# PATIENT REGISTRATION

## PATIENT DEMOGRAPHICS

DATE: ____________________

Legal Name: First________________________ MI______ Last__________________________ Preferred Name: ______________

SS# __________________________ DOB:____________________

Legal Sex: ☐ M ☐ F

Address: ________________________________________Apt # ________ City__________________ State______ Zip ____________

Phone: Home__________________________ Work________________________________ Mobile__________________________

E-Mail____________________________________________________ ☐ No Email

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed

Need Interpreter ☐ Yes ☐ No Preferred Language____________________ Written Language________________________

Race: ☐ Asian ☐ Black ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

## PARENT / LEGAL GUARDIAN INFORMATION (IF APPLICABLE)

Parent/Legal Guardian Name__________________________________ DOB______________ Mobile____________________

## COMMUNICATION PREFERENCES

By checking one of the boxes for Preferred Communication Method, I agree to receiving communications and/or correspondence from Texas Health.

Preferred Communication Method: ☐ No Preference ☐ Mail ☐ Phone ☐ E-mail ☐ My Chart ☐ Accept Text Messages

Do you have any communication difficulties/ special needs? Visually Impaired ☐ Yes ☐ No Hearing Impaired ☐ Yes ☐ No Special Needs ☐ Yes ☐ No

If yes, please list: ____________________________________________________________________________

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

## PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physican________________________________________________________ ☐ No Primary Care Physician

## EMERGENCY CONTACT

Name____________________________ Rel to Patient______________ Home Phone________________ Mobile________________

## EMPLOYMENT

Employer Name________________________________ Employment Status: ☐ Disabled ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed

FOR OFFICE USE ONLY:

Patient Name______________________
MRN______________________

## FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First__________________________ _MI________ Last__________________________ DOB______________

Relationship: Spouse Father Mother Other (Please Specify): ______________________________

Address: ______________________________Apt #__________ City____________________ St_________ Zip __________

Phone: Home________________________ Mobile__________________________ Work____________________

Employer Name__________________________ Employment Status: ☐ Student ☐ Part Time ☐ Full Time ☐ Retired ☐ Disabled ☐ Unemployed

## INSURANCE INFORMATION

PRIMARY INSURANCE __________________________ ID # __________________________ Group #________________

Subscriber Name______________________________ Sex: ☐ M ☐ F Patient Relationship to Subscriber________________

Subscriber's DOB____________ Employer____________________ Employment Status: ☐ Part Time ☐ Full Time ☐ Retired ☐ Disabled ☐ Unemployed

SECONDARY INSURANCE__________________________ ID #__________________________ Group #________________

Subscriber Name______________________________ Sex: ☐ M ☐ F Patient Relationship to Subscriber________________

Subscriber's DOB____________ Employer____________________ Employment Status: ☐ Part Time ☐ Full Time ☐ Retired ☐ Disabled ☐ Unemployed

## HOW YOU HEARD ABOUT US

☐ Family/Friend ☐ Email ☐ Newspaper / Magazine Ad ☐ Organization Website ☐ Internet Search ☐ Television Commercial ☐ Organization Newsletter
☐ Other ________________ ☐ Referring Physician ________________ ☐ Coach______________ ☐ Trainer______________

## ACKNOWLEDGMENT

I certify the information provided herein is complete and accurate. I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

Patient or Legal Guardian Printed Name ______________________________________________

Patient or Legal Guardian Signature ______________________________________ Date________________

## FINANCIAL AND PAYMENT GUIDELINES

**Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.**

- Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.
- I authorize direct payment of my insurance benefits to Texas Health for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Texas Health or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.
- I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.
- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

## RELEASE OF INFORMATION, PRIVACY PRACTICES & ASSIGNMENT OF BENEFITS

- Texas Health is committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Texas Health.

I have read, fully understand and agree to the above **financial and payment guideline, release of information & assignment of benefits, and privacy practices**.

