New Patient Packet

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Welcome!

Thank you for choosing NeuroTexas

This New Patient Packet has been compiled in two sections to provide you with our office's policies, procedures, and required documents. The first section is designed as a guide to our office policies and procedures. The second section is to be completed by the patient or patient representative. The information you provide will assist our physicians and staff to offer the best possible care.

We understand that patients have questions and concerns and hope to answer many of them on the following pages. Please read through this packet as it should be helpful in preparing you for your upcoming appointment. If after reading this you have unanswered questions, please feel free to give our office a call.

You can find a complete list of staff with contact information on our website, www.neurotexas.net.

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New Patient Appointment

We have enclosed all New Patient forms in this packet. Please complete them prior to arriving for your appointment. These forms can be found on our website, www.neurotexas.net, should you need additional copies. You may fax the forms in advance to (512) 474-1118. If you are unable to complete prior to your appointment, please arrive thirty minutes early to complete necessary paperwork.

If you have had an MRI, CT, or other imaging within the last six months, please inform our scheduler of the location and date of the procedure(s). In certain cases, we may be able to obtain the films without your intervention. If we cannot obtain your films on our own, you will be asked to bring a CD to our office on the day of your appointment. Regardless, please bring all films, media, reports, and records in your possession that you feel are pertinent to your condition.

Remember to bring your insurance card(s) with you to your visit.

Office Hours & Appointments

Our office is open from 8:00AM to 5:00PM daily, excluding weekends and holidays, during which time you may call to schedule an appointment or obtain information. Phone hours are from 8:30AM to 4:30PM. Patients are seen by appointment only. Patients are seen each day in the order of their scheduled appointments.

Please be on time to your appointment as we must respect the right of each patient to be seen at his/her scheduled appointment time. If you are late to your appointment in excess of fifteen minutes, we will reschedule your appointment for another clinic day.

Our physicians are surgeons and thus on-call for emergencies. Please be aware that situations beyond our control may necessitate the delay or rescheduling of your appointment. We apologize in advance. Our office staff strives to limit any inconvenience to patients and will do our best to communicate any changes to your appointment with as much notice and courtesy as possible.

We understand that at times patients may have a need to cancel or reschedule an appointment. We will happily accommodate your scheduling needs. Please call our office at least 24 hours prior to your appointment date and time so we may offer your slot to another patient.

Emergencies

If you feel you have a life-threatening emergency, please dial 911 or go to your nearest emergency facility. If you have a non-life threatening emergency during regular office hours, call our office and talk with our medical assistant. If you need the doctor after-hours, our office number will connect you to our telephone answering service. These individuals have special instructions and know where to reach the doctor "on call". Since our physicians share call responsibilities, please understand that you may not be able to communicate directly with your personal physician until the next business day.

Prescriptions

Prescriptions can only be refilled MONDAY through THURSDAY 8:30AM to 4:30PM and Friday 8:30AM to 12:00PM. All prescription refill requests made after 12:00PM on Friday will be called in the following Monday. Please note that controlled substances, such as narcotic pain medication **cannot be called or faxed into a pharmacy.** Patient or a designated individual may come to our office to pick up a written script, or a prescription may be mailed to your home address. **Please note that the after-hours doctor on call will not authorize medication refills or prescribe new medication.**

Financial Policy

Please read the Financial Responsibility on page 18. Our business office can answer any additional questions that you may have. ***If you have any questions regarding your statement please contact 1800-994-0371.***

Medical Forms

Seven working days are necessary to complete paperwork.
Medical forms ***cannot*** be completed on the day when you are seen by your doctor. Do not bring forms to surgery as they can easily be misplaced. All forms must be delivered to our office.

Medical Records

All medical records requests must either be faxed to 512-474-1118 or emailed to jbravo@neurotexas.net. Our request form is located on our website www.neurotexas.net under Patient Forms. All other medical records inquiries can be emailed to jbravo@neurotexas.net.

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Location & Parking

PHONE NUMBER FOR ALL LOCATIONS: (512) 474-1114

CENTRAL AUSTIN
St. David's Medical Office Building
3000 North IH-35, Suite 600
Austin, Texas 78705
Directions: ***Parking Garage 2*** is located on 30th Street between the IH-35 access road and Red River St. Once parked in ***Parking Garage 2***, take the central bank of elevators to the 6th floor, and NeuroTexas is located immediately off the elevators. Please be prepared to pay for parking. If you are over the age of 65, parking is free with valid identification.

