Baylor St. Luke's Medical Group
Baylor College of Medicine

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:

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Patient Name ______________________________________ DOB:___________________________

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: ______________________________________

Baylor St. Luke's Medical Group

Baylor College of Medicine

Patient Name ______________________________________ DOB:___________________________

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 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- 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-to be made on my behalf directly to Baylor St. Lukes Medical Group· _______ **(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- for any services furnished to me by providers employed by Baylor St. Lukes Medical Group- to the extent permitted by law. I authorize Baylor St. Lukes Medical Group- 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-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- 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: 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 of 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.

Baylor St. Luke's Medical Group™ Baylor College of Medicine

Patient Name ______________________________________ DOB:___________________________

Advanced Practice Providers (APPs): Baylor St. Lukes Medical Group employs APPs 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 APPs 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 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 Name ______________________________________ DOB:___________________________

Patient Portal Consent Form

The patient portal is a secure web portal that allows you as a patient 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: ____

Baylor St. Luke's Medical Group

Baylor College of Medicine

Patient Name ______________________________ DOB: ______________________

Patient Authorization for Greater Houston Healthconnect

__________________[NAME OF PARTICIPANT] participates in Healthconnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect.

By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect **for the limited purposes of treatment, payment and health care operations**. You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

Your health information that may be shared through Healthconnect includes:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of lab tests, x-rays and other test
- Medication (current and in the past)
- Personal information such as name, address, telephone number, gender, ethnicity and age
- Names of providers and dates of services
- Alcohol, drug abuse, mental and behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect. Your revocation will be effective within three (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

Patient Name: ____

Signature of Authorized Person: ______________________________ Date: ______________

Name (if different from Patient): ____________________ Relationship to Patient: ______________

Initial here if you do NOT want your providers to see your records through Healthconnect. ______

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Baylor St. Luke's Medical Group

Baylor College of Medicine

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:________________________________ **BIRTHDATE:**______________

ADDRESS: ________________________________ **TELEPHONE NO:** (____)____________

____

____

1. I hereby authorize **Baylor St. Luke's Medical Group to:**

☐ Disclose/release the specified health information:

TO:________________________________

____

____

____

____

Telephone No: (___)______________

Fax No: (___)__________________

☐ Receive the specified health information:

FROM:________________________________

____

____

____

____

Telephone 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.

Signature: ________________________________ Date: ______________

Baylor St. Luke's Medical Group™ | Baylor College of Medicine

Patient Name ____________________________________ DOB:_________________________

PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name of Minor: ____________________________________ Date of birth: _____________

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

1. Parent's name: ____
   Phone (office/home): ____
2. Parent's name: ____
   Phone (office/home): ____
3. Other (relationship): ____
   Phone (office/home): ____

Signature: ____

Date: ____

Print name and relationship: _____________________________________

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.

Signature: ______________________________________ Date: __________________

Printed name: ___________________________________ Phone: _______________

Baylor St. Luke's Medical Group

Patient History Form

Patient Name: ___________________________________ **DOB:** __________________________

Medications

Please list all medications you are currently taking, prescription and nonprescription, and their dosage:

Medication Name	Dose	Frequency

Allergies:

Are you allergic to any medications? YES or NO
If yes please list the name of the medication and the type of reaction:

____
____
____
____
____

Are you allergic to any foods? YES or NO
If yes please list:

____
____

***Please provide a medication list of ALL prescription and nonprescription (herbal supplements, vitamins, etc).**

Past Medical History

Please indicate if you have experienced any of the following conditions:

- ☐ Alcohol Dependence
- ☐ Allergies (pollen, food)
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clots
- ☐ Broken Bones
- ☐ Cancer type: ________________
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Esophageal Reflux
- ☐ Gallbladder Stones
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Fatty Liver Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures/Epilepsy
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke (CVA)
- ☐ Other Chronic Diseases:

  ____
  ____
  ____

Patient Registration Form
Baylor St. Luke's Medical Group

Surgical History

Patient Name ______________________________ DOB:______________________

Please check all that apply and that date of the procedure:

	Date
☐ Appendectomy	___/___/___
☐ Back surgery	___/___/___
☐ Carpal Tunnel Release	___/___/___
☐ Cataract extraction	___/___/___
☐ Colon surgery	___/___/___
☐ Coronary Artery Bypass Graft	___/___/___
☐ **Coronary Stent**	___/___/___
☐ **Gallbladder Removal**	___/___/___
☐ **Gastric Bypass or sleeve**	___/___/___

	Date
☐ **Heart Catheterization**	___/___/___
☐ Hernia repair	___/___/___
☐ Hip replacement	___/___/___
☐ Knee replacement	___/___/___
☐ Liver Biopsy	___/___/___
☐ **Pacemaker/Defibrillator**	___/___/___
☐ Thyroidectomy	___/___/___
☐ Tonsillectomy	___/___/___
☐ Other: ________________	___/___/___

Female Surgical History

Please check all that apply:

	Date
☐ Bilateral Tubal Ligation	___/___/___
☐ **Breast Augmentation**	___/___/___
☐ Breast Biopsy	___/___/___
☐ **Breast Reduction**	___/___/___
☐ Cesarean Section	___/___/___
☐ D and C (dilation and curettage)	___/___/___
☐ Mastectomy	___/___/___
☐ TAH/BSO Total Abdominal Hysterectomy)	___/___/___
☐ Vaginal Hysterectomy	___/___/___
☐ Other: ________________	___/___/___

Male Surgical History

Please check all that apply:

	Date
☐ Prostate biopsy	___/___/___
☐ TURP (Trans-Urethral Resection of the Prostate)	___/___/___
☐ Vasectomy	___/___/___
☐ Other: ________________	___/___/___

Family History

Please check of any family member has had any of the following conditions and indicate the name of the affected member, the age of the onset and/or if it was the cause of death.

