neurotexas®
Brain & Spinal Surgery

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 *(first and last)*: _____ Primary Care Physician *(first and last)*:_____

Pain Management Physician *(first and last)*: _____Cardiologist *(first and last)*: _____

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?**

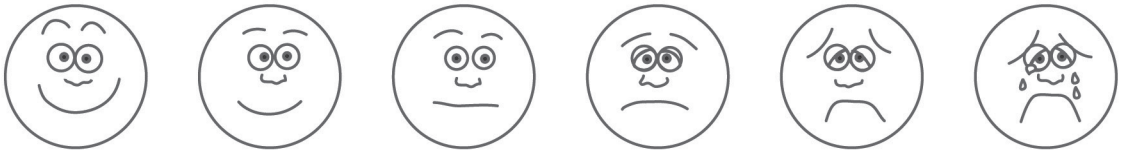
Leg: ☐ Left ☐ Right ☐ Both ☐ Above Knee ☐ Below Knee

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

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

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10



No Pain Mild Moderate Severe Very Severe Worst Possible

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)

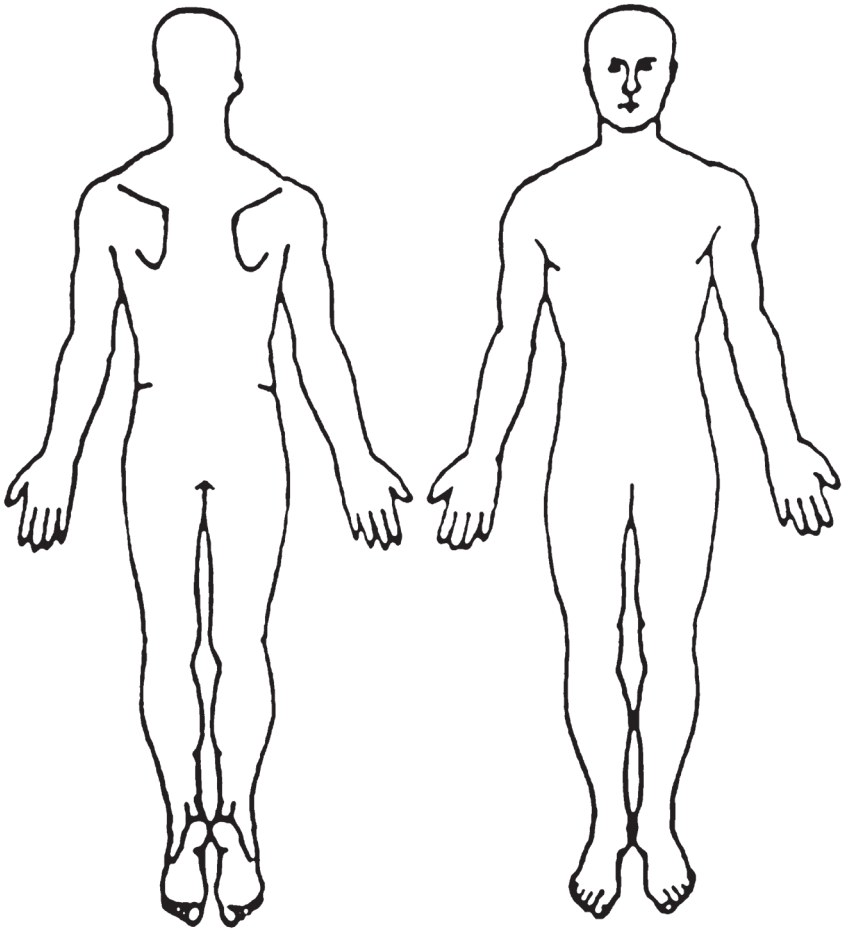
☐ Heavy ☐ Numbness ☐ Tingling ☐ Weakness ☐ Headache ☐ Dizziness ☐ Nausea
☐ Vomiting ☐ Fatigue ☐ Balance problems
☐ Bowel or bladder problems ☐ Other _____

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

Name: _____

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

_____

_____

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? ☐ Yes ☐ No
If yes, type: ☐ Marijuana ☐ Heroin ☐ Cocaine / Crack Cocaine ☐ Methamphetamine
☐ Still using ☐ Quit, when _____

Do you use Tobacco?

