Authorizations, Acknowledgements, and Agreements

INSURANCE REQUIREMENTS: I understand that my contract for services provided is between Baylor St. Lukes Medical Group (Clinic) and myself. The Clinic will process insurance claims as a courtesy for our patients and will accept direct payment from the insurance carrier for the portion of the charges that are covered by my plan. I understand that I am responsible for providing the clinic with my insurance carrier information. I understand that I am responsible for all co-pays, any plan deductibles that have not be met, charges above plan allowable charges when Clinic is non-participating with the plan, and charges not covered by the terms of my policy. I understand I will be responsible for payment in the event Medicaid or my personal insurance determines requirements set forth by my insurance company were not met, some or all services provided were not deemed medically necessary, or services were non-covered under my plan. Such services may include but is not limited to office visits, preventative medicine examination, pre-employment exams, treatment for an accident, laboratory studies, genetic studies, medications, physical therapy, x-rays, procedures, or emergency room care my insurance company does not deem as emergent or that I failed to obtain either pre or post treatment authorization per the terms of my policy. **_____ (initial)**

SELF PAYMENT ACCOUNTS: I understand that if I do not have insurance coverage that I am personally responsible for all charges incurred at the time of my appointment. I understand that the clinic cannot determine the cost of services prior to the visit and that some charges may not be available at the time services are rendered. I agree to pay any balance due. It is my responsibility to contact the Revenue Cycle Representative Billing Vendor at Group One at (844)231.1166 if I am unable to pay my account in full for any charges billed to me. The Clinic will provide information, upon request, regarding available community healthcare resources that may be available to patients who qualify based on financial need. **_____ (initial)**

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Baylor S. Lukes Medical Group- Memorial Hospital - Lufkin , Livingston, San Augustine, LabCorp, Quest Diagnostics, GenPath, and/or other reference labs who performed diagnostic testing to release any medical information or statement of charges associated with the services provided to the following: other healthcare providers who provide services to me, any organization or healthcare provider requiring the medical information for payment of claims associated with the services I receive, any person or entity who has agreed to be Responsible Party for payment of the services I receive or for any purpose needed for healthcare operations. **_____ (initial)**

DIRECT PAYMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND MEDICAID: I request payment of authorized benefits for services furnished by or in Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, and San Augustine to be made on my behalf directly to Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, and San Augustine. **_____ (initial)**

MEDICARE DRUG AND IMMUNIZATION DENIAL: I have been informed outpatient Medicare coverage does not include drugs, biologicals determined by Medicare to be self-administrable or vaccinations. I understand if I am a Medicare recipient, I will be responsible for payment. **_____ (initial)**

MEDICARE, MEDIGAP AND MEDICAID BENEFITS: I request that payment of authorized Medicare, Medigap and/or Medicaid benefits, be made on my behalf to Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, and San Augustine for any services furnished to me by providers employed by Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, and San Augustine to the extent permitted by law. I authorize Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, San Augustine, LabCorp, Quest Diagnostics, GenPath, and/or other reference labs to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. **_____ (initial)**

AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges Baylor St. Luke Medical Group- Memorial Hospital - Lufkin, Livingston, and San Augustine in accordance with its regular rates and terms. However, I am aware that any patient arriving at the facility will have a medical screening examination performed regardless of the ability to pay. **_____ (initial)**

ACKNOWLEDGMENT NOTICE OF PRIVACY PRACTICES: Beginning April 14, 2003, Federal law requires that healthcare providers give you a copy of their Notice of Privacy Practices the first time you present for services and, subsequently, anytime a change is made in the wording of their notice. The notice explains how the healthcare provider maintains the privacy of your health information. **_____ (initial)**

CONSENT TO TREATMENT: I consent to examination and/or treatment provided by Baylor St. Lukes Medical Group- Memorial Hospital – Lufkin, Livingston, and San Augustine under the instructions of a Physician, Advanced Nurse Practitioner, or Physician's Assistant. This may include radiologic examination, laboratory procedures, anesthesia, medical and surgical treatment, or other services provided by the clinic. I understand that additional consents may be required for specific procedures and/or treatments. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination by the providers/clinic. This consent has been fully explained to me, and I understand its conditions. **_____ (initial)**