CEDAR PARK
Baylor Scott and White office
910 East Whitestone Boulevard
Cedar Park, Texas 78613

FREDERICKSBURG
Pedernales Medical Group office
205 West Windcrest, Suite 310
Fredericksburg, Texas 78624

HORSESHOE BAY
Scott & White Specialty Clinic
201 Bay West Boulevard
Horseshoe Bay, Texas 78657

LA GRANGE
St. Mark's Professional Building
Two St. Mark's Place, Suite 104
La Grange, Texas 78945

LAKEWAY
Baylor Scott and White Specialty Building
200 Medical Parkway, Suite 380
Lakeway, Texas 78738

SAN MARCOS
San Marcos Family Medicine Office
2406 Hunter Road, Suite 106
San Marcos, Texas 78666

SOUTHWEST AUSTIN
Southwest Medical Village
5625 Eiger Road, Suite 210
Austin, Texas 78735

Patient Rights & Responsibilities

We consider you a partner in your care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. NeuroTexas encourages respect for the personal preferences and values of each individual. It is our goal to ensure that your rights as a patient are observed.

- You and your family have the right to access an interpreter if you are deaf or do not speak or understand English.
- All patients have a right to refuse a recommended treatment, to the extent permitted by law, and to be informed of the medical consequences of this action. All patients are responsible for their own actions if they refuse treatment or do not follow the doctor's recommendations.
- All patients have the right to every consideration of privacy. Patients are responsible for being considerate of the privacy of other patients. Telephones, televisions, radios, and lights should be used in a manner agreeable to others.
- All patients have the right to expect that all communications and records pertaining to their care will be treated as confidential, except in cases such as suspected abuse and public health hazards, when reporting is permitted or required by law.
- All patients have the right to receive considerate care that respects their personal values and belief systems. We ask our patients to be considerate and respectful of medical center personnel.
- All patients have the right to examine and receive an explanation of their bill, regardless of the source of payment. Patients have the responsibility to provide information necessary for claim processing and to be prompt in payment of their bills.
- All patients have the right to know the rules and regulations that apply to patient care and conduct and are responsible for following those rules and regulations.
- All patients have a right to receive an explanation of their treatment program and to ask for further clarification if the course of treatment is not understood. Patients have the responsibility to cooperate in their treatment program.

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Notice of Privacy Practices

Each time you visit NeuroTexas a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your Personal Health Information (PHI), serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of this state and the nation
- Source of data for our planning and marketing
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

NeuroTexas is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

WORKER COMPENSATION
We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

LEGAL PROCEEDINGS
We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to subpoena, discovery request or other lawful process.

Notice of Privacy Practices - continued

ABUSE/NEGLECT
We may disclose your PHI to a public health authority by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONORS
We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the medical examiner or coroner to perform other duties authorized by law. We may disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ or tissue donation purposes.

INMATES
We may use or disclose your PHI if you are an inmate of a correctional facility, and your physician created or received your PHI in the course of providing care to you.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

LAW ENFORCEMENT
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

REQUIRED USES AND DISCLOSURES
Under the law, we must make disclosure to you and when required to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of CFR Section 164.
Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.
If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our office or directly to the Secretary of Health and Human Services. To file a complaint, you must do so in writing within 180 days of the suspected violation, providing as much detail regarding the suspected violation as possible and mail to:

NeuroTexas, PLLC • 3000 North IH-35, Suite 600 • Medical Office Building at St. David's • Austin, TX 78705

There would be no retaliation for your filing a complaint. For more information or additional questions you may contact our practice administrator at 512.474.1114.