☐ Never ☐ Yes, _____ years _____ packs per day
☐ Quit after _____ years _____ packs per day Date quit: _____
Type: ☐ Cigarettes ☐ Cigars ☐ Dip / Chewing ☐ E Cigarettes

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

Do you have a history of abuse/addiction to prescription medication?

☐ Yes ☐ No If yes, Type: _____

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. Prescription refills will require 48 business hours to process.
6. Refills **WILL NOT** be made on weekends, holidays, or after 4:00PM on business days. Please do not call the after-hours medical service for medication refills. These requests will not be addressed until the following business day.
7. NeuroTexas does not have the ability to manage long-term pain. Our office will prescribe appropriate medications post-surgery for up to 6 weeks post-operatively per physicians' orders. Any patient requiring medications for a longer duration will be referred to Pain Management for additional care.

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

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.

_____
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 persons 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 my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; 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 Baylor Scott & White Health – Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508.

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 BSWH and NeuroTexas.

_____

Patient Signature | Date

_____

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

_____

Witness (if patient has Representative sign) | Date

BAYLOR SCOTT & WHITE HEALTH

Baylor Scott & White HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

neurotexas® Brain & Spinal Surgery

I hereby authorize: _____

Address: _____

Telephone: _____ Fax Number: _____

To release the information indicated from the medical record of:

Patient Name	Date of Birth	Medical Record Number
Street Address	City, State Zip	Telephone Number

Please release this information to:

Individual/Organization Name		Telephone Number
Neurotexas		512-654-4550
Street Address	City, State Zip	Fax Number
5625 Eiger Rd, Ste 150	Austin, TX 78735	512-654-4551

Please release the following information for these treatment dates: _____

Please provide information in this format: □ Paper copies □ CD □ USB Drive

Include this information (if applicable): □ Alcohol/Drug □ Genetics □ HIV/AIDS □ Mental Health

Purpose: Continued Care

□ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary)

□ EKG/EEG/EMG reports

□ Immunization records

□ Laboratory reports

□ Radiology reports

□ Radiology images

□ Other: _____

_____

_____

I understand the following:

- I am not required to sign this authorization to obtain treatment.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization in writing at any time except to the extent the healthcare provider has already relied on this authorization. To revoke my authorization, I will provide a written request to _____.

This authorization will expire in 180 days or at the date or event specified here: _____

Signature of Patient or Legal Representative	Printed Name of Patient or Legal Representative	Date
	Representative's Authority to Act for Patient	

GENERAL CONSENT TO TREAT

1. **General Consent** I consent to allowing the applicable Baylor Scott & White Health affiliated facilities listed below ("Facility") to provide me with necessary medical service, evaluation, diagnosis, treatment, and care (collectively, "care"). My consent includes any examinations, imaging, laboratory tests (including, but not limited to, tests to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), medications, medical treatment, and/or other services rendered by physicians, advance practice professionals, technical assistants, their associates, and other healthcare providers including nurses and other Facility staff (collectively, "providers"), which are advisable during the course of my evaluation, diagnosis, care, and treatment. Further, I agree and understand that care provided to me within the Emergency Department is considered an admission to the Facility even if I am not admitted to an inpatient bed. This consent is continuing in nature during the entire course of my care, unless specifically revoked by me.

Baylor Scott & White All Saints Medical Center - Ft. Worth
Baylor Scott & White Ambulatory Endoscopy Center
Baylor Scott & White Continuing Care Hospital
Baylor Scott & White Heart and Vascular Hospital - Dallas
Baylor Scott & White Heart and Vascular Hospital - Ft. Worth
Baylor Scott & White McLane Children's Medical Hospital
Baylor Scott & White Medical Center - Austin
Baylor Scott & White Medical Center - Brenham
Baylor Scott & White Medical Center - Buda
Baylor Scott & White Medical Center - Centennial
Baylor Scott & White Medical Center - College Station
Baylor Scott & White Medical Center - Grapevine
Baylor Scott & White Medical Center - Hillcrest
Baylor Scott & White Medical Center - Irving
Baylor Scott & White Medical Center - Lake Pointe
Baylor Scott & White Medical Center - Lakeway
Baylor Scott & White Medical Center - Marble Falls
Baylor Scott & White Medical Center - McKinney
Baylor Scott & White Medical Center - Plano
Baylor Scott & White Medical Center - Pflugerville
Baylor Scott & White Medical Center - Round Rock
Baylor Scott & White Medical Center - Taylor
Baylor Scott & White Medical Center - Temple
Baylor Scott & White Medical Center - Waxahachie
Baylor Scott & White The Heart Hospital - Denton
Baylor Scott & White The Heart Hospital - McKinney
Baylor Scott & White The Heart Hospital - Plano
Baylor University Medical Center
HealthTexas Provider Network
Hillcrest Family Health Center
Hillcrest Physician Services
Scott & White Clinic

