



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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY

Social Security Number	Gender	Email Address (to access your records and for satisfaction survey)
<input type="text"/> - <input type="text"/> - <input type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	<input type="text"/>

Responsible Party	Relationship to Patient	Patient's Mobile Phone	Call	Msg
<input type="text"/>	<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Address	Apartment #	Patient's Home Phone	Call	Msg
<input type="text"/>	<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

City	State	ZIP	Work or Other Phone	Call	Msg
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Emergency Contact	Emergency Contact Phone 1	Emergency Contact Phone 2
<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="text"/> () - <input type="text"/>

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	Group Number	Policy Number
<input type="text"/>	<input type="text"/>	<input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY	<input type="text"/>	<input type="text"/>

If Accident: Date	Time	Accident Details
<input type="text"/> MM / <input type="text"/> DD / <input type="text"/> YYYY	<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> () - <input type="text"/>	<input type="text"/>

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** [\[mailto:noreply@iqhealth.com\]](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.

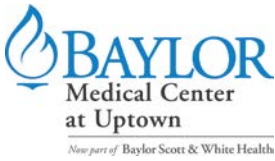
Please enter your email address here:

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**.



Comunicación preferencias con respecto a del paciente su PHI

Preferencias de comunicación telefónica

Etiqueta de identificación del paciente lugar aquí

Home # _____

Work # _____

Mobile # _____

Preferencias de comunicación de correo electrónico

Correo electrónico Address _____

Con el fin de servir mejor a nuestros pacientes y comunicarse con respecto a sus servicios y obligaciones financieras utilizaremos todos los medios de comunicación para acelerar esas necesidades. Proporcionando la información anterior estoy de acuerdo que Baylor Medical Center en Uptown o uno de sus agentes legales puede utilizar los números de teléfono proporcionado me envíe una notificación de texto, mediante un mensaje de voz pre-recorded artificial mediante el uso de un servicio de marcación automática o dejar un mensaje en un contestador. Si se ha proporcionado una dirección de correo electrónico, Baylor Medical Center en Uptown o uno de sus agentes legales puede comunicarse conmigo con una notificación por correo electrónico con respecto a mi cuidado, nuestros servicios o mi obligación financiera.

Preferencias de comunicación de correo

¿Podemos enviar correo a tu domicilio? ***(Si no, proporcione una dirección de correo alternativa más abajo).***

¿Aparte de usted, su compañía de seguros y proveedores de salud involucrados en su atención, quien hablamos con su información de salud? (Marque todas las que apliquen)

Nombre Teléfono

O cónyuge _____

O cuidador _____

O niño _____

Padres o _____

O otros _____

¿Tienes alguna información de salud que le gustaría ser confidencial de cualquier persona o personas? Si es así, describa específicamente la información y la persona o personas más abajo:

Reconozco que ha dado la oportunidad a solicitar restricciones sobre el uso o divulgación de mi información de salud protegida.

Reconozco que he tenido la oportunidad de solicitar medios alternativos de comunicación de mi información de salud protegida.

Paciente o Representante Personal firma Fecha _____

Imprimir nombre relación al paciente _____