Baptist Health System

HEALTHLINK

HealthLink Consent for Treatment and Medical History

PATIENT NAME:_____

DATE OF BIRTH:_____

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.

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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.

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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

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NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

PATIENT NAME:_____

DATE OF BIRTH:_____

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)

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

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PATIENT NAME:_____

DATE OF BIRTH:_____

OUTPATIENT PHYSICAL REHABILITATION PATIENT MEDICAL HISTORY AND FUNCTIONAL SURVEY

NEW PATIENT VESTIBULAR QUESTIONNAIRE

1. When was the onset date of your dizzy symptoms?_____
2. List any prior head/neck/brain surgeries/procedures:

   _____
3. Do you have Falls?_____ Near falls/close calls? _____
4. What daily activities are you having a hard time doing because of dizziness:

   _____
5. What are your goals for treatment? _____
6. Are any of the following a part of your medical history?

   ☐ Migraine headaches ☐ Frequent Neck Pain/headaches

   ☐ Diabetes ☐ Neurologic problems/Head trauma

   ☐ Visual impairments ☐ Hard of hearing ☐ Left ☐ Right ☐ Both Ears

   ☐ High or Low Blood Pressure ☐ Ringing in your Ears

   ☐ Heart Attack ☐ Neuropathy

   ☐ Balance Problems ☐ Arthritis

   ☐ Sleep Apnea ☐ Seasonal or environmental allergies
7. How many 8 ounce servings of water do you drink in a day?_____
8. How many 8 ounce servings of caffeine do you drink a day (including coffee, tea, soft drinks)?

   _____ COFFEE _____TEA _____ SOFT DRINKS (LIST ALL # SERVINGS THAT APPLY)
9. Do you drink alcohol? ☐ Yes ☐ No _____drinks/day
10. Do you eat regular meals or do you skip meals?

    ☐ Regular Meals Skips: ☐ BF ☐ Lunch ☐ Dinner
11. How many TOTAL hours of sleep do you get a night? _____
12. Do you add salt at table or eat out at restaurants often? ☐ Yes ☐ No
13. Is the stress level in your life: ☐ High ☐ Average ☐ Low

_____ _____ _____
Patient Signature Date Time

_____ _____ _____ _____
Therapist Signature Emp# Date Time

Baptist Health System HEALTHLINK

PATIENT NAME:_____

DATE OF BIRTH:_____

OUTPATIENT HOME MEDICATION LIST

Height (in)_____ Weight (lbs)_____ kg_____ Diabetes ☐Y ☐N Dialysis ☐Y ☐N	Allergies / Intolerance(s)	Reaction(s)
FEMALES ONLY Pregnant ☐Y ☐N Breastfeeding ☐Y ☐N		

Source: ☐As stated by patient / family ☐Outpatient pharmacy ☐Physician office list ☐H & P ☐Nursing home / Home health

Disposition of Medications: ☐Sent home with patient/family (name)_____

DIRECTIONS: List all prescription and non-prescription medications used prior to this visit, including: aspirin, insulin, eye drops, inhalers, nutritional and herbal supplements and all pumps or patches. If more than one form is required to document all medications, indicate the number of forms in the space listed on line 15.

DO NOT USE ABBREVIATIONS:

iu	qd	MS	u
MgSO4	qod	MS04	

With a zero always lead and never follow a decimal point.
For example use (Xmg) not (X.0mg), (0.Xmg) not (Xmg).

	Drug Name	Dose (strength)	Route	Frequency	Indication	Initials	DC Date	New Date
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.	_____ Number of forms required to document all medications. This is page _____.							

Not taking any home medication(s)

Form reviewed by: (Signature/Title)	Emp #:	Date:	Time:

Initials	Signature/Title	Emp #	Date	Time