TELEPHONE CALLS: Women's Health office staff/providers do not return calls while seeing patients. Your call will be returned either at lunch or after seeing patients for the day. If your call is due to a medical emergency, the front office staff can take the call and notify provider to get direct instructions from them. In case of emergency after hours you should go the emergency room or your choice. **_____ (initial)**

In the event that an individual is suspected to be exposed to my blood or body fluid, I consent to be tested to determine whether or not my blood contains contagious viruses, including Hepatitis B, Hepatitis C and Human Immunodeficiency Virus. I understand there will be no charge to me for such laboratory testing done as a result of exposure.

Mid-Level Providers: Baylor St. Lukes Medical Group employs mid-level providers also known as Advanced Nurse Practitioners or Physician Assistants. These providers are licensed by the State of Texas to provide care under the supervision of licensed physicians. Some insurance plans will not reimburse for their services and/or they may pay only for a percentage of the services. It is the patient's responsibility to determine your coverage prior to treatment. Patients who are treated by Mid-Level providers are responsible for the charges regardless of the coverage provided by their insurance carriers. _____ **(initial)**

Prescriptions: All prescriptions are filled electronically. As a result information about **ALL** medications you are taking will be shared by SureScripts and RXHub, (Vendors who transmits prescriptions) with the Clinic and any other healthcare provider or medical institution that is treating you. ***There is not an option to opt out of this process.*** _____ **(initial)**

Patient Portal: The patient portal is a secure web site that allows you as a patient age 18 and older to access your Personal Health Record (PHR). By using the patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Baylor St. Lukes Medical Group for any network infractions beyond our control. _____ **(initial)**

Communications: The clinic adheres to all Federal, State, and Local regulations concerning sharing of personal health information. Regulations allow for sharing of personal health information between healthcare providers/healthcare facilities that treat you. You may authorize others to obtain this information on your behalf. _____ **(initial)**

Please indicate here how you would like for us to communicate with you

Who can we talk to:	*How should we reach them*	*What we can talk about*
□ *Self*	○ *Home #_____* ○ *Cell Phone #_____* ○ *Work #_____* ○ *Voice Mail Message* ○ *US Postal Service Mail* ○ *Text Message or Email*	○ *All Information related to my care* ○ *Appointment Reminders* ○ *Scheduling* ○ *Billing Information* ○ *Test Results* ○ *Follow-up on Care* ○ *Other (List)_____*
□ *Spouse/Significant Other* *Name:_____*	○ *Home #_____* ○ *Cell Phone #_____* ○ *Work #_____* ○ *Voice Mail Message* ○ *US Postal Service Mail* ○ *Text Message or Email*	○ *All Information related to my care* ○ *Appointment Reminders* ○ *Scheduling* ○ *Billing Information* ○ *Test Results* ○ *Follow-up on Care* ○ *Other (List)_____*
□ *Children* *Name:_____* *Name:_____* *Name:_____* *Please list contact info for each child.*	○ *Home #_____* ○ *Cell Phone #_____* ○ *Work #_____* ○ *Voice Mail Message* ○ *US Postal Service Mail* ○ *Text Message or Email*	○ *All Information related to my care* ○ *Appointment Reminders* ○ *Scheduling* ○ *Billing Information* ○ *Test Results* ○ *Follow-up on Care* ○ *Other (List)_____*
□ *Other* *Name:_____* *Name:_____* *Name:_____* *Please include relationship and phone number for each person on the list. Use back of form if needed.*	○ *Home #_____* ○ *Cell Phone #_____* ○ *Work #_____* ○ *Voice Mail Message* ○ *US Postal Service Mail* ○ *Text Message or Email*	○ *All Information related to my care* ○ *Appointment Reminders* ○ *Scheduling* ○ *Billing Information* ○ *Test Results* ○ *Follow-up on Care* *Other (List)_____*
Is there anyone who should not receive information regarding your care:		