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Patient Registration Form

Please use black ink only

Patient Information: **Date:** _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

DOB: ____/____/____ SSN: _____ Sex: ❒ F ❒ M

Marital Status: ❒ S ❒ M ❒ D ❒ W Employer: _____

Email Address: _____ Contact Via Email: ❒ Yes ❒ No

Primary Language: _____ Race: _____ Ethnicity: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Insurance:

Insurance Name: _____ Name of Insured: _____

DOB: ____/____/____ (if not the patient)

Relationship to Patient: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Member ID: _____ Group #: _____

Secondary Insurance Name: _____ Name of Insured: _____

Relationship to Patient: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Member ID: _____ Group #: _____

Is this Visit related to an:

On the job injury ❒ Yes ❒ No

Auto accident ❒ Yes ❒ No

How did you hear about NeuroTexas? _____

_____

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Initial Visit History *Please use black ink only*

Name: _____ Date: _____

D.O.B.: ____/____/____ Age: _____ Height: ____' ____" Weight: _____ lbs

Referring Physician: _____ Primary Care Physician:_____

Pain Management Physician: _____

What is the purpose of your visit today?

_____

_____

Where is your problem located?

❒ Head ❒ Neck ❒ Middle Back ❒ Lower Back ❒ Other: _____

If you have numbness, where is it located?

Leg: ❒ Left ❒ Right ❒ Both ❒ Above Knee ❒ Below Knee

Arm: ❒ Left ❒ Right ❒ Both ❒ Above Elbow ❒ Below Elbow

How long have you had this problem?

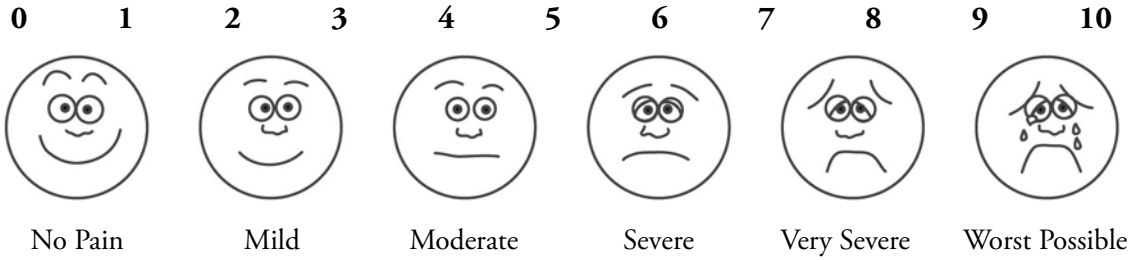
❒ _____Days ❒ _____Weeks ❒ _____Months ❒ _____Years

Does the pain radiate anywhere? ❒ No ❒ Yes, where?

Leg: ❒ Left ❒ Right ❒ Both ❒ Above Knee ❒ Below Knee

Arm: ❒ Left ❒ Right ❒ Both ❒ Above Elbow ❒ Below Elbow

On a scale of 1-10, how bad is your pain?



Name: _____

When do your symptoms occur/worsen? (Check all that apply)

❒ Bending or stooping ❒ Coughing or straining ❒ Driving ❒ Prolonged sitting
❒ Prolonged standing ❒ Walking up stairs ❒ Lying flat ❒ Weight bearing
❒ Physical activity ❒ Twisting ❒ Walking ❒ Lifting ❒ Constantly ❒ At rest
❒ Other _____

Under what circumstances did your symptoms begin? (Check one box)

❒ Accident at work ❒ At work (not accident) ❒ Accident at home ❒ Motor vehicle accident
❒ Following surgery ❒ Following illness ❒ No apparent reason ❒ Other _____

If accident (auto or work related injury), in what state were you when it occurred?

_____ Date of occurrence? _____

When is your pain the worst?

❒ When you wake up ❒ Later in the morning, after breakfast ❒ Various times during the day
❒ At the end of the day ❒ At night ❒ Does the pain wake you up?
❒ Other _____

Does anything, other than medication, relieve your pain? _____

Describe your pain? (Check all that apply)

❒ Throbbing ❒ Shooting ❒ Stabbing ❒ Sharp ❒ Cramping ❒ Burning ❒ Aching

Do you have any associated symptoms? (Check all that apply)

