



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**.



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)

	<u>Name</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse	_____	_____
<input type="checkbox"/> Caretaker	_____	_____
<input type="checkbox"/> 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: _____