2. **Telemedicine** I consent to the Facility providing me with necessary care through telemedicine / telehealth, or through the use of electronic communications such as video or virtual communications, with providers who are located at a different site(s) ("off-site providers"). I agree and understand that I may be billed for any out of pocket costs such as co-pay, deductible, or coinsurance based on my health or insurance plans.
3. **Teaching Location** I agree and understand that the Facility may be a teaching Facility and residents, fellows, and students from various teaching programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my providers. I consent to allow residents, fellows, students, and authorized individuals to participate and observe the care provided to me as determined by my providers and as permitted by Facility policy.
4. **Independent Contractor** I agree and understand that the Facility may have one or more agreements with providers who are not employees of the Facility. I hereby consent to receive care from such providers and recognize that as independent contractors, the Facility is not responsible for the care or lack of care provided by these individuals. I understand that all such medical decisions regarding my care at the Facility are made by such providers and not by the Facility. **I also understand that I may receive a separate bill from these providers.** I may request a listing of the providers who have been granted medical staff privileges to provide medical services at the Facility.
5. **Control Over Decisions** I agree and understand that I have the right to make decisions about my care and that my providers and I will discuss and agree upon my care.
6. **Testing After Accidental Exposure** I agree and understand that Texas law provides, if any provider or healthcare worker is exposed to a patient's blood or other bodily fluid, Facility may perform test(s) on the patient's blood or other bodily fluid to determine the presence of any communicable disease. I consent to the testing for communicable diseases, in the event of an accidental exposure to a provider, healthcare worker, or other individual.
7. **State Reporting Requirements** I agree and understand that the Facility or provider is 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. Also, I understand that the Facility is required by law to report certain activities including abuse or neglect.
8. **Personal Property** I agree and understand that I am responsible for my personal property. I understand that any and all valuables or other articles of personal property should be placed in the care of a family member or other authorized representatives. The Facility is not responsible for the safekeeping of these items. If available, I understand that the Facility maintains a safe or secure area for property and valuables, and that I may utilize this safe or secure area according to Facility policy; however, the Facility cannot guarantee the security of these items.
9. **Notice Regarding Physician Ownership** If I am receiving care at Baylor Scott & White Heart and Vascular Hospital – Dallas/Fort Worth, Baylor Scott & White The Heart Hospital – Plano/Denton/McKinney, Baylor Scott & White Ambulatory Endoscopy Center, or an outpatient department of one of these facilities, I acknowledge that I am aware that one or more of the physicians providing my treatment at the Facility or one of its outpatient departments may have an ownership interest in the Facility.
10. **Financial Responsibility** I agree and understand that regardless of any and all assigned benefits/monies, I am responsible for the total charges for services rendered. I further agree that all amounts are due upon request and are payable to the Facility and any provider providing me care. I agree to pay for any and all charges and expenses incurred or to be incurred. **I understand that independent providers (which could include, for example only, anesthesiologists, radiologists, pathologists, emergency medicine physicians, advance practice professionals, and other independent providers of health care services) providing me care may be considered out-of-network on my health or insurance plans although the Facility may be considered in network. I understand my insurance may not cover some services provided to me. I am responsible for asking about and understanding my insurance coverage for my providers and facilities. I understand if I desire additional information as to the providers who may be involved in providing my care, I can either ask my treating provider (who may know some of the specialists or groups who could be involved) or I can request a list of Facility-based physician groups by calling the following toll free number: (877) 810-0372. This list is updated annually and is subject to change without prior notice. Only my insurance carriers can confirm the nature and extent of my coverage and which facilities and providers will be considered in-network.** I further understand and agree that should my account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I shall pay all charges for reasonable attorneys' fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts,

GENERAL CONSENT TO TREAT

either current or bad debt. Further, I hereby consent to credit bureau inquiries for any and all permissible purposes. I understand that I may request information from the Facility on whether it has a contract with my health or insurance plans and under what circumstances I may be responsible for payment of amounts not paid by my health or insurance plans.