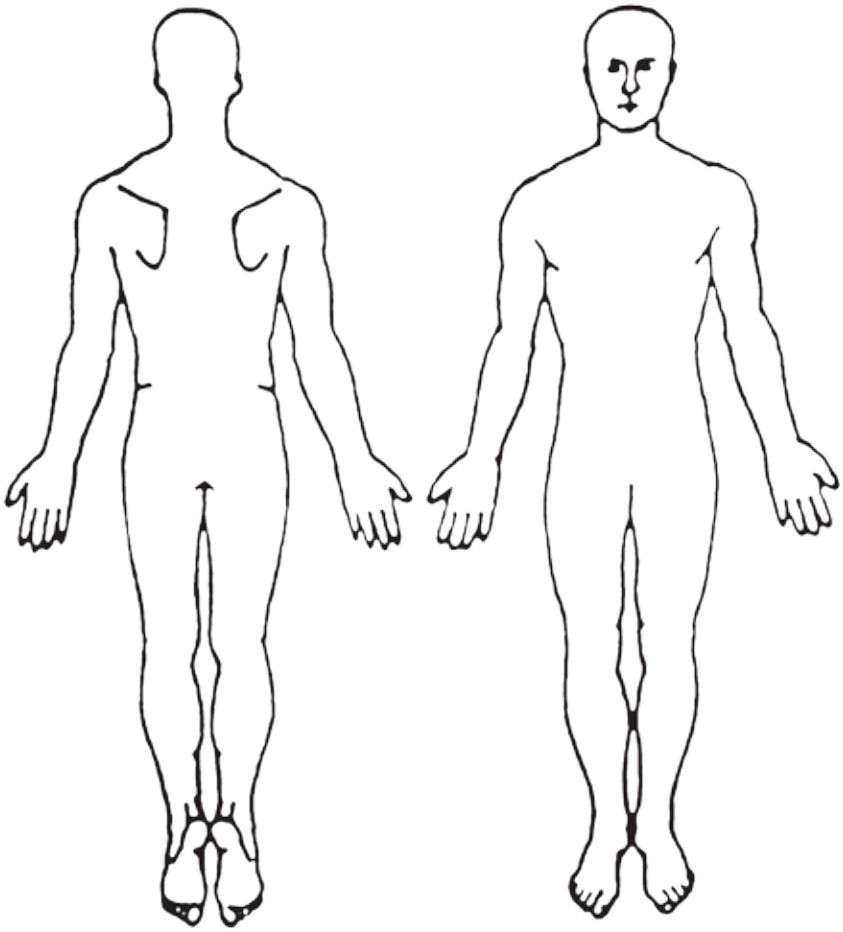
❒ Heavy ❒ Numbness ❒ Tingling ❒ Weakness ❒ Headache ❒ Dizziness ❒ Nausea
❒ Vomiting ❒ Fatigue ❒ Balance problems
❒ Bowel or bladder problems ❒ Other _____

Have you had difficulty with? (Check all that apply)

❒ Handwriting ❒ Grip strength ❒ Dropping items ❒ Buttoning your shirt
❒ Opening jars ❒ Picking up coins ❒ Getting out of a chair ❒ Getting up out of bed
❒ Pain with flexion/bending forward ❒ Pain with extension/bending backwards

Name: _____

Place an X on the areas where you are experiencing your symptoms.



Which of the following have been adversely affected by your painful condition?

❒ Activities of daily living ❒ Normal lifestyle ❒ Work activities ❒ Sleep

❒ Excercise ❒ Sexual Activity

Please check the aids or devices that you use:

❒ Wheelchair ❒ Crutches ❒ Walker ❒ Cane **Use**: ❒ Recent ❒ Longterm

Do you exercise? ❒ Yes ❒ No ❒ Unable to due to pain

❒ Type _____

❒ Frequency _____

Name: _____

What treatments have you had for this condition in the last <u>two</u> years?

TREATMENTS		FACILITY NAME / DOCTOR
Physical Therapy	❒	
Pain Injections	❒	
Chiropractor	❒	
Anti-Inflammatories (Ibuprofen / Aspirin)	❒	
Prescription Painkillers	❒	
Oral Steroids (Medrol Dosepak)	❒	
Acupuncture	❒	

Does your pain medication:

❒ Relieve most of your pain? ❒ Relieve about 75% of your pain?

❒ Relieve about 50% of your pain ❒ Relieve about 25% of your pain

❒ Relieve only a slight amount of pain?

❒ How long does your relief last after taking your pain medication? _____ hrs

List ALL medications you are currently taking.

