Your Provider is a HealthTexas Physician

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

HealthTexas Provider Network is the 2nd largest subsidiary of Baylor Health Care System. We are a large network of close to 800 providers serving patients in almost 200 care sites throughout North Texas and Fort Worth who are dedicated to providing you with outstanding quality and service when it comes to caring for your medical needs.

Having your healthcare needs overseen by a HealthTexas physician means that your care is coordinated across our network and the Baylor Health Care System.

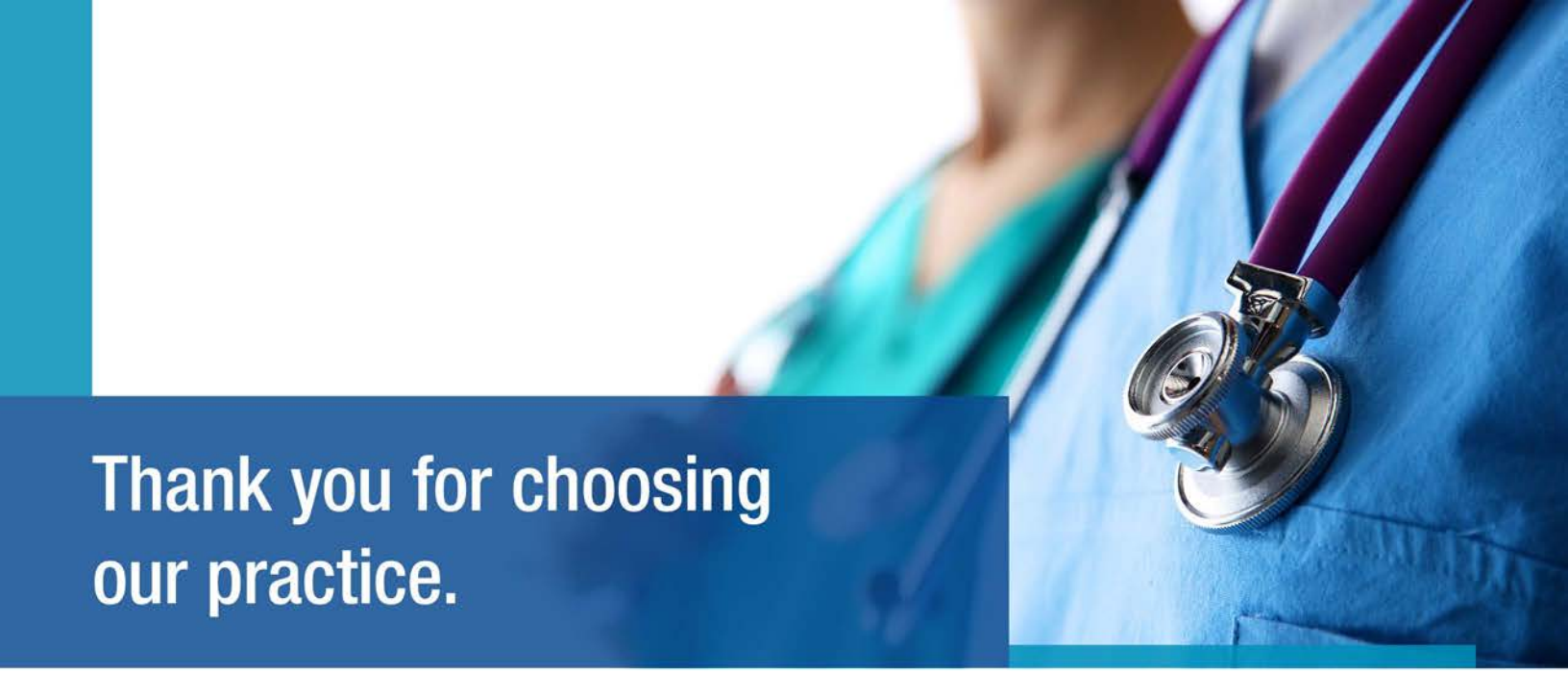
As long as you are seeing a HealthTexas primary or specialty care physician, we will have your completed registration packet and medical record securely stored in our Electronic Health Record system giving any HealthTexas physician access to the information they need to provide you and your family with the best care possible.