11. **Medicare and Medicaid** If I have Medicare or Medicaid, I acknowledge 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 my eligibility.
12. **Outpatient Department** Charges I agree and understand if I receive care in an outpatient department, I may receive two bills including a bill for Facility services (also known as a facility fee) and a separate bill for the physician or other provider services (also known as professional services).
13. **Assignment of Benefits** I hereby irrevocably assign, transfer and convey to the Facility and any provider providing care to me, any and all benefits, interests and rights (including, but not limited to, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third party reimbursement, or prepaid healthcare plan for services rendered or products that I receive from the Facility. Notwithstanding the foregoing, my assignment of benefits, interests, and rights is not effective if I have signed an agreement with the Facility assuming responsibility for paying for services rendered by the Facility providers as out-of-network and retaining the responsibility to bill my insurance company.
14. **Responsible Parties** Upon receiving any care from the Facility and any provider providing care to me, I have assigned my rights of recovery from any Responsible Party to the Facility and any provider providing care to me. I understand that I may not assign, waive, compromise or settle any rights or causes of action that I may have against any Responsible Party, person or entity who causes an injury or illness treated by a Facility provider, without the express prior written consent of the Facility. This right is independent, separate and apart from any other right acquired by the Facility, including but not limited to a lien filed under the Texas Property Code. I also agree to reimburse, first, the Facility for services provided out of any claim made against a Responsible Party. I acknowledge that for any financial assistance, uninsured patient discount or any other discount from the Facility covering medical benefits for illness or injury caused by an act or omission of a Responsible Party, the Facility reserves the right to reconsider and reverse the financial assistance, uninsured patient discount, or any other discount. Financial assistance, uninsured patient discount, or any other discounts/adjustments are considered an action of last resort. Therefore, the Facility reserves the right to dismiss, or reverse any such adjustments or discount on any account at any time. For purposes of this document, a Responsible Party includes any of the following: a tortfeasor individually, a tortfeasor's insurance company, any underinsured / uninsured automobile insurance coverage that provides benefits to a patient, no fault insurance coverage, any award, settlement or benefit paid under any worker's compensation law, claim or award, any indemnity agreement or contract, and/or any other payment for a patient as compensation for injuries sustained or illness suffered as a result of the negligence or liability of any individual or entity.
15. **Release of Information** I agree and understand that the Facility may release my healthcare information for payment purposes and any other purpose permitted by law. Further, the Facility may release my information to other providers for my continued care. I also authorize the release of medical information to organ transplantation services should I be identified as a potential organ donor. I agree that any leftover specimens sent to the laboratory may be used for medical education, validation, and authorized research.
16. **Communication** I authorize the Facility and providers, along with any billing service and 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.
17. **Retention of Records** I agree and understand that the Facility will retain my medical records for the required retention period. I acknowledge that the Facility may authorize the disposal of medical records at the end of this retention period.
18. **Notice of Privacy Practices** I acknowledge that I have received a copy of the Facility's "Notice of Privacy Practices." I acknowledge that I can obtain an additional copy of the "Notice of Privacy Practices" on the Facility's website.
19. **Patient Rights and Advance Directives** I acknowledge that I have received information about my right to accept or refuse care. I have the right to make an advance directive, or living will. I am not required to have an advance directive to receive care. If I give the Facility an advance directive, my provider will follow it to the extent permitted by law.
20. **Patient Representative** I acknowledge that I have the right to name a representative who will make decisions on my behalf in the event I am unable to. I may designate a representative in writing or by telling my provider. My representative will be involved in my care plan, unless I expressly withdraw this designation in writing or by telling my provider.
21. **Photography** I consent to the videotaping, photographing, and/or other recording of myself and/or the portion(s) of my body involved in my care for medical education, internal quality control, performance improvement, and/or other related uses. I understand that for the purposes listed above I have the right to request cessation of the recording or filming. I also understand that for those purposes I have the right to rescind consent for the use of the recordings, videotapes and/or photographs up until a reasonable time before the recording or film is used. I understand the recording or film is the property of the Facility.
22. **Warranty and Guarantee** I agree and understand 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 rendered by the Facility or providers.
23. **Governing Law** I agree and understand that all care rendered will be governed by Texas law and in the event of a dispute any action will only be brought in a Texas court in the county / district where all or substantially all the care was provided.