MEDICATION	DOSAGE	FREQUENCY	DURATION

List any medications you are allergic to and your reaction to them:

_____

_____

Name: _____

Have you previously had any films taken? ❒ Yes ❒ No

Facility: _____

Type of Film: _____ Date: _____

Facility: _____

Type of Film: _____ Date: _____

Are you allergic to contrast iodine? ❒ Yes ❒ No

Are you claustrophobic? ❒ Yes ❒ No

Do you have any metal in your body? ❒ Yes ❒ No

If yes, please describe:

_____

_____

Do you have a history of kidney problems? ❒ Yes ❒ No

If yes, please describe:

_____

_____

Do you have difficulty with intubation? ❒ Yes ❒ No

List any past medical history (e.g. heart attack, cancer, diabetes, high blood pressure, etc.):

_____

_____

List any surgeries you have had along with the approximate year of each surgery:

_____

_____

Name: _____

List any family medical history (e.g. heart attack, cancer, etc.) and identify relative:

_____

_____

Who do you live with? ❒ Alone ❒ Significant Other ❒ Family

Do you have any children? ❒ Yes ❒ No Ages (if appl.) _____

What is your occupation? _____

Do you drink alcohol? ❒ None ❒ Socially/Occasionally ❒ Quit/Sober _____years
❒ In AA ❒ Frequency _____

Do you now use, or have you used illegal drugs? ❒ Never used

❒ IV drugs still use _____ quit when _____

❒ Marijuana still use _____ quit when _____

❒ In recovery how long _____

❒ Currently addicted

Do you currently use Tobacco? If yes, for how long? _____ years.

❒ Never ❒ Smoke _____ cigarettes per day ❒ Smoke _____ cigars per day

❒ Smoke _____ pipefull(s) per day ❒ Chews _____ pouches per week

❒ Dips _____ cans per week

Do you live in a house with a smoker? ❒ Yes ❒ No

Do you have an Advanced Care Plan (i.e. Will, Medical Power of Attorney)? ❒ Yes ❒ No

If yes, who is named to make decisions on your behalf if the need should arise?

_____

Have you received a flu vaccine this season/year? ❒ Yes ❒ No

Have you received a pneumonia vaccine this season/year? ❒ Yes ❒ No

Name: _____

Please check anything you are experiencing or have recently experienced.

GENERAL/CONSTITUTIONAL:
❒ Fever ❒ Chills ❒ Change in Appetite ❒ Headaches ❒ Weakness ❒ Fatigue
❒ Bleeding ❒ Sickle Cell ❒ HIV ❒ AIDS ❒ Hepatitis A | B | C (circle) ❒ Sleep Apnea

EYES:
❒ Cataracts ❒ Glaucoma ❒ Blurred Vision ❒ Double Vision ❒ Eye Pain ❒ Visual Loss

EARS/NOSE/THROAT:
❒ Hearing Loss ❒ Recurrent Ear Infections ❒ Nose or Throat Problems ❒ Ringing in Ears ❒ Nosebleeds
❒ Vertigo ❒ Taste Abnormality ❒ Voice Changes

CARDIOVASCULAR:
❒ Heart Attack ❒ Congestive Heart Failure ❒ Cardiac Bypass ❒ High Blood Pressure ❒ Irregular Heartbeat
❒ Murmur ❒ Chest Pain ❒ Ankle Edema ❒ Significant Cardiac History ❒ Vascular Disease
❒ Syncope ❒ Blood Clots ❒ High Cholesterol

RESPIRATORY:
❒ Asthma ❒ Chronic Bronchitis ❒ Emphysema ❒ COPD ❒ Shortness of Breath ❒ History of Pneumonia

GASTROINTESTINAL:
❒ Bowel Incontinence ❒ Peptic Ulcer ❒ GERD ❒ Crohn's Disease ❒ IBS ❒ Abdominal Pain
❒ Constipation ❒ Diarrhea ❒ Nausea ❒ Vomiting ❒ Weight Changes

GENITOURINARY:
❒ Repeated Urinary Tract Infections ❒ Blood in Urine ❒ Discharge ❒ Urinary Incontinence

MUSCULOSKELETAL:
❒ Posture Abnormalities ❒ Arthritis ❒ Abnormal Muscles ❒ Muscle Pain ❒ Swelling
❒ Wasting or Atrophy ❒ Night Cramps ❒ Recent Trauma or Injury ❒ Fractures ❒ Migratory Pain
❒ Muscular Weakness ❒ Abnormal Joints ❒ Osteoporosis

