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UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER

New Patient Information

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ Suffix- Jr, Sr, etc. _____ Mr, Mrs, Ms, Dr _____ M / F Sex

Date of Birth _____ Social Security Number _____ Alias- Nickname (Last, First, Middle) _____

Permanent Address _____ City _____ Zip _____ State _____ County _____ Country _____

Contact Phone #'s (**CIRCLE** the Primary #) : Home# _____ Work# _____ Cell # _____

Marital Status : _____

If Temporary Address : *Must have* **:** Begin date _____ End Date _____

Address _____ City _____ Zip _____ State _____ County _____ Country _____

REFERRING PHYSICIAN AND PRIMARY CARE PROVIDER (PCP) INFORMATION

What provider referred you to our clinic today? _____
Name *Address* *Phone#*

Name of **PCP** (Last , First) _____ Address _____ Office Phone # _____

EMPLOYMENT INFORMATION

Name of Employer _____ Employer Phone Number _____ Employer Address (Street, City, Zip Code) _____

Occupation **:** _____ Employment Status**:** _____

EMERGENCY CONTACT INFORMATION

1. _____ _____ _____
Name (Last, First, Middle) Relationship to Patient Telephone (hm, work, cell)

2. _____ _____ _____
Name (Last, First, Middle) Relationship to Patient Telephone (hm, work, cell)

GUARANTOR (If not self, complete this info)

Relationship to Patient _____ Last Name _____ First Name _____ Middle Name _____ **M / F** Sex

Social Security _____ Date of Birth _____ Home Phone _____ Work Phone _____

Permanent Address _____ City _____ Zip _____ State _____ County _____ Country _____

Name of Employer _____ Employer Phone Number _____ Employer Address (Street, City, Zip Code) _____

Occupation**:** _____ Employment Status**:** _____

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PRIMARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self or ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (If not self, complete this info)

Relationship to Patient	Last Name	First Name	Middle Name	M / F Sex

Social Security Number	Date of Birth	Home Phone	Work Phone

Permanent Address	City	Zip	State	County	Country

Name of Employer	Employer Phone Number	Employer Address (Street, City, Zip Code)

Occupation: Employment Status:

SECONDARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self or ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (If not self, complete this info)

Relationship to Patient	Last Name	First Name	Middle Name	M / F Sex

Social Security Number	Date of Birth	Home Phone	Work Phone

Permanent Address	City	Zip	State	County	Country

Name of Employer	Employer Phone Number	Employer Address (Street, City, Zip Code)

Occupation:_____ Employment Status: _____

IF THIRD INSURANCE, PLEASE LIST

Name of Insurance_____ Subscriber_____DOB_____

Please be ready to provide at the front desk :

1. ***Your insurance card(s)***
2. ***Your driver's license or ID***
3. ***Visit copay***

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UT HEALTH SCIENCE CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS, CONSENT FOR TREATMENT, AND ASSIGNMENT OF BENEFITS

Authorization for Release of Medical Records

Initials _____ I authorize UT Medicine San Antonio to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care and medical treatment.

Consent for Treatment

Initials _____ As a consulting adult and/or legal guardian, I agree to permit the physicians and staff of UT Medicine San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at UT Medicine San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

Assignment of Benefits

Initials _____ I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to UT Medicine San Antonio. I understand that I am responsible to follow up with insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize UT Medicine San Antonio to release all information necessary to secure payment.

I have read the Authorization Release of Medical Records, Consent for Treatment and Assignment of Benefits.

Patient Name :_____ **Date:**_____
PRINT

Signature of Patient
Or Legal Guardian :_____ **Date:**_____

Relationship to Patient _____

Witness: _____ **Date:**_____

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UT HEALTH SCIENCE CENTER

UT Medicine at San Antonio

NOTICE FOR REQUEST OF DISCLOSURE OF SOCIAL SECURITY NUMBER

(Patient Billing and Collections)

Disclosure of your Social Security Number ("SSN") is required of you in order for UT Medicine San Antonio to bill and collect for patient services. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN for this purpose. Failure to provide your SSN, however, may result in us not filing claims for your patient care because commercial insurance requires a SSN. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Medicine collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have UT Medicine correct information about you that is held by UT Medicine and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Medicine at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to UT Medicine HIPAA Compliance
By mail to: 6126 Wurzbach Road San Antonio TX 78238
By e-mail to: UPGPrivacy@UTHSCSA.edu
By fax to: (210) 257-1436
In person at: 6126 Wurzbach Road San Antonio TX 78238