Patient Signature or Legally Authorized Representative	Date and Time	Relationship to Patient
	/ / :	

BSWH USE ONLY

☐ Patient Unable to Sign

Clinical Attestation Confirming Patient's Inability to Sign	Date and Time
	/ / :

(Refer to Facility Informed Consent Policy for Legally Authorized Representative.)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/ Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This Notice of Privacy Practices ("Notice") describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members. An Affiliated Covered Entity ("ACE") is a group of Covered Entities, Health Care Providers and Health Plan under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the BSWH ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the BSWH ACE and as permitted by HIPAA and this Notice. As an ACE, BSWH may add or remove Covered Entities as part of the BSWH ACE. For a complete current list of the members of the BSWH ACE, please visit our website at www.BSWHealth.com/PrivacyMatters.The list will also be made available upon request either at our facilities or by contacting us toll-free at 1-866-218-6920.

This Notice will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you by:
  - Contacting the Health Information Management Department at the hospital or the outpatient clinic directly where you received care; or
  - Calling the Customer Advocacy line for Scott and White Health Plan ("SWHP") at 254-298-3000 or toll-free at 1-800-321-7947, FirstCare at 1-800-884-4901 or RightCare at 1-855-897-4448 or writing to 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy, if you are a member of the health plan.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization:
  - Send written notice to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300,Temple, TX 76508.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request an Amendment:
  - Send written notice to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- We will not ask you the reason for your request.
- You may request a confidential communication by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- You may request this restriction by:
  - Contacting us in writing at the Office of HIPAA Compliance,2401 S. 31st Street, MS-AR-300, Temple, TX 76508.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request a list of those with whom we've shared information:
  - Contact us in writing at the Office of HIPAA Compliance,2401 S. 31st Street, MR-AR-300, Temple, TX 76508.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may also view a copy of this Notice on our websites.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your privacy rights have been violated

- You can complain if you feel we have violated your privacy rights by:
  - Contacting us toll-free at 1-866-218-6920, by visiting www.BSWHealth.com/PrivacyMatters or in writing at the Office of HIPAA Compliance,2401 S. 31st St., MS-AR-300, Temple, TX 76508.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W.,

Washington, D.C. 20201, calling toll-free at 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- For questions or other complaints, you may also contact:
  - The outpatient clinic directly or the Patient Relations Department at the hospital where you received care toll-free at 1-866-218-6919.
- For questions or other complaints relating to Health Plan Coverage:
  - contact the Customer Advocacy line for SWHP at 254-298-3000 or toll-free at 1-800-321-7947, FirstCare at 1-800-884-4901 or RightCare at 1-855-897-4448 .
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again by letting us know you wish to opt-out of any further fundraising communications.
- Information on how to opt-out will be included in any fundraising communications you may receive.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We may use your health information to give you information about treatment alternatives or health related benefits/services that may be of interest to you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- We can use and share your health information as necessary to operate and manage our business activities related to providing and managing your health care insurance.

Example: We might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

Communications regarding treatment alternatives and appointment reminders

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Bill for our services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for our services.

For payment

- We can use and share your health information for payment of premiums due to us, to determine your coverage, and for payment of health care services you receive.

Example: We might tell a doctor if you are eligible for coverage and what percentage of the bill might be covered.

For underwriting purposes

- We may use or share your health information for underwriting purposes; however, we will not use or share your genetic information for such purposes.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as the ways mentioned below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Student immunizations to schools

- We may disclose proof of your child's immunizations to their school based on your verbal or written permission.