Patient Printed Name ______________________________ DOB:______________

Patient Signature ______________________________ Date______________

Parent/Legal Guardian Printed Name ______________________________

Parent/Legal Guardian Signature______________________________ Date______________

**FACILITY NAME MUST BE FILLED IN BLANK BELOW**

*THPGPAYPRIACK*

Texas Health

Patient Name: ______________

DOB: ______________

MRN: ______________

**Payment and Privacy Acknowledgement**

I authorize the Texas Health Resources facilities, Texas Health Physicians Group and Texas Health Urgent Care to use my medical information as described in the Notice of Privacy Practices for my continuing medical treatment and to release my medical information to my health care providers using the Health Information Exchanges in which facilities participate. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the Texas Health Resources HIE, however some information may be included. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient provider and no longer protected. A Health Information Exchange is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. Your information will be stored with the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the Health Information Management Department (Medical Records Department) of the Texas Resources facilities, Texas Health Physicians Group or Texas Health Urgent Care for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing. Obstetric patients only: I also give this authorization for any child(ren) born to be during this hospitalization.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

☐ I authorize ☐ I do NOT authorize
the release of my medical information to the Health Information Exchanges in which facilities participate:

**Acknowledgment:**
I, the undersigned, certify that I have read and fully understand the information in this Consent for Health Information Exchange form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

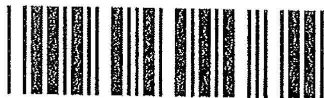
Signature ____________ Printed Name ____________ Date ________ Time ________

**If the person signing this form is not the patient, please give full name, relationship to patient, phone number and address:**

Name ____________ Relationship ____________

Phone Number ____________ Address ____________

**FACILITY NAME MUST BE FILLED IN BLANK BELOW**



*HIE*

PATIENT IDENTIFICATION

CONSENT FOR HEALTH INFORMATION EXCHANGE
EXTHR402 (09/20)

## AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION TO OTHERS

Patient Information

Legal Name: First_______________________________ MI________ Last___________________________________

DOB: _________________________

Address: __________________________________________Apt # _________ City_______________ State________ Zip _______________

Phone: Home_________________________________ Work________________________________________

Mobile__________________________________

I authorize the release of information to the following individuals.

Effective Date _____________________________

Name _____________________________________________________ Relationship to Patient_____________________________________

Home Phone______________________ May We Leave a Message? ☐ Y ☐ N

Mobile__________________________ May We Leave a Message? ☐ Y ☐ N

You may release the information regarding the following services to the person named above: ☐ Appointments ☐ Billing ☐ Medical Care

Name _____________________________________________________ Relationship to Patient_____________________________________

Home Phone______________________ May We Leave a Message? ☐ Y ☐ N

Mobile__________________________ May We Leave a Message? ☐ Y ☐ N

You may release the information regarding the following services to the person named above: ☐ Appointments ☐ Billing ☐Medical Care

I authorize Texas Health and its representatives to use the additional contact information listed above to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care as indicated. This authorization will remain in effect until I provide written notification to Texas Health of changes or updates.

I have read, fully understand, and agree to the above release of medical information to others.

Patient Printed Name ________________________________________________

Patient Signature ____________________________________________________ Date______________________________

**FACILITY NAME MUST BE FILLED IN BLANK BELOW**

Patient Name: ___________________________
DOB: ___________________________
MRN: ___________________________

**Authorization to Verbally Release Information - Others**

# Consent to Treat

I hereby authorize employees and agents of Texas Health (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Today's Date: ______________________________

Print Patient's Name: ______________________________________________________

Patient Date of Birth: ______________________________________________________

Legal Guardian (if different than patient) ________________________________________

Patient or Legal Guardian Signature ____________________________________________

**Authorization to Treat a Minor**
**(Ages 0-18th Birthday)**

Patient's Legal Name: First_________________________ MI_______ Last_________________________

Patient's DOB: ____________________

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Texas Health to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Texas Health of changes or update. I authorize Texas Health to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my child's appointments, insurance, billing information, test results and/or medical care.