☐ Adopted

	Mother	Father	Sibling(s)	Children
☐ Alcoholism				
☐ Alzheimer's				
☐ Heart Disease				
☐ Cancer ☐ Type:__________				
☐ Depression				
☐ Diabetes				
☐ High Cholesterol				
☐ Hypertension				
☐ Kidney Disease				
☐ Osteoporosis				
☐ Stroke				
☐ Seizures				

***Please provide any additional family history that is not listed above.**

Patient Registration Form

Baylor St. Luke's Medical Group

Social History

Patient Name ______________________________ DOB:______________________

Do you currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day? ____________

What year did you start smoking? ________

Have you previously smoked? ☐ Yes ☐ No If yes, how many packs per day? ____________

What year did you start smoking? ________ What year did you stop smoking? __________

Other tobacco units per day (cans, cigars, etc.)? ☐ Yes ☐ No

Units per day? _______ Years used? ________ Year quit? ________

Do you drink caffeine? ☐ Yes ☐ No Type?__________________ Amount Daily? _________

Do you drink alcohol? ☐ Yes ☐ No ☐ daily ☐ weekly ☐ monthly Amount: ______________

What do you typically drink? ____

Do you use any recreational drugs/Marijuana? ☐ Yes ☐ No ☐ daily ☐ weekly ☐ monthly Amount: _____

==

Are you sexually active? ☐ Yes ☐ No Preference? ☐ Male ☐ Female ☐ Both

Contraception? __________________

If relevant: Any past pregnancies? ☐ Yes ☐ No How many? _____ How many deliveries? _______

Last menstrual cycle? ___/___/___ Age of menstrual onset? ______

Martial Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Occupation: _______________________ ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Preferred Pharmacy Information

Local Pharmacy: ____

Address & Phone Number: ____

Mail in Pharmacy: ____

Address & Phone Number: ____

Immunizations

Do you have copies of your immunization records? ☐ Yes ☐ No

Health Maintenance (if applicable)

Last Wellness Exam: ___/___/___	Flu Vaccine: ___/___/___
Last Mammogram: ___/___/___ Results:__________	Pneumonia Vaccine:
-Which facility? ____________________	-Prevnar-13: ___/___/___
Last Pap Smear: ___/___/___ Results: __________	-Pneumovax-23: ___/___/___
Colonoscopy: ___/___/___ Results: ___________	Tetanus Vaccine: ___/___/___
-Specialist/Where? ________________	Shingles Vaccine: ___/___/___
Last Bone Scan: ___/___/___ Results:__________	

ALL ACTIVE SPECIALISTS WHO PARTICIPATE IN YOUR CARE

Doctor: __________________	Specialty: _______________
Doctor: __________________	Specialty: _______________
Doctor: __________________	Specialty: _______________
Doctor: __________________	Specialty: _______________
Doctor: __________________	Specialty: _______________

ADDITIONAL INFORMATION

____

____

____

____

____

Baylor St. Luke's Medical Group

Baylor College of Medicine

Informed Consent to Telemedicine Consultation
Baylor St. Luke's Medical Group

Patient Name: ___________________________________ **Date:** ___________________________

To the Patient: ***You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to this telemedicine consultation.***

I voluntarily request Doctor, Physician Assistant, or Nurse Practitioner______________________ to provide a telemedicine consultation.
Their area of specialty is _____________________________________

I have been asked by my healthcare provider to take part in a telemedicine consultation with Baylor St. Luke's Medical Group and it physicians, associates, technical assistants, affiliated hospitals and other deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult is done through a two-way video and/or audio link-up whereby the physician or other healthcare provider can see my image on the screen and/or hear my voice. However, unlike a traditional medical consult, the physician or other healthcare provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face to face visit.
3. Since the telemedicine consultant's practice in a different location and does not have the opportunity to meet with me face to face, they must rely on information provided by me or my onsite healthcare providers. The telemedicine consultant cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this technology. These include but are not limited to:
   - Interruption of the audio/video link.
   - Disconnection of the audio/video link.
   - A picture that is not clear enough to meet the needs of the consultation.
   - Electronic tampering.

   If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, educational, quality or technical purposes

Informed Consent to Telemedicine Consultation
Baylor St. Luke's Medical Group

Patient Name: ___________________________________ **Date:** __________________________

8. I will not receive any royalties or other compensation for taking part in this telemedicine consult.
9. I understand I can make a complaint regarding my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or call the Complaint Hotline at 800-201-9353.
10. I understand that visits done via Zoom or Healow carry potentially lower levels of encryption which are temporarily allowed by the Centers for Medicare and Medicaid Services (CMS) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, the undersigned patient, do hereby understand and state that I agree to the above consent.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree. I volunteer to participate in the telemedicine examination. I authorize Baylor St. Luke's Medical group and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _________Time:_______ Date:________Time:__________

Signature: ____________________________ Witness: ______________________
Patient

Interpreter (if applicable) ____________________________