Do research

- We can use or share your information for health research.

Food and Drug Administration (FDA)

- We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests

We can use or share health information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Electronic Health Information Exchange (HIE)

- We maintain electronic health information about you from other health care providers or entities that are not part of our healthcare system who have treated you or who are treating you and this information is also stored in the HIE.
- Our healthcare system and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law.
- We monitor who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.
- You may opt-out of the HIE by providing a written request to the Office of HIPAA Compliance, 2401 S. 31st Street, MS-AR-300, Temple, TX 76508. If you opt-out, your information will still be stored in the HIE, but your information will not be viewable through the HIE.
- You may opt back in to the HIE at any time.
- You do not have to participate in the HIE to receive care.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our websites.

_____

Signature

_____

Date

GUIDE TO YOUR CARE AND PATIENT RIGHTS AND RESPONSIBILITIES

Important information about medical and ethical issues

Our goal while you are a patient is to help you experience the best possible outcome. For this to happen, everyone—you, your family and your health care team—must all work together and communicate clearly. This guide is provided to help you understand how you and your family can work with your health care team toward the goal of achieving the best possible outcome, as well as to help you understand your rights and responsibilities. We know that a facility can be a confusing place. You may have many different members of your health care team who visit when your family isn't nearby. Physicians and nurses may use words you don't understand. You may have questions about facility rules or your rights as a patient. You may be very sick and hard choices may need to be made about your treatment. Making those decisions can be difficult and emotions may be strong. We hope the information you find in this guide will ease your mind, make you feel comfortable communicating with your health care team about your treatment or any other issues, and enhance the experience of both you and your family.

The rights and responsibilities recognized at Baylor Scott & White Health ("BSWH") are as follows:

- BSWH is committed to respecting the rights of BSWH patients and their surrogate decision-makers, designated representatives, support persons, and families in accordance with ethical standards, federal and state law, and facility accreditation standards. Along with those rights, patients also have certain responsibilities.
- Patients are informed of their rights and responsibilities. Communication assistance is available to patients, through the services of a translator or interpreter, in order for patients to receive the information in a manner they understand.
- Patients have the right to have a family member, surrogate decision-maker, support person, or designated representative and the patient's physician promptly notified of their admission to a BSWH facility.
- BSWH will collaborate with patients and their surrogate decision-makers to promote patient health and welfare by recommending treatments based on medical science and health care professional judgment.
- We will treat all with dignity, compassion, and respect for personal values, including spiritual beliefs.
- Patients will not be discriminated against for any reason.
- Patients have the right to receive information in a language and form necessary for their understanding and agreement with, or refusal of, the treatment recommended. If patients are unable to receive this information, it is given to their surrogate decision-maker.
- Patients have the right to formulate advance directives such as living wills, and we will respect those directives within the law and facility policy.
- Patients have the right to receive information about our policies on advance directives and the initiation, maintenance or withdrawal of life sustaining treatments. Further, patients have the right to receive information about Cardiopulmonary Resuscitation ("CPR") and our policies on Code Status Orders including Full Code, Do Not Attempt Resuscitation ("DNAR"), and Limited Code ("LC") orders.
- Patients may request, or have their surrogate decision-maker, designated representative, support person, and/or physician request on their behalf, a discharge planning evaluation to be performed and to have that information given to the patient, surrogate decision-maker, designated representative, support person, and physician. When appropriate, a discharge planning evaluation is offered to outpatients.
- Patients have the right to accept or refuse visitors of their choosing except when such visitors might interfere with their medical treatment or the treatment of others.
- Patients have a right to privacy as outlined in law and regulation.
- Patients have a right to a copy of their medical records in accordance with law and facility policy.
- Patients have the right to consent or refuse to consent to participation in research and to the involvement of students and residents in their care.

Limitations on rights:

- Patients do not have a right to testing or treatments that are unavailable in our facilities.
- Patients do not have a right to testing or treatment which, in the treating physicians' judgment, is medically inappropriate for their condition.