Benefits of Belonging to HealthTexas Provider Network:

- **One Time Form Completion**
  The registration forms you are filling out today will only have to be **filled out once.** (Some additional patient information may need to be updated annually)
- **Electronic Health Record (EHR) system**
  The EHR stores your medical records (including any medications, allergies or health issues you may have) and allows physicians easy access to referrals, consultations, and patient education materials.
- **Improved Coordinated Care**
  Our primary care sites are recognized by the National Committee for Quality Assurance (NCQA) as Physician Connections-Patient-Centered Medical Homes (PPC-PCMH) allowing our physicians to coordinate your care seamlessly across our network of specialists, labs, and hospitals in accordance with your specific needs.

We appreciate your trust in us and thank you for choosing a HealthTexas physician to meet and monitor your healthcare needs. You can now find a HealthTexas physician with the touch of a button. Download your HealthTexas physician finder app, free from the App store on your iPhone. You can also check **www.healthtexasdoctors.com**.

Patient-Centered Medical Home
NCQA
RECOGNIZED PRACTICE



Thank you for choosing our practice.

We look forward to providing you with professional health care in a friendly and welcoming environment. In order to best partner with you in your care, we have outlined expectations below which will promote an ideal provider-patient relationship.

We pledge to:

- Treat patients with respect and dignity.
- Learn about the person as well as the condition.
- Partner with our patients in medical decision making.
- Engage, listen and clearly explain issues to our patients so that time spent with us exceeds their expectations.
- Strive to make each patient feel as though he or she is our only patient.
- Make patients feel that we are always on their side because effective care can never be delivered in opposition.
- Aim to return phone calls promptly.
- Strive to be timely and respect our patient's time as much as our own.
- Thank patients for waiting when we are behind schedule.
- Respect patient privacy.
- Earn patient's loyalty through our behavior.

What we need from you:

- Treat others with courtesy, respect and dignity.
- Be patient and understanding.
- Inform our office of any pertinent changes in your contact information, health issues, medications, other healthcare providers, insurance and employment.
- To arrive on time for scheduled appointments.
- Call the office as soon as you are aware you cannot make an appointment or are running late.
- Provide payment for services provided.
- Follow the agreed upon treatment plan and inform your care team of any changes.
- Ask questions if directions and procedures are not understood.

Mission

To deliver the highest value patient experience through quality, safety, accessibility, and cost-effectiveness, enhanced by medical education and research in collaboration with Baylor Scott & White Health.

Vision

To improve the health and well-being of those we serve.

Values

Integrity	Teamwork	Innovation
Servanthood	Excellence	Stewardship

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Patient Demographics & Insurance

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	Mobile Phone ☐ Primary Number ☐ Yes, you can communicate information via SMS text for appointment reminders.	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the physician you are seeing today? ☐ Billboard ☐ Community Event/Health Fair ☐ Digital/Web Advertising ☐ Friend or Family Member ☐ Mailer/Postcard ☐ New Neighbors Program ☐ News Story/Broadcast ☐ Newspaper/Magazine Ad ☐ Physician Referral ☐ Radio Commercial ☐ TV Commercial

Responsible Party

Complete this section only if the patient above is a minor

Responsible Party Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone	Work Phone	Mobile Phone	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	

Consent to Treat & Financial Responsibility

Acct #

BaylorScott&White HEALTHTEXAS PROVIDER NETWORK

Consent to Treat

I hereby authorize employees and agents of HealthTexas Provider Network (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

SIGNED ELECTRONICALLY AT THE PRACTICE.

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

Signature of Patient, Parent, or Legal Guardian **Date**

Race, Ethnicity & Language

Acct #

HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Race

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Some Other Race
- ☐ Unknown
- ☐ Patient Declined

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White or Caucasian:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Ethnicity

Which category best describes your ethnicity?

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

Language

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Chinese
- ☐ Dutch
- ☐ Hindi
- ☐ Other_____

_____ _____

Patient Name (please print) **Date**

Patient Preferences Regarding Communication of PHI. (Patient Health Information)

Acct #

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

- ☐ Home Phone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Mailed Letter
- ☐ Guardian
- ☐ My BSWHealth

If the above method of communication is by phone, please check the appropriate box below **(check one):**

- ☐ Leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that HealthTexas is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like HealthTexas to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

1 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

2 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Patient Name (please print)

SIGNED ELECTRONICALLY AT THE PRACTICE.

Signature of Patient, Parent, or Legal Guardian **Date**

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 Scott & White Health Plan ("SWHP") Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947 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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- 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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

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 BSWH and SWHP member 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, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- 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:
  - SWHP members contact the Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947.
- 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, 2001 Bryan St., Suite 2200, Dallas, TX 75201. 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 BSWH and SWHP member websites.

Effective Date: December 2018