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ THE FORGOING, AND IS THE PATIENT OR THE DULY AUTHORIZED Representative OF THE PATIENT, AND AGREES TO THESE TERMS UNLESS SPECIFIED IN WRITING ABOVE. ***THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING***

Patient Signature: _____ Date:_____

Patient Representative Signature: _____

Reason for Representative Signature: ☐ Child ☐ Guardian ☐ Power of Attorney ☐ Other (Specify) _____

Note: Non-custodial parents; guardians or those with Health Care Power of Attorney must have a copy of the supporting documents on file with this office.

Patient Demographic Form

PATIENT INFORMATION

Prefix: ☐ Dr. ☐Miss ☐ Mr. ☐Mrs. ☐Ms. ☐ Sir		Primary Care Physician:	
Last Name:		Date of Birth (mm/dd/yy)	
First Name:	MI:	Gender: ☐ Male ☐ Female ☐ Transgender	
Previous Name(s):		Social Security Number:	- -
Email Address:		Home Phone:	( ) -
Mailing Address:		Cell Phone:	( ) -
City:		Work/Other Phone:	( ) -
State:	Zip Code	Okay to Leave Message at Phone: ☐ Home ☐ Cell ☐ Work/Other	
Marital Status: ☐ Single ☐Married ☐ Partner ☐Divorced ☐Widowed ☐Legally Separated		Student Status: ☐ Full-time ☐ Part-time ☐ Not a Student	
		PATIENT'S EMPLOYMENT INFORMATION:	
Street Address: ☐ Same as Mailing Address (if different, complete below)		Employment Status: ☐ Full-time ☐ Part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Active Military Duty	
Street Address Line 1:		Employer Name:	
Street Address Line 2:		Street Address Line:	
City:		City:	
State:	Zip Code:	State:	Zip Code:
Residence Type: ☐ Skilled Nursing Home ☐ Nursing Home ☐ Residential Home (Assisted Living) ☐ Private Home		Employer Phone:	( ) -

EMERGENCY CONTACT INFORMATION

Last Name:		Home/Cell Phone:	( ) -
First name:		Work Phone:	( ) -
Relationship to Patient:		Date of Birth:	

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

(This section must be completed if patient is under 18 years of age.)

☐Same As Patient ☐Individual ☐Company ☐Legal ☐Work Comp		Relation to Patient:	Date of Birth:
Last Name:		Gender: ☐ Male ☐ Female	
First Name:	MI:	Social Security Number:	- -
Mailing Address Line 1:		Home Phone:	( ) -
Mailing Address Line 2:		Cell Phone:	( ) -
City:		Work/Other Phone:	( ) -
State:	Zip Code	Employer Name:	
Street Address: ☐ Same as Mailing Address (if different, complete below)		Employer Phone:	( ) -
Street Address:		Mailing Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:

Pharmacy Information

Name of Pharmacy:	Address:	City:

PRIMARY INSURANCE INFORMATION

Insurance Company Name:		Street Address ☐ Same as Patient (if different, please complete below)	
Subscriber No.:			
Group No:		Street Address Line 2:	
Policy Holder Name: ☐ Same as Patient (if different, please complete below)		City:	
Last Name:		State:	Zip Code:
First Name:	MI:	Employer:	
Date of Birth: / /	SSN: - -	Patient Relationship to Insured (Policy Holder):	
Telephone: ( ) -	Gender: ☐ Male ☐ Female	☐Self ☐Spouse ☐Parent ☐Grandparent ☐Other_____	