Patients have the responsibility to:

- Provide a complete and honest medical history.
- Cooperate with all necessary examination, testing and treatment recommended. If a patient is unwilling to do so, we will consider the patient responsible for the consequences and the patient should seek treatment elsewhere.
- To show respect at all times for our staff, other patients, and visitors.
- To pay for that portion of medical treatment not covered by insurance or to disclose to us any need for financial assistance.
- To speak up and ask questions if the patient or surrogate decision-maker does not understand or feels dissatisfied with the treatment and care we are providing, or if the patient or surrogate decision-maker feels the patient is unsafe while under our care.

A patient's guardian, next of kin, surrogate decision-maker, support person, or designated representative may exercise, to the extent permitted by law, the rights delineated on behalf of the patient and take on the responsibilities of the patient if a patient:

- Has been adjudicated incompetent in accordance with the law;
- Is found by their physician to lack decision-making capacity or to be mentally incapable of understanding the proposed treatment or procedure;
- Is unable to communicate their wishes regarding treatment; or
- Is a minor.

Who is on my health care team?

Throughout this guide we refer often to your health care team. Depending on many factors, your health care team may be made up of any number of individuals. Every team member brings special expertise. These individuals will identify themselves, their professional status, if applicable, their relationship to others on the team, and their role in your treatment and care.

Goals and types of treatment

The most basic goal of medicine is to fix or cure your health problem. If a complete cure is not possible, the goal of the health care team is to try to slow down the problem or make it go away for a while (remission). Perhaps the most important goal is to provide you with comfort and relief of suffering at all times. You will receive medically appropriate treatment to meet these goals and we hope that you will do well.

Communicating with your health care team

Good communication is essential to every part of medical treatment. It is important when things are going well. It may be even more important when things are not going well and the outcome you and your family expected is not being achieved. Either way, it is vital that you, your family and your health care team communicate clearly. You should feel free to discuss any topic associated with your care and treatment with members of your health care team. For example, you may want to discuss:

- Your diagnosis
- Goals of your treatment
- The types of treatment appropriate to meet those goals
- The benefits, burdens, and risks of treatment as well as the probability of success. It is important that you discuss your goals and the types of treatment with your physicians, nurses and your family while you are able to speak for yourself. How do you want to be treated if you have an accident or an illness and become so sick you can't speak for yourself? Who should speak for you and what should they say?
- The importance of advance care planning

The process of thinking about who should speak for you if you can no longer speak for yourself and considering the goals and intensity of your treatment is called advance care planning. When thinking about who should speak for you, consider how trustworthy that person is and how available they are. Think about what you would want them to say on your behalf. This is easy if you are only temporarily unable to speak for yourself and recovery is expected. But what if you become so sick that you can no longer communicate, and cure is no longer possible? If you make these decisions in advance, you will be relieving your family and loved ones from making these decisions for you. You should think about these questions:

- What physical, mental or financial burdens would you be willing to accept to temporarily stay alive longer (or prolong dying) in that circumstance?
- What quality of life would you want to have to make staying on a breathing machine or dialysis worthwhile?
- Would you be willing to live confined to a bed in a nursing home, unable to care for yourself?
- How important is pain control to you—not only physical, but mental and spiritual?
- What if you were permanently unconscious and could not feel pain, hunger, thirst, happiness, love or joy, but could be kept alive with a tube in the stomach to provide artificial nutrition and hydration?

GUIDE TO YOUR CARE AND PATIENT RIGHTS AND RESPONSIBILITIES

These are hard questions and they often have deeply personal answers. Whatever your answers are, the best way to communicate them is by completing an advance directive such as a Living Will and/or a Medical Power of Attorney.

Advance directives have been clearly shown to improve patient care in the setting of serious illness and to lessen family stress. If you do not have an advance directive at the time of admission, we hope you will complete one. It is never too late to do so, and a copy can be placed in your medical record. You are not required to complete an advance directive. Whether or not you choose to complete an advance directive, your care, treatment and services that you receive will not be affected, nor will your decision result in any discrimination against you. To help you face questions you may have about advance directives and to complete an advance directive, you may request the following additional resources from your nurse, social worker, chaplain or physician, or you may access advance directive resources online at BSWHealth.com

If I complete an advance directive, can I change my mind?

Yes, you may cancel, or revoke any advance directive simply by destroying the document, signing and dating a written statement that states your desire to cancel the directive, or telling your doctor or nurse. You may also review and revise your advance directive. If you choose to change an advance directive, you must execute a new one.