Name ______________________________ Relationship____________________

Phone________________________

Name ______________________________ Relationship____________________

Phone________________________

Parent/Legal Guardian Printed Name______________________________________________

Mobile Phone ______________________________________________

Parent/Legal Guardian Signature______________________________ Date____________________

**FACILITY NAME MUST BE FILLED IN BLANK BELOW**

*THPGAUTHMIN*

Patient Name: ____________________
DOB: ____________________
MRN: ____________________

Patient Name: ______________________________ DOB: ______________

## CONSENT TO TEXT MESSAGING

Texas Health offers the choice to get text messages to a number I give. Messages may include private information protected under federal and state law. I understand that text messages are not encrypted and not secure. There is a risk that protected health information may be seen by third parties. Message and data rates may apply. My consent is effective until revoked.

❑ **I agree to get text messages as stated above**

❑ **I do not agree to get text messages as stated above**

______________________ ______________________ ______________ ______________

Signature | Printed Name | Date | Time

**If the person signing this form is not the patient, please give full name, relationship to patient, phone number and address:**

______________________________ ______________________________

Name | Relationship

______________________ ______________________________________

Phone Number | Address

FACILITY NAME MUST BE FILLED IN BLANK BELOW

PATIENT IDENTIFICATION

**CONSENT TO RECEIVE INFORMATION AS TEXT MESSAGE**

Patient Name: ______________________ DOB: ____________

## Consent for Telehealth Services/Virtual Visit Care and Treatment

**General Consent:** I consent for Patient, which may be defined as me, my child or a person for whom I have legal responsibility, to receive care and treatment at a Texas Health facility, entity or program (collectively referred to as "Texas Health") through Telehealth Services (which may also be referred to as a Virtual Visit or Telehealth). Telehealth Services may be provided by physicians, advanced practice providers, and other health care providers employed or contracted by or affiliated with Texas Health ("Telehealth Providers") and may include the evaluation, diagnosis, consultation on, and treatment of Patient's medical or health condition using advanced telecommunications technology. I understand that photos or video of Patient may be taken in connection with Telehealth Services and for operational, quality improvement, research, and education purposes. I understand that Texas Health may be a teaching facility and agree that residents, fellows, students and other approved individuals may observe and participate in the Telehealth Services under appropriate supervision.

I understand that Telehealth Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telehealth. Telehealth Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination, and (iii) must rely on information provided by Patient. I further understand that Telehealth Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telehealth Services, or distortions of images or other information from electronic transmissions. I acknowledge that the Telehealth Providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission.

If the Telehealth Providers determine that Telehealth Services do not adequately address Patient's medical needs, Patient will be referred for on-site medical evaluation. If Patient's condition is urgent / emergent, or if the Telehealth session is interrupted due to a technological or equipment failure, I agree Patient will obtain follow up care and treatment as needed.

I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

**Independent Providers:** The Telehealth Providers are independent physicians or providers who work for Texas Health.

**No Guarantee:** I acknowledge that no guarantees or warranties have been made as to treatment or services provided at Texas Health.

**Notice of Complaints:** To file a complaint or grievance with Texas Health, you may call 877-847-9355. A complaint regarding a physician Telehealth Provider may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, or by calling 1-800-201-9353, or by visiting their website at www.tmb.state.tx.us.

**Text / Voice / Automated Messaging:** I authorize Texas Health to send communications by text message, voice and automated calls to the cell phone number I provide. I acknowledge that standard data rates and fees will apply, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify Texas Health of Patient's health care needs.

**Duration of Consent:** I understand and agree this Consent for Telehealth Services Care and Treatment is valid for all Telehealth Services/Virtual Visits, for the present and future visits for one year from the date of signature below unless I revoke the consent prior to that time.

***I have read and understand the information in this Consent for Telehealth Services/Virtual Visit Care and Treatment form, and understand that by not signing this Consent I will not be treated.***

______________________ ______________________
Signature of Patient/Parent or Legally Authorized Representative* Date/Time

______________________ ______________________
Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**
**** Witness must be an adult, over the age of eighteen (18) years, of sound mind and not a participant in the medical treatment.**

**HOSPITAL NAME MUST BE FILLED IN BLANK BELOW**

*TELEVVC*

PATIENT IDENTIFICATION

**General Consent for Telehealth Services**
**Virtual Visit and Acknowledgements**