash
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Sexual/Menstrual Dysfunction	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Rubella
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Polio
<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> GI Disorder	<input type="checkbox"/> Nervousness	_____

Women Only: Pregnant: Yes No

Planning Pregnancy: Yes No

Men Only: It common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No

Habits:

<input type="checkbox"/> Smoke: Packs Daily _____ How Long _____ <input type="checkbox"/> Interested in Quitting?	<input type="checkbox"/> Coffee: Cups Daily _____ Other Caffeine _____	<input type="checkbox"/> Diet: Salt intake: _____ Fat intake: _____
<input type="checkbox"/> Exercise Routine : _____	<input type="checkbox"/> Alcohol: Type: _____ Amount _____	<input type="checkbox"/> Other: _____

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 Fort Worth** 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	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:
<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"/> Written Communication
<input type="checkbox"/> OK to mail to my home address _____

<input type="checkbox"/> OK to mail to my work/office address _____

<input type="checkbox"/> 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

Preferencia del Paciente Concerniente a Comunicación de Información de Salud

I. Quien se puede contactar

Yo permito a **Baylor Family Medicine at Fort Worth** a divulgar y usar información relacionada con mi(s) condición(es) médica(s) a los siguiente miembros de mi familia, otros familiares y/o amigos personales:

_____ Nombre	_____ Número de teléfono	_____ Relación
_____ Nombre	_____ Número de teléfono	_____ Relación
_____ Nombre	_____ Número de teléfono	_____ Relación

_____ No deseo dar permiso a miembros de mi familia, otros familiares o amigos personales para recibir información relacionada con mi(s) condición(es) médica(s).

II. Como se puede contactar

Deseo ser contactado de la siguiente manera:

Teléfono en Casa:	Teléfono del Trabajo:
<input type="checkbox"/> Está bien a dejar mensaje con información detallada	<input type="checkbox"/> Está bien a dejar mensaje con información detallada
<input type="checkbox"/> Sólomente deje el número para devolver la llamada	<input type="checkbox"/> Sólomente deje el número para devolver la llamada

Comunicación por escrito

Está bien el enviar información por correo a mi residencia _____

Está bien el enviar información por correo a mi trabajo/oficina _____

Está bien el mandar información por el fax _____

Este acuerdo es indefinido y continua hasta que sea suspendido por escrito. Comprendo que pedidos para recibir información médica de otras personas que no sean las mencionadas en esta forma vá a requerir una autorización especial antes de divulgar cualquier información médica.

Firma del paciente o del representante legal

Fecha

Secure Messaging

Get your Lab Results EMAILED to you from your PHYSICIAN

Attention Baylor Family Medicine at Fort Worth Patient!

We are excited to announce that now you can receive your lab results from your physician via Secure Messaging! Secure Messaging is a “secure” email that you will receive from your physician that will connect you to a “secure” link to review your results from your computer. Secure Messaging can also be used by your physician to communicate changes in your medication and directions for your next visit.

Please ask a Baylor Family Medicine at Fort Worth staff member about signing up for Secure Messaging and the benefits that you will receive from getting your results **faster**. Signing up is quick and easy, just complete the forms and your results will be “emailed” to you once your physician has reviewed them. You will also be given directions on how to access the link along with setting up your own personal password.

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

Instructions for Receiving 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

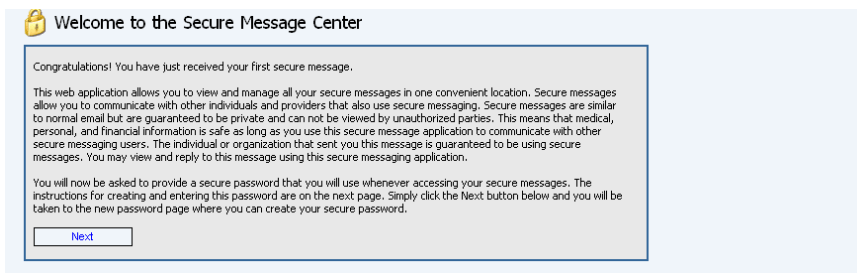
Secure Message


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

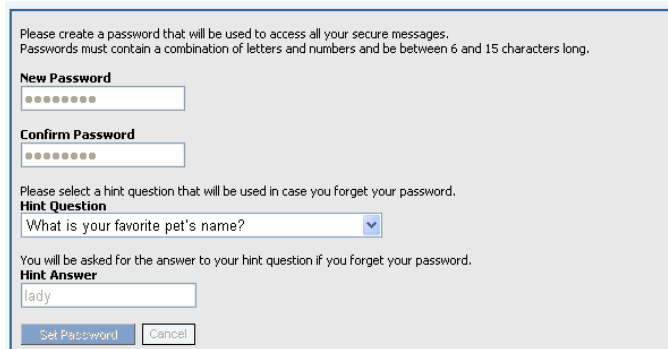
To retrieve this message click on the following link

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 the referring physician office for help.
6. You will be able to **view the secure message but will not have the option to reply**.