SKIN:
❒ Rash ❒ Dryness ❒ Boils ❒ Skin Eruptions ❒ Significant Skin Disorders ❒ Abnormal Skin Pigments

NEUROLOGICAL:
❒ Stroke ❒ Tremors ❒ Dizziness ❒ Numbness ❒ Tingling Sensation ❒ Paralysis ❒ Muscle Weakness
❒ Speech Problems ❒ Gait Disturbance ❒ Seizures

PSYCHIATRIC:
❒ Anxiety ❒ Depression ❒ Forgetfulness ❒ Memory Loss ❒ Irritability ❒ Adjustment Problems
❒ Hallucinations/Delusions ❒ Taking Psychiatric Medication

ENDOCRINE:
❒ Diabetes ❒ Change Hand or Feet Size ❒ Obesity ❒ Abnormal Sex Development ❒ Sterility
❒ Thyroid Disease ❒ Unusual Weakness ❒ Weight Change ❒ Prostate ❒ Abnormal Growth
❒ Abnormal Hair Distribution ❒ Abnormal Head Size ❒ Abnormal Body Proportion ❒ Breast Discharge

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Pain Management Medication Agreement

The vast majority of our patients use pain medications appropriately, but pain medications have a potential for misuse and are therefore closely controlled by local, state, and federal authorities. Tolerance with repeated use is a characteristic feature of these medications and is a potential limitation to their use in pain management. To prevent any misunderstanding between you and your doctor, we have developed the following rules.

I agree to accept responsibility to know whether there are any Controlled Substances in any medications that I take.

1. I agree to not ask multiple doctors for Controlled Substance medication prescriptions.
2. No prescriptions will be refilled early.
3. No prescription will be refilled if I lose or destroy any of my medication.
4. I will get all of my prescriptions filled at one pharmacy which is:
   Name: _____ Phone: _____
5. Refills will only be authorized during normal clinic hours of 8:30AM – 4:00PM Monday – Thursday, 8:30AM – 12:00PM Fridays. **Refills will not be made on weekends, holidays or at night. Please do not call the after-hours medical service for medication refills.**
6. NeuroTexas does not have the ability to manage long-term pain. Our office will prescribe appropriate medications pre- and post-surgery up to 4-6 weeks post-operatively per physicians' orders. Any patient requiring medications for a longer duration will be referred to pain management for additional care.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present a valid picture identification and sign for the prescription.

_____(Patient initials) I wish to designate the following family member / friend to pick-up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____(Patient initials) I am currently under the care of a pain management physician and will not obtain controlled medications from NeuroTexas.

I understand and agree to follow these patient rules for Pain Management while under the care of NeuroTexas. The NeuroTexas staff has answered any and all questions to my satisfaction. If I do not follow these rules completely, the clinic physicians and staff reserve the right to stop any further prescribing of these medications. I have received a copy of this agreement.

_____
Signature of Patient

_____ _____
Printed Name of Patient Date

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Permission for Verbal Communication

Patient Name | Date of Birth | Phone Number (s)

Full Address (City, State, and Zip Code)

I permit Baylor Scott & White Health (BSWH) and NeuroTexas physicians and staff to discuss my personal medical health information, in person and/or by telephone, with the following family members and/or friends involved in my medical care for the following purposes:

- To orally schedule or confirm my appointments;
- To discuss results of diagnostic tests, diagnosis, prognosis, and treatment plans; or
- To discuss billing and payment for medical services:

I understand that this document applies to all departments, healthcare providers and/or employees with BSWH and NeuroTexas. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

Name | Relationship | Phone Number

1._____

2._____

3._____

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to BSWH – HIM Department or to NeuroTexas.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here _____.

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at BSWH0 and NeuroTexas.

Patient Signature | Date

Patient's Representative on behalf of patient | Relationship to patient | Date

Witness (if patient has Representative sign) | Date

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General Consent / Financial Responsibility / Advance Directives

IMPORTANT INFORMATION — PLEASE READ CAREFULLY BEFORE SIGNING

1. **General Consent** I voluntarily request and consent to hospital care or outpatient treatment ordered by my healthcare professionals. This includes but is not limited to diagnostic testing (such as lab and x-rays), medical, nursing, or surgical treatment or anesthesia services. This consent is continuing in nature unless specifically revoked by me.

