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.***

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

Formulario de detección de embarazo

(Edades 12 a 55 años)

Patient Name: ____ Age: ___________________

1.) estás embarazada o crees que puede estar embarazada? _________ Y ________ N
(Si "Sí", por favor notifique a personal inmediatamente).

2.) ha tenido una histerectomía o después de la menopausia son? _________ Y ________ N
(Si "Sí", por favor, firme a continuación).

3.) has tenido un período menstrual durante los últimos 30 días? _________ Y ________ N
(Si no, necesitará tener una prueba de embarazo).

4.) por favor dar la fecha del primer día de su último período menstrual. ________________________

5.) esta fecha cae en los últimos 10 días? _________ Y ________ N
(Si "Sí", por favor, firme a continuación).

6.) están actualmente practicando alguno de los siguientes anticonceptivos? _________ Y ________ N

A.) ___ la ligadura de trompas
B.) socio vasectomía ___
C.) ___ anticonceptivos orales
D.) ___ condón
E.) ___ diafragma
F.) Foam _________________
G.) IUD _________________
H.) otros ___

7.) **si no estás practicando todas las medidas de control de la natalidad, ha tenido actividad sexual desde su última menstruación que puede ponerte en riesgo de embarazo?__________ Y __________ N**

He dicho que no estoy embarazada y solicitar el procedimiento ordenado de proyección de imagen de realizarse.

Firma del paciente: ___ Fecha: ___

Firma del testigo: ___ Fecha: ___

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

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