SECONDARY INSURANCE INFORMATION

Insurance Company Name:		Street Address: : ☐ Same as Patient (if different, please complete below)	
Subscriber No.:		Street Address Line 1:	
Group No.:		Street Address Line 2:	
Policy Holder Name: ☐ Same as Patient (if different, please complete below)		City:	
Last Name:		State:	Zip Code:
First Name:	MI:	Employer:	
Date of Birth:	SSN: - -	Patient Relationship to Insured (Policy Holder):	
Telephone: ( ) -	Gender: ☐ Male ☐ Female	☐Self ☐Spouse ☐Parent ☐Grandparent ☐Other_____	

How did you hear about us:

☐ Physician Referral Dr. _____

☐ Existing Patient Name: _____ (If you wish to share)

☐ Radio / Television / Billboard (please circle)

☐ Newspaper / Magazine Name: _____

☐ Website / Social Media Type: _____

☐ Family / Friends / Employee (please circle)

☐ Other: _____

Patient Portal Consent Form

The patient portal is a secure web portal that allows you as a patient age 18 and older to access your Personal Health Record (PHR) including medications, lab results, and medical history via the Internet.

Please read the following policy carefully:
• We offer the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the patient portal at any time and for any reason.

•. You must call our office if you have an urgent matter to discuss. Please do NOT use the portal for emergencies.

• If you are not receiving emails from us, please check your SPAM email folder before contacting us.

• By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Baylor St. Lukes Medical Group (Clinic) responsible for any network infractions beyond our control.

Choose a user name on the form below for log in purposes. A temporary password will be given that you will be allowed to change at log in.

Email Address: _____

Desired Username: _____

Print Name: _____ Date: _____

Signature: _____

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **BIRTHDATE**:_____

ADDRESS: _____ **TELEPHONE NO:** (____)_____

_____

_____

1. I hereby authorize CHI St. Luke's Health to:

☐ Disclose/release the specified health information: Receive the specified health information:

TO:_____ FROM:_____

_____ _____

_____ _____

_____ _____

_____ _____

Telephone No: (___)_____ Telephone No: (__)_____

Fax No: (___)_____ Fax No: (__)_____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

☐ Complete medical record Dates of service_____
[OR the records marked below]

- ☐ Emergency Department Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Report of Procedure
- ☐ Pathology Report
- ☐ Heart Diagram
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physicians' Orders
- ☐ Nursing Notes
- ☐ OTHER
- ☐ (specify)_____

☐ Diagnostic films/Digital Images (specify) _____

☐ Billing Records (specify)_____

3. For the purpose of: _____

4. If you are requesting copies of your own medical record, indicate here if you would prefer to receive via:

- ☐ Encrypted CD/DVD or
- ☐ e-Delivery via a secure portal. Please provide email address for this option.

_____

5. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse; mental or behavioral health or psychiatric care, excluding psychotherapy notes.

6. I understand that CHI St. Luke's Health may charge a fee for the costs associated with processing this request.

7. CHI St. Luke's Health may deny this request to inspect and copy health information in certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional chosen by CHI St. Luke's Health will review your request and the denial. The person conducting the review will not be the person who denied the request. CHI St. Luke's Health will comply with the outcome of the review.

8. This authorization is given freely with the understanding that:
   a) I may revoke this authorization at any time, except where information has already been released.
   b) The revocation must be in writing and a form is available from the medical record department.
   c) This authorization will expire 180 days from date of signature unless otherwise specified; expires _____.
   d) CHI St. Luke's Health may not condition treatment or payment upon obtaining this authorization.
   e) A photocopy or fax of this authorization is as valid as the original.
   f) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ Signature of Patient

_____ Date

_____ Signature of Patient's Representative

_____ Representative's Printed Name

_____ Relationship to Patient

_____ Date

CHI St. Luke's Health
STAFF

☐ **Verified identity of person picking up records.**

Date verified: **Name and Department:**

To Be Complete By Areas Other Than Health Information

Management Date authorization received: ____

Date information released: _____
Name and title of CHI St. Luke's Health staff member processing request:

_____. After processing request, please forward Authorization form to the Health Information Management Department.