If you are admitted within the facility where else can I get help?

If you are admitted within the facility there are specially trained social workers, nurses, and chaplains who can help you with advance care planning concerns. You may also have ethical concerns as you consider potentially serious issues. All Baylor Scott & White facilities have access to ethics committees and ethics consultants who may offer counsel and assist in resolving ethical issues that might arise. These services are provided free of charge. You, your family or health care decision maker, your physician or any member of your health care team may request guidance from a Baylor Scott & White facility ethics committee. For further information, your physician, nurse, social worker or chaplain can help you reach the ethics committee at your facility or you may call one of the phone numbers at the end of this handout. You may also wish to consult your personal or family lawyer if you have questions about advance care planning.

What if there is disagreement about ethical issues?

On rare occasions there may be ethical disagreements between you, your family and/or health care providers. We believe good communication can prevent most ethical disagreements. It is also worth remembering the following:

- We will make every reasonable attempt to honor your treatment preferences within the mission, philosophy and capabilities of the facilities and the accepted standards of medical practice. This includes those expressed by an advance directive or by others on your behalf if you lack an advance directive and are unable to make decisions.
- We respect your right to reject treatments offered.
- We do not recognize an unlimited right to receive treatments that are medically inappropriate.
- Texas law, specifically Chapter 166 of the Texas Health & Safety Code, provides a process for resolving ethical disagreements between you, your family, and/or health care providers in those rare cases where further communication does not resolve the disagreement. This process relies on ethics consultants and ethics committees available at each facility to help as needed.

At some point, you may be asked to make hard choices about treatment when cure of your illness is no longer possible, and emotions may be strong. We have provided this information in hopes of helping you better understand your rights, responsibilities and ethical issues associated with being in the facility. We hope a better understanding will improve communication, treatment and lessen stress for all.

Complaints

We welcome your feedback at all times, both positive and negative. If you have any complaints, we hope you will:

- First report your complaint to the clinical manager for the unit or facility involved. The bedside nurse will help you identify the clinical manager.
- We will investigate your complaint through our formal complaint process, and we will give you a response. Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services and/or the Joint Commission by e-mail, fax, letter or phone at the contact numbers and addresses listed below.

Grievance Process Information

We will investigate your complaint through our formal complaint process, and we will give you a response.

Patient Privacy or Confidentiality Complaints: (866) 245-0815
Billing Concerns: (800) 994-0371
Patient Relations: (866)218-6969

Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services by email, fax, letter or phone at the contact numbers and addresses listed below.

Medicare Beneficiaries

Texas Department of State Health Services
Attn: Customer Service Coordinator
PO Box 149347, MC – 1913
Austin, TX 78714-9347
Email: customer.service@dshs.texas.gov
Phone:1-888-963-7111

The Joint Commission
Office of Quality and Patient Safety
One Renaissance Blvd.
Oakbrook Terrace, IL. 60181
www.jointcommission.org
Phone: 1-800-994-6610
Fax: 630-792-5636

Have a right to take complaints including quality of care, disagreement with a coverage decision, or wishes to appeal a premature discharge to the Quality Improvement Organization ("QIO") for Texas Medicare beneficiaries at the contact number and address listed below.

KEPRO
Rock Run Center
5700 Lombardo Center, Suite 100 Seven Hills, OH 44131
(888) 315-0636
Fax (844) 878-7921
KEPRO.Communications@hcqis.org

HMO Patient's Right to File a Complaint:

You may send a complaint to your HMO if you are not happy with your HMO's operations, procedures, or the health care services you received from your doctors. HMOs must meet required deadlines to resolve your complaint and must give you a written answer. If you are not happy with the HMO's decision, you can appeal the decision to the HMO's appeal panel. The appeal panel members cannot be the same individuals who reviewed or decided your complaint. Call or write to your HMO to find out more about the HMO's complaint and appeal process. You may also contact the Texas department of insurance for more information about your rights and about HMO requirements at the following address and telephone numbers:

Texas Department of Insurance
HMO complaint helpline 1-800-252-3439
In Austin, call 512-463-6515 Servicio en español

_____
Signature

_____
Date