BAYLOR Medical Center at Uptown

Radiology Department
Patient Registration

Patient Label

Please provide your driver's license or photo ID and insurance card at time of registration.

Patient Last Name | **First Name** | **MI** | **Date of Birth** MM / DD / YYYY

Social Security Number - - | **Gender** M ☐ F ☐ | **Email Address (to access your records and for satisfaction survey)**

Responsible Party | **Relationship to Patient** | **Patient's Mobile Phone** ( ) - | **Call** ☐ **Msg** ☐

Address | **Apartment #** | **Patient's Home Phone** ( ) - ☐ ☐

City | **State** | **ZIP** | **Work or Other Phone** ( ) - ☐ ☐

Emergency Contact | **Emergency Contact Phone 1** ( ) - | **Emergency Contact Phone 2** ( ) -

May we send mail to your home address? Yes ☐ / No☐ If not, please provide an alternate mailing address:

street or p. o. box apt. # city state zip

Insurance | **Subscriber Name** | **Subscriber DOB** MM / DD / YYYY | **Group Number** | **Policy Number**

If Accident: Date MM / DD / YYYY | **Time** | **Accident Details**

Work Related? Yes ☐ No ☐ | **Employer** | **Employers Phone** ( ) -

Religious Preference | **Preferred Language**

Other than you, your insurance company and healthcare providers involved in your care, with whom can we share your healthcare information? (Please enter all that apply.)

Name	Phone Number	Relationship
	( ) -	
	( ) -	
	( ) -	
	( ) -	

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:

I hereby verify the above information is true and correct.

Patient or Legal Guardian Signature | **Date** / / | **Time**

Witness Signature | **Date** / / | **Time**

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CONSENT FOR TREATMENT: I, the undersigned, request and authorize ***Baylor Medical Center at Uptown***, and all its physicians, surgeons, technicians, nurses, and other qualified personnel, whether employed directly by the hospital or brought in on a consulting basis, to provide any medical/surgical treatment, diagnostic tests and hospital care which the attending physician or designee(s) may deem necessary or beneficial for my health. **Initial** ☐

FINANCIAL AGREEMENT: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines, however, the responsibility for the balance of this account falls on you. **Initial** ☐

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to ***Baylor Medical Center at Uptown*** and any physicians, including, but not limited to ER physicians, radiologists, etc. of the insurance benefits specified and otherwise payable to me, but not to exceed the Hospital's regular charges for these services. **Initial** ☐

RELEASE OF INFORMATION: I authorize ***Baylor Medical Center at Uptown*** and any physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this emergency department visit to any organization which is, or may be liable or responsible for payment of charges associated with my care, and for all other purposes of benefit payment. If my injury is work-related, I authorize ***Baylor Medical Center at Uptown*** to release any information from my medical records to my employer and/or its designee.
Initial ☐

PHYSICIANS SERVICES: Emergency Department physicians, radiologists, pathologists, surgeons, etc. are independent contractors, and are not employees of ***Baylor Medical Center at Uptown***. Physicians' services are billed separately.
Initial ☐

PERSONAL ITEMS and MEDICATIONS: I understand that ***Baylor Medical Center at Uptown*** is not responsible for lost or stolen personal or valuable items or medications. **Initial** ☐

PATIENT RIGHTS: I have received a copy of the **PRIVACY NOTICE, PATIENT RIGHTS and GRIEVANCE POLICY.**
Initial ☐

SENSORY OR PHYSICAL IMPAIRMENTS: I understand ***Baylor Medical Center at Uptown*** has resources to meet most special needs for patients with sensory or physical impairments. **I do ☐ / do not ☐** have special needs. **Initial** ☐

Identified needs:

Patient or Legal Guardian Signature **Date** / / **Time**

Witness Signature **Date** / / **Time**

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Texas law requires healthcare facilities to ask patients to identify their own race and ethnic background. If the patient fails or refuses to identify their own race and ethnic background, facility staff will use its best judgment in making the identification.

Race:

- ☐ American Indian, Eskimo or Aleut
- ☐ Asian or Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other: (including multi-racial, mixed) _____
- ☐ Prefer Not to Answer

Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Prefer Not to Answer

Patient or Legal Guardian Signature _____ **Date** / / **Time** _____

Witness Signature _____ **Date** / / **Time** _____

Access to Health Records Online

If you would like to have access to your records for this radiology visit online, please provide your email address below. You should receive an email invitation to join ***myHealth*** from ***United Surgical Partners*** ***[mailto:noreply@iqhealth.com]*** Please check your SPAM folder if you don't find it in your inbox.

