BAPTIST HEALTH SYSTEM

HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

## HealthLink Consent for Treatment and Medical History

Patient Name:_____ Social Security #:_____

Date of Birth (DOB):_____ Age:_____ Date of surgery/Injury:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone:_____ Secondary Phone:_____

E-mail:_____

Primary Person on Insurance (If not patient):_____ DOB:_____

Referring Physician:_____ Primary Care Physician:_____

Emergency Contact:_____

Emergency Contact Phone:_____ Relationship:_____

Is your injury/condition due to a car accident? ☐Yes ☐No Receiving Home Health? ☐Yes ☐No

Appointment Reminder Option (Check One): _____Call _____Text message

Consent to Medical and Related Health Care: I consent to the admission to Healthlink, an outpatient facility of Baptist Health System, referred to as "Facility", and consent to treatment and procedures that my doctor thinks are needed. I also understand that the delivery of health care services and treatment may involve risks of injury or even death. No guarantees are made to me regarding the result of examination or treatment at Healthlink.

Payment Agreement/Assignment of Benefits: I agree (on behalf of the patient, and, if I am the parent of a minor child, also on my own behalf) to pay all charges and expenses for services at the rates set by the Facility, unless a different rate is set by the Facility's contract with my managed care or insurance company. I understand that failure to pay these charges within 45 days after billing may result in referral to an agency or attorney for collection, in which case I agree to pay reasonable attorneys' fees and collection expenses in addition to the balance of the account. I agree that if the account results in a credit balance, this credit balance will be applied to any other debt I owe to the hospital and the balance refunded to me.

I assign to the Facility all (i) rights in benefits or compensation otherwise payable to me by any insurance company (this includes, but is not limited to, health or medical insurance coverage, auto or homeowners' insurance including uninsured motorist coverage and personal injury protection) and any other payor, and (ii) rights, claims and causes of action against anyone who may be financially responsible for the injury or illness which caused or contributed to my hospitalization, including funds from any settlement. I understand that it is not the Facility's responsibility to file claims or file suit on my behalf. It is my responsibility, within the applicable time limits, to seek all insurance reimbursement, obtain all proper pre-authorizations, file any lawsuits against any financially responsible parties, and appeal any denials. I understand that my failure to take these actions may result in a denial of reimbursement or money otherwise due me, in which case I would still be responsible for the full amount of the Facility bills.

Baptist Health System

HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

## HealthLink Consent for Treatment and Medical History

Medicare/Medicaid Payment: If I have coverage through Medicare or Medicaid, I certify that the information given by me in assigning payment under Medicare or Medicaid is correct. I request that payment of authorized Medicare or Medicaid benefits be paid directly to this Facility on my behalf. I authorize this Facility to release any information about me that is necessary to act on this request for payment.

Attendance Policy: We respectfully request 24 hours advance notice of appointment cancellations. Consistent care is important for progress. If you have three (3) cancellations or two (2) no-shows, you will be discharged as a patient. Please speak to your therapist if extenuating circumstances arise.

Teaching: Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital or the Facility under appropriate supervision. Unless I notify the Facility that I do not want to participate in these educational programs, I agree that trainees may participate in and/or provide care to me while I am a patient at the Facility.

Personal Property: As a patient, I am encouraged to leave personal items at home. I have been informed by the Facility that the clinic maintains a place for personal effects. I understand that the Facility accepts no responsibility for loss of any personal effects that I or others bring to the clinic for me. I release this Facility and its agents for damage to or loss of my property.

Notice of Electronic Check Conversion: If I provide a check as payment, I authorize this Facility to use information from my check to make a one-time electronic funds transfer (EFT) from my account or to process the payment as a check transaction. If this Facility uses information from a check to make an EFT, the funds may be withdrawn from my checking account the same day.

Advanced Directives:

Patient has an advanced directive or living will: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has Medical Durable Power of Attorney: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has designated a Health Care Surrogate: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Name of designated Health Care Surrogate: _____

Phone Number: _____ Relationship to patient: _____

I would like to receive further information about Living Wills and other advanced directives: ☐No ☐Yes

Patient Rights and Responsibilities: I received Patient Rights and Responsibilities information explaining my rights and my responsibilities as a patient in this Facility, including how to file a complaint and grievance.

Consent to Contact:

I consent and authorize this Facility, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, debt collectors, and other contracted staff (any or all of these is referred to as "Provider") to use automated telephone dialing systems, text messaging systems and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to the health care law, health care coverage, care follow-up, and other healthcare information or (2) provide telemarketing messages (including pre-recorded messages) during a call or via text message that delivers a "health care" message made by, or on behalf of, a "covered entity" or its "business associate," as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103.

Telephone messages may be played by a machine automatically when the telephone is answered, whether answered by me or someone else. These messages may also be recorded by my answering machine. I give the Provider permission to call or send a text message to any telephone number. I give the Provider permission to play pre-recorded messages or send text messages with information about my transactions over the phone, and understand that such information may not be encrypted or secure.

