

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	
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 (5) Who? _____ <input type="checkbox"/> Other Professional (6) <input type="checkbox"/> Existing Patient (10) <input type="checkbox"/> Family (8) <input type="checkbox"/> Friend (1) <input type="checkbox"/> Word of Mouth (9) <input type="checkbox"/> Baylor Hospital (19) <input type="checkbox"/> Health Plan/Insurance Company (17) <input type="checkbox"/> Emergency Room (7) <input type="checkbox"/> Direct Mail (18) <input type="checkbox"/> 1-800-4-BAYLOR Referral Line (3) <input type="checkbox"/> Website/Internet (13) <input type="checkbox"/> Walk-In (4) <input type="checkbox"/> Newspaper Advertisement (15) <input type="checkbox"/> Radio/TV (16) <input type="checkbox"/> Event (11) <input type="checkbox"/> Location (14) <input type="checkbox"/> Yellow Pages (2) <input type="checkbox"/> Unknown (20)				

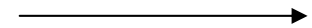
Responsible Party

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

Insurance Information

Name of Primary Insurance Company		Phone # ()	Name of Secondary Insurance Company		Phone # ()
1.			2.		
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)



Name: _____ Date: _____

DOB: _____ Primary Care Physician: _____

Daytime Phone Number: _____

Tuberculosis Exposure? Y/N

MRSA - STAPH INFECTION? Y/N IF Y, WHERE? _____

PAST MEDICAL HISTORY

(CHECK ALL APPLICABLE)

- Epilepsy/Seizure
- Depression
- Bipolar
- Anxiety
- Asthma
- Emphysema
- Sleep Apnea
- High Cholesterol
- High Blood Pressure
- Stroke
- Diabetes

- Thyroid Problems
- Enlarged Prostate
- Kidney Stones
- Diverticulitis
- Gastritis
- GERD-Reflux-Heartburn
- Blood Clots
- Bleeding Disorder - Type?

Other _____

CANCER Y/N TYPE _____ TREATMENT _____

HEART DISEASE INFO

- Chest Pain Y/N When _____
- Congestive Heart Failure Y/N When _____
- Heart Attack Y/N When _____
- Catheterization Y/N When _____
- Heart Stents Y/N When _____
- Heart Vessel Bypass Y/N When _____
- Echo/EKG Y/N When _____
- Stress Test Y/N When _____
- Pacemaker/Defibrillator Y/N When _____
- Irregular Heart Beat Y/N What Kind?(I.E. Atrial Fibrillation) _____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? Y/ N

PLEASE LIST REACTIONS? _____

ARE YOU ALLERGIC TO LATEX? Y/N

PATIENT NAME _____

DOB: _____

DAILY MEDICATION

Names/Doses/Directions: (Include over the counter and aspirin products)

_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL HISTORY (CIRCLE ONE)

Married Single Divorced Widowed Separated Children # _____

(MARK ALL APPLICABLE)

Tobacco Products Y/N If Y, # pack(s) per day _____
 Snuff/Chew Y/N _____
 Alcohol Y/N If Y, what kind/how much _____
 Street Drugs Y/N If Y, what type _____

PREVIOUS SURGICAL HISTORY (MARK ALL APPLICABLE)

Endoscopy Y/N DATE: _____
 Colonoscopy Y/N DATE: _____ Polyps Y/N Hemmorhoids Y/N
 Gallbladder Surgery Appendix Surgery
 Hernia Surgery Thyroid Biopsy/Surgery

OTHER SURGERIES:

TYPE OF SURGERY	YEAR	DOCTOR	WHERE

FAMILY HISTORY

Does any family member have any medical conditions? (Mom,Dad, brother, sister, grandparents,great grandparents) If so please list:

Heart Disease _____
 Diabetes _____
 Stroke _____
 Thyroid Disease _____
 Cancer(What Kind?) _____
 Other _____

Mother:Living/Deceased

Father:Living/Deceased

Patient _____ Patient ID# _____

WAXAHACHIE SURGICAL SPECIALISTS
Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to *Waxahachie Surgical Specialists* 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 give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).
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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

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)

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