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UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER

UT Medicine San Antonio
Consent for Disclosure and Acknowledgement of Receipt of Notice for Social Security Number

CONSENT FOR DISCLOSURE OF SOCIAL SECURITY NUMBER FOR PATIENT BILLING AND COLLECTIONS

I hereby consent to the disclosure of my Social Security Number by UT Medicine San Antonio for the stated purpose listed on Notice.

Patient Name (Print): _____

Patient Signature: _____

Date Consent Signed: _____

Acknowledgement of Receipt of Notice of Request for Social Security Number for Patient Billing AND COLLECTIONS

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio's Notice of Request for Social Security Number on the date indicated. If you have any questions regarding the information in the Notice of Request for Social Security Number for Patient Billing; please do not hesitate to contact the Clinic Manager or the UTM Administrator indicated on your Notice.

Patient Name (Print): _____

Patient Signature: _____

Date Notice Received: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose: The University of Texas Health Science Center at San Antonio (UT Health Science Center) and its faculty, students, residents, employees, and non-employees follow the privacy practices described in this Notice. The UT Health Science Center maintains your health information in records that are kept in a confidential manner, as required by law. The UT Health Science Center must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: The UT Health Science Center has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. UT Health Science Center may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, UT Health Science Center may use and disclose your health information to improve the quality of care, and for education and training purposes of UT Health Science Center students, residents, and faculty.

How Will the UT Health Science Center Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- UT Health Science Center directories, which may include your name, general condition, religious affiliation, and your location in the UT Health Science Center. (*)
- Family members or close friends involved in your care or payment for treatment. (*)
- Disaster relief agency if you are involved in a disaster relief effort. (*)
- To inform you of treatment alternatives or benefits or services related to your health. (*)
- Fundraising activities by the UT Health Science Center. Such information will be limited to your name, address, and phone number. If you do not want us to contact you for fundraising efforts, please contact the Office of Development at (210) 567-9219. (*)
- Appointment reminders.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.

- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other lawful request.
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects, which requires a special approval process by the University.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information, unless you allow the UT Health Science Center in writing to do so. For example, we will not use your photographs for presentations outside the UT Health Science Center without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Alcohol and drug abuse information has special privacy protections. The UT Health Science Center will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form(s) provided by the UT Health Science Center:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to inspect and copy.** You have the right to review and obtain a copy of your medical or health record. Psychotherapy notes may not be inspected or copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the UT Health Science Center. The UT Health Science Center will comply with the outcome of the review.

- **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the UT Health Science Center. The UT Health Science Center is not required to accept the amendment.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or operations within the past six (6) years for paper health records, and for electronic health records you may request three (3) years, including disclosures for treatment, payment, or operations. After the first request, there may be a charge.
- **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our Web site, http://www.uthscsa.edu/hipaa/patientrights.html. A more detailed Notice is also available at this Web site if you would like more information about these practices.

Requirements Regarding This Notice. The UT Health Science Center is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. The UT Health Science Center may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. Each time you register at the UT Health Science Center for health services, you may receive a copy of the Notice in effect at the time.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

UT Health Science Center's Privacy Officer
Office of Regulatory Affairs & Compliance
7703 Floyd Curl Drive, Mail Code 7861
San Antonio, TX 78229-3900
(210) 567-5212

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, D.C. 20201

We will not penalize or retaliate against you in any way for making a complaint to the UT Health Science Center at San Antonio or to the Department of Health and Human Services.

Contact UT Health Science Center's Privacy Officer at (210) 567-5212 if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

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UT HEALTH SCIENCE CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of the UT Health Science Center at San Antonio's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in UT Health Science Center's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Health Science Center Patient Privacy Officer as indicated on your Notice.

Patient Name (Printed):

_____

If Patient Representative, Name (Printed):

_____

If Patient Representative, Relationship to Patient (Printed):

_____

Account # or Medical Record #:

_____

Signature:

_____

Date Notice Received:

_____