Baylor Scott & White Surgicare Cityview

Financial Agreement/Assignment of Benefits:

FINANCIAL POLICY AND AGREEMENTS: Prior to your visit we will contact your insurance company to verify your benefits. Depending on your coverage, you may be responsible for un-met deductibles, co-insurance, co-pays or other out of pocket expenses that are not covered by insurance. An estimate of anticipated charges for services will be available as soon possible. Estimates may vary significally from the final charges based on a variety of factors, including but limited to the course of treatment, intensity of care, physician practices and the necessity of providing additional goods and services. You may receive separate bills from your Physician as well as other providers of Anesthesiology, Pathology and/or Laboratory. Full payment is expected at time of service. All returned checks will be subject to a Non-Sufficient Fund fee of $28.00. I authorize payment of Medicare benefits and/or any other insurance carrier(s) be made on my behalf to BSW Surgicare Cityview for the Ambulatory Surgery Center's fees.

CONSENT TO TELEPHONE CALLS FOR CARE RELATED MATTERS AND FINANCIAL COMMUNICATIONS:
With regards to the services and items rendered and/or my related financial obligations, I expressly agree and consent that the Surgery Center and any associated affiliate/vendor providing quality improvement, customer service, billing or collection services may contact me by any method of contact such as telephone or automated dialing service, texting to any number(S) I have provided or have been obtained by the Surgery Center or any of its associated affiliates/vendors. I understand I may also receive an email survey.

HIPAA PRIVACY NOTICE / RIGHTS AND RESPONSIBILITIES/ADVANCE DIRECTIVES / DISCLOSURE OF OWNERSHIP:
I have been offered/received a copy of the Facility's HIPAA Privacy Notice and the Patient Rights and Responsibilities, Advance Directives and Disclosure of Ownership. I have had the opportunity to review its contents and ask any necessary questions. ( ) I do not have an Advance Directive ( ) I have an Advance Directive _____ **Please Initial)**
(will need copy on file)

STATE REQUIRED ETHNICITY AND RACE:
Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital/facility patients. Facilities are required to ask patients to identify their own race and ethnic backgrounds. This information is used to determine whether or not all citizens of Texas are receiving access to adequate healthcare.

Mark the box that most accurately identifies the patient's ETHNIC background:
Question #1: ( ) HISPANIC ( ) NON-HISPANIC ( ) REFUSE TO ANSWER

Mark the box that most accurately identifies the patient's His/Her RACE:
Question #2: ( ) AMERICAN INDIAN/ESKIMO/ALEUT ( ) ASIAN OR PACIFIC ISLANDER
( ) AFRICAN AMERICAN ( ) CAUCASIAN ( ) OTHER: Includes all other responses not listed. Patients who consider themselves as multiracial or mixed should choose this category. ( ) REFUSE TO ANSWER

I have received verbal and written notice of the content within this document in a language and manner I understand. I have read and have full understanding of the Assignment of Benefits as well as the financial policy of BSW Surgicare Cityview.

( ) **Patient is a Minor or has POA**

_____ _____ _____
PATIENT SIGNATURE DATE SSN#

_____ _____ _____
(or Parent/Legally Designated Representative) DATE Please indicate relationship to Patient

Baylor Scott & White Surgicare Cityview
Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other #_____

Email Communication Preferences:

Email Address: _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that BSW Surgicare Cityview, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message using an automated dialing service or leave a voice message on an answering device. If an email address has been provided, BSW Surgicare Cityview, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? [ ] YES [ ] NO

(**If no, please provide an alternate mailing address below**.) _____

TEXTING:

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact, you by text message please sign this consent below. If you consent to receiving text messages, you also agree to promptly update BSW Surgicare Cityview when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message. Date

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Relationship to Patient **Date**