

# 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](http://www.neurotexas.net).



## NEW PATIENT APPOINTMENT

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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](http://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

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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

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**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

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**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 also note that the after-hours doctor on call will not authorize medication refills or prescribe new medication.**

## FINANCIAL POLICY

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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

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**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

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**All** medical records requests must either be faxed to 844-331-3877 or emailed to RR@scanstat.com. You may also mail requests to 100 Medical Parkway, Austin, Texas 78738 ATTN: HIM. Our request form is located on our website [www.neurotexas.net](http://www.neurotexas.net) under Patient Forms. All other medical records inquiries can be emailed to RR@scanstat.com. For questions, or to check the status on your request please call 512-654-1226.

## LOCATION & PARKING

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**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

### **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

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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.

## NOTICE OF PRIVACY PRACTICES

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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

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### **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.

**PATIENT REGISTRATION FORM** *Please use black ink only*

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**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?**

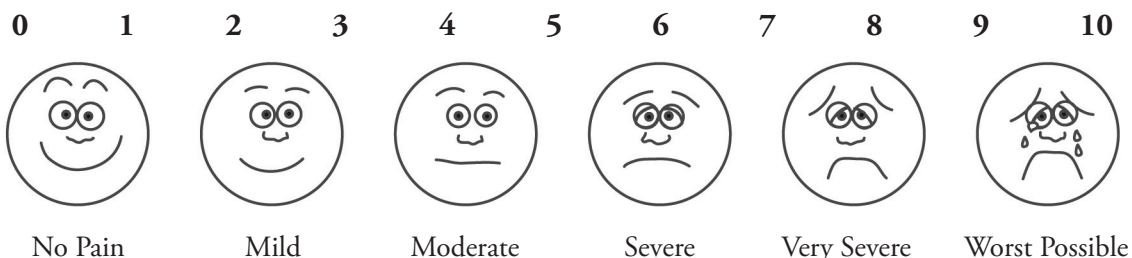
\_\_\_\_\_ Days  \_\_\_\_\_ Weeks  \_\_\_\_\_ Months  \_\_\_\_\_ Years

**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: \_\_\_\_\_

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**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 \_\_\_\_\_

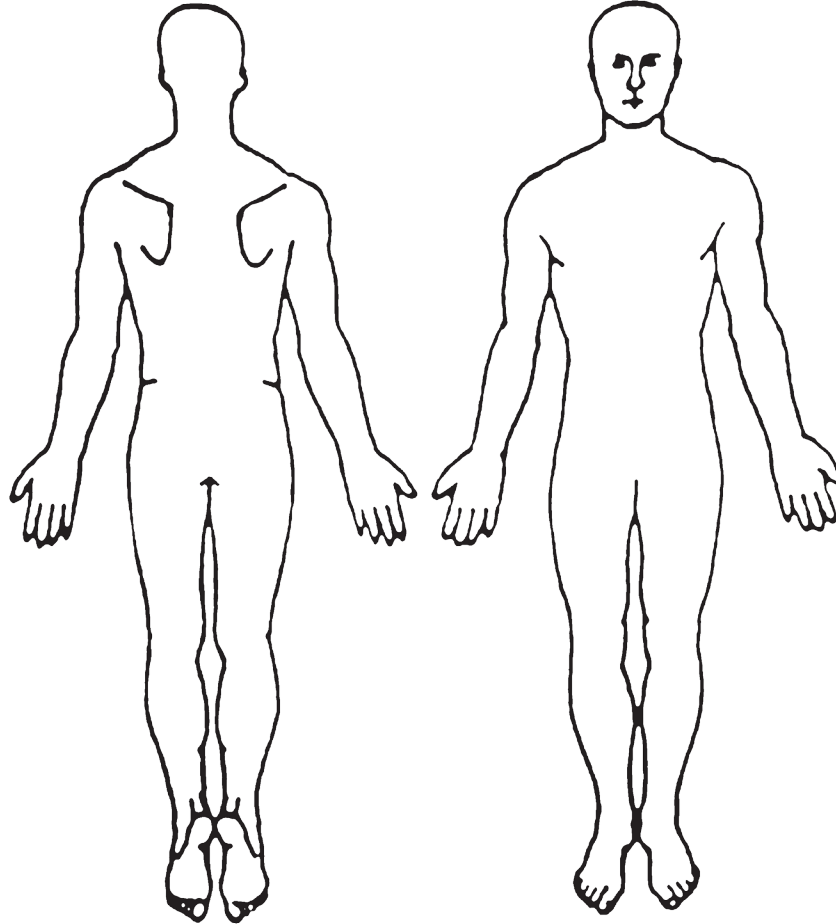
**Have you had difficulty with?** (Check all that apply)

- 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: \_\_\_\_\_

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**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  
 Exercise  
  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 two years?**

TREATMENTS		FACILITY NAME / DOCTOR
Physical Therapy	<input type="checkbox"/>	
Pain Injections	<input type="checkbox"/>	
Chiropractor	<input type="checkbox"/>	
Anti-Inflammatories (Ibuprofen / Aspirin)	<input type="checkbox"/>	
Prescription Painkillers	<input type="checkbox"/>	
Oral Steroids (Medrol Dosepak)	<input type="checkbox"/>	
Acupuncture	<input type="checkbox"/>	

**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: \_\_\_\_\_

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**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:

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

If yes, please describe:

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**Do you have difficulty with intubation?**    Yes    No

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

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

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Name: \_\_\_\_\_

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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: \_\_\_\_\_

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**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

## 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



## PERMISSION FOR VERBAL COMMUNICATION

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Patient Name	Date of Birth	Phone Number (s)
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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
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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
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Patient's Representative on behalf of patient	Relationship to patient	Date
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Witness (if patient has Representative sign)	Date
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## GENERAL CONSENT / FINANCIAL RESPONSIBILITY / ADVANCE DIRECTIVES

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### 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.

## GENERAL CONSENT / FINANCIAL RESPONSIBILITY / ADVANCE DIRECTIVES - 3

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: \_\_\_\_\_