2. **Teaching Institution** I understand that Baylor Scott & White Health (BSWH)includes teaching facilities. Students and residents from various programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my healthcare providers.

3. **Control Over Decisions** I have the right to make decisions about my care. My healthcare professionals and I will discuss and agree upon my care.

4. **Testing After Accidental Exposure** During my care, a healthcare worker may be exposed to my blood or body fluids. If this happens, my blood may be tested for certain diseases, such as Human Immunodeficiency Virus (HIV).This will be done at no cost to me.

5. **State Reporting Requirements** I understand that BSWH and NeuroTexas are required by law to report certain infectious diseases, such as HIV and tuberculosis, to the State Health Department or the Centers for Disease Control and Prevention.

6. **Personal Property** I understand that I am responsible for my personal property. BSWH and NeuroTexas are not responsible for safekeeping these items. At my request, some facilities may provide locked storage for personal items.

7. **Financial Responsibility** I agree to pay for the healthcare services provided to me by BSWH and NeuroTexas, whether or not I have health insurance. I agree that all amounts are due and payable at the time of service or upon request. I understand that BSWH and NeuroTexas may obtain a credit report to assess my ability to pay for healthcare services.

8. **Medicare and Medicaid** If I have Medicare or Medicaid, my financial obligations may be limited by law. Other insurance carriers may limit my obligations by contract or policy benefit guidelines. If I do not have insurance coverage, I may ask for help to determine programs for which I may be eligible.

9. **Provider Based Institution** I understand that BSWH and NeuroTexas include provider based institutions under Medicare. Because of this, I may receive separate bills for facility services (Part A) and physician services (Part B), even if I do not have Medicare.

10. **Insurance, Authorization, and In-Network Coverage** I understand my insurance may not cover some services provided to me. I am responsible for asking about and understanding my insurance coverage and selecting my healthcare providers and facilities. Only my insurance carriers can confirm the nature and extent of my coverage and which providers will be paid in-network.

General Consent / Financial Responsibility / Advance Directives - 2

11. **Assignment of Benefits** I authorize my insurance carriers to pay BSWH and NeuroTexas directly for the services provided to me.

12. **Release of Information** I understand that BSWH may release my healthcare information to my insurance carriers for payment purposes. Baylor Scott & White Health and NeuroTexas may release information to other providers for my continued care.

13. **Communication** I authorize the hospital and my healthcare professionals, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, digital voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

14. **Retention of Records** I understand that BSWH and NeuroTexas will keep my medical records for the minimum time periods required by state and federal law. After this time, my records may be destroyed in a manner that protects their confidentiality.

15. **Notice of Privacy Practices** I acknowledge that I have received a copy of BSWH's and NeuroTexas' "Notice of Privacy Practices" (pages 6 and 7).

16. **Patient Rights and Advance Directives** Information has been made available to me about my right to accept or refuse medical treatments. I have the right to make an advance directive, or living will. I am not required to have an advance directive to receive medical treatment. If I give BSWH and NeuroTexas an advance directive, my caregivers will follow it to the extent permitted by law.

17. **Patient Representative** I have the right to name a representative who will make decisions on my behalf. I may designate a representative in writing or by telling my healthcare provider. My representative will be involved in my treatment/care plan throughout my inpatient stay or outpatient visit, unless I expressly withdraw this designation in writing or by telling my healthcare provider.

18. **Photography** I understand that BSWH is a teaching institution, and that possible videotaping, photographing, video monitoring, or other recording of me or parts of my body involved in diagnosis, treatment, or for patient safety purposes may be used. This may be done for medical education, quality improvement, or for other reasons related to treatment and/or operations. I will discuss this with my caregiver if I do not want my recordings used for these purposes.

19. **Laboratory Samples** I agree that any left over specimens sent to the laboratory may be used for medical education, validation and authorized research. These samples will not identify me by name to protect my privacy.

20. **Smoking Cessation** Information has been made available to me about smoking and tobacco use and the importance of stopping smoking.

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21. **Warranty and Guarantee** I am aware that the practice of medicine is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care.

ACKNOWLEDGEMENT: By my signature below, I certify I have read and completely understand the content of this document and agree to its terms.

Patient/Legal Guardian Signature:_____

Patient Name (Printed): _____

Date: _____ DOB: _____