Baptist Health System

HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

## HealthLink Consent for Treatment and Medical History

I promise that, unless I indicate otherwise, I own or customarily use the telephone numbers I give the Provider. I also promise to notify the Provider in writing within 30 days if I change phone number(s). I understand that Provider will continue to use the number I provide unless I provide notice of a change, and, therefore, failure to notify Provider may result in missed or delayed communications. I also give the Provider permission to communicate such information to me via electronic mail, and understand that such information may not be encrypted or secure.

I agree that the Provider will not be liable to me for any calls or electronic communications, even if information is communicated to an unintended recipient (including, for example, contacts to a previous number that I have not notified the Provider is no longer used by me).

I understand that, when I receive such calls or electronic communications, I may incur a charge from the company that provides me with telecommunications, wireless and/or Internet services. I agree that the Provider has no liability for such charges. I understand that consent to receive calls/messages is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and may request a copy of this form. I am the patient, the patient's legal representative, or am authorized by the patient as the patient's general agent to act on his or her behalf to accept the terms of this form. I understand and accept the terms of this Consent for Treatment form. If I have any questions, I have had an opportunity to ask questions about anything I don't understand.

| Printed Name of Patient | Signature of Patient/Patient's Agent or Representative | Date | Time |
|---|---|---|---|
| Patient's DOB | Clinic Representative/Employee# | Date | Time |

Translator: I have accurately and completely read the document to the patient or patient's representative in the language requested by the patient or patient's representative.

Translator _____ Date / Time _____

Witness _____ Date / Time _____

Baptist Health System
HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

## NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____
Name of Patient Signature of Patient

_____ / _____ / _____
Date Signed

_____ _____
Name Patient's Personal Representative Signature of Patient's Personal Representative

_____ / _____ / _____
Date Signed

**FOR INTERNAL USE ONLY**

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

____ - ____ (Version: As noted on NPP) ____/____/____ (Date: As noted on NPP)

Baptist Health System
HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

## *PHI DISCLOSURE TO FAMILY MEMBERS*

You may authorize us to contact a family member regarding your medical care or financial matters. This is to achknowledge that you authorize HEALTHLINK to disclose your PHI to the following individuals (check all that apply):

Name:_____ Relationship to Patient:_____

Telephone:()_____ Email:_____

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

Name:_____ Relationship to Patient:_____

Telephone:()_____ Email:_____

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

| Print Name of Patient | Signature of Patient/Patient's Agent or Representative | Date | Time |
|---|---|---|---|
| Patient's DOB | Clinic Representative/Employee # | Date | Time |

BAPTIST HEALTH SYSTEM

# AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I hereby authorize HEALTHLINK CARDIAC REHAB to release the information specified
PHYSICIAN / HEALTH FACILITY

below relative to the following period of service: THROUGHOUT DURATION OF CARDIAC REHAB PROGRAM.
MONTH / YEAR OF TREATMENT

Name of Patient: _____

Address: _____
STREET / CITY / STATE / ZIP

Date of Birth: _____ SS#: _____ Phone: _____

Release To: _____ for the purpose
FACILITY / INDIVIDUAL TO RECEIVE INFORMATION

of CARDIAC CARE.

**THE FOLLOWING INFORMATION IS TO BE RELEASED:**

- ☐ Admission Face Sheet
- ☑ Billing Records/Financial Information
- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History and Physical Exam
- ☐ Lab Results
- ☑ Medication Record
- ☐ Nurse's Notes
- ☐ Operative Report
- ☑ Outpatient Record
- ☐ Physician Orders
- ☐ Respiratory Treatment Notes
- ☐ Progress Notes
- ☐ PT/RT/OT Record
- ☐ X-Ray Reports
- ☑ Other, please specify: any and all cardiac rehab records

I understand that upon release of the selected information above, this information may be subject to redisclosure by the recipient and Baptist Health System is not liable for redisclosure. The records to be furnished or reviewed include information concerning my case history and the treatment, examinations, or hospitalization, including but not limited to, any and all information related to testing, diagnosis and treatment for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I, the undersigned, understand this information may include reference to psychiatric treatment or testing, evaluation, or treatment for substance abuse. The hospital, employees, and physician are released from liability for release of these records.

**IMPORTANT — If patient deceased, please check one box below:**

- ☐ I am the Administrator/Executor for the deceased and have attached the Letters / Testamentary.
- ☐ There is no court appointed Administrator/ Executor and I am the next of kin.

_____
SPECIFY RELATIONSHIP TO THE DECEASED

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PATIENTS LEGALLY ASSIGNED REPRESENTATIVE (WHEN APPLICABLE) DATE

_____
RELATIONSHIP TO PATIENT (WHEN APPLICABLE)

This information has been released to you from records where confidentiality is protected by Federal Law. Federal Regulations (42 Code of Federal Regulations, Part 2) prohibits you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A photocopy shall have the same effect as an original.

This authorization is subject to revocation at any time except to the extent that action has been taken. All requests for revocation must be in writing to the Health Information Management Department. This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.

**Internal Use Only:** ☐ Records Reviewed ☐ Copies Provided

**Name:**

**Date of Birth:**

■ Evaluation
☐ 18th Session
☐ Discharge

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "O" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score:_____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ⓢ | ⓢ | ⓢ | ⓢ |

Patient Signature: _____ Date:_____ Time: _____

Clinical Staff Signature: _____ Date: _____ Time: _____