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.***

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**