Patient Satisfaction Survey

We would like you to have a voice in our quality improvement. With your permission, we will email you a survey to allow you to give us feedback about your experience as a patient at ***Baylor Medical Center at Uptown***. Your email address will be kept confidential, and not used for any other purpose.

Please enter your email address here: _____

Disclosure of Physician Ownership

Baylor Medical Center at Uptown meets the Federal definition of a physician-owned hospital, and a list of the hospital's owners that are physicians (or their immediate family members) is available upon request. Radiologists are independent contractors, not owners or employees of ***Baylor Medical Center at Uptown***.

Baylor Medical Center at Uptown is committed to providing clinical excellence in a safe, attractive environment for you and your family members. We are proud that many of the physicians who practice here have chosen to have ownership in this hospital. Their ownership enables them to have a voice in the administration and policies of our hospital. This involvement helps to ensure the highest quality of care for you.

If you have any questions concerning this notice, please feel free to ask your physician or the Chief Executive Officer at ***Baylor Medical Center at Uptown.***

Informed Consent for CT Scan With or Without Contrast Injection

PATIENT'S NAME: _____ MEDICAL RECORD NUMBER: _____

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

Inform the technologist if you are pregnant, or think you may be pregnant.

CONSENT TO IMAGING PROCEDURE: Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as computerized tomography (CT) scan to aid in diagnosing and treating your medical condition. This is a diagnostic test that utilizes radiation (x-ray) and a computer to produce images of internal body structures. As part of your CT exam, a contrast agent containing iodine may be injected into your vein in order to produce better images. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. For abdominal CT imaging, you will be asked to drink a type of contrast containing barium and or an iodinated form of oral contrast, gastrograffin. The CT procedure may be conducted without the contrast agents, but the images may not be as helpful to the radiologist and your physician. If you wish to refuse either oral and/or IV contrast, inform the technologist and the CT will be conducted without the contrast agents.

POTENTIAL RISKS: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. CT exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important to inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma, or other allergic conditions, any history of anemia, sickle cell anemia, or kidney disorder, are pregnant or breast feeding you must inform the technologist. The safety of contrast for children under the age of two has not been established.

PATIENT SIGNATURE: I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

I understand that the physicians participating in my care at BMC@U are not employees or agents of Baylor Medical Center at Uptown Hospital. They are either independent physicians engaged in the private practice of medicine or are licensed physicians participating in the care of patients as part of a post-graduate medical education program. Physicians who may participate in my care in addition to my attending physician include, but are not limited to radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, pulmonologists, gastroenterologists and nephrologists. The physicians participating in my care may or may not be financial partners at Baylor Medical Center at Uptown.

_____ _____

SIGNATURE OF PATIENT OR LEGAL RESPONSIBLE PERSON (STATE RELATIONSHIP) **DATE**

_____ _____

WITNESS TO SIGNATURE DATE

BAYLOR
Medical Center
at Uptown
Now part of Baylor Scott & White Health

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Place Patient Identification Label Here

Home # _____

Work # _____

Mobile # _____

E-Mail Communication Preferences

Email 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 Medical Center at Uptown or one of its legal agents 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. If an email address has been provided, Baylor Medical Center at Uptown or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

_____

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

_____

_____

Other than you, your Insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	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:

_____

_____

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

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

Pregnancy Screening Form

(Ages 12-55 years)

Patient Name: _____ Age: _____

1.) Are you pregnant or do you think you may be pregnant? _____ Y _____ N
(If "yes", please notify staff immediately).

2.) Have you had a hysterectomy or are post-menopausal? _____ Y _____ N
(If "yes", please sign below).

3.) Have you had a menstrual period within the last 30 days? _____ Y _____ N
(If "no", you will need to have a pregnancy test).

4.) Please give the date of the 1st day of your last menstrual period. _____

5.) Does this date fall within the last 10 days? _____ Y _____ N
(If "yes", please sign below).

6.) Are you currently practicing any of the following birth control? _____ Y _____ N

A.) Tubal Ligation _____
B.) Partner Vasectomy _____
C.) Oral Contraceptives _____
D.) Condom _____
E.) Diaphragm _____
F.) Foam _____
G.) IUD _____
H.) Other _____

7.) **If you are NOT practicing any birth control measures, have you had sexual activity since your last menstrual period that may put you at risk of pregnancy?** _____ Y _____ N

I have stated that I am NOT pregnant and request the ordered Imaging procedure be performed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NAME: [PatientLast], [PatientFirst]
ACT#: [PatientId] GENDER: [Sex]
DOB: [DOB] AGE: [Age]
DR: [PhyLast], [PhyFirst]
DOS: [DOS]