Dear Student-Athletes and Parents,

All students who wish to participate in athletics who will be in 7th, 9th and 11th grades for the 2019-20 school year must have a physical completed. This also includes those who have not had one in the past year.

Thursday, May 16th (one day only) from 3:30 – 5:30 pm, BSWHealth Family Medical Center at Terrell, located at 200 N. Virginia Street, will be providing PHYSICALS for all Terrell ISD student-athletes.

A parent/guardian must accompany the student. If the parent/guardian cannot be present due to unforeseen circumstances, prior arrangements **must be made before May 16th** by contacting Coach Williams. The fee for the physical will be $10.00. If a student is unable to pay the $10.00, please contact Coach Williams so arrangements can be made prior to May 16th.

All pages accompanying this packet will need to be completed and signed and presented at the clinic. Coaches will provide bus transportation from both the middle school and high school to the clinic directly following school dismissal. Students may be picked up from the clinic or back at school after all physicals have been completed. If the doctor does find a medical issue that needs further attention, the parent/guardian will be contacted and the student, parent/guardian moved to an area for consultation.

In addition to this packet and your physical exam, student-athletes are required to complete a health packet online at terrellisd.rankonesport.com. All 4 pages will need a parent/guardian and student signature along with a parent/guardians' email address. The online forms must be completed for you to participate in athletics.

If you have any questions or concerns, please feel free to contact me at 972-563-2347 or alyssa.williams@terrellisd.org.

Alyssa Williams, MS, LAT, ATC
Head Athletic Trainer
Terrell ISD
972-563-2347
alyssa.williams@terrellisd.org

Patient Demographics & Insurance

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone ☐ Primary Number	Work Phone ☐ Primary Number	Mobile Phone ☐ Primary Number ☐ Yes, you can communicate information via SMS text for appointment reminders.	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the physician you are seeing today? ☐ Billboard ☐ Community Event/Health Fair ☐ Digital/Web Advertising ☐ Friend or Family Member ☐ Mailer/Postcard ☐ New Neighbors Program ☐ News Story/Broadcast ☐ Newspaper/Magazine Ad ☐ Physician Referral ☐ Radio Commercial ☐ TV Commercial

Responsible Party

Complete this section only if the patient above is a minor

Responsible Party Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone	Work Phone	Mobile Phone	
E-mail (Allows us to send you important messages.)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security Number	Sex ☐ Male ☐ Female	Date of Birth	

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City	State / Zip	City	State / Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City	State / Zip	City	State / Zip

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Name:
DOB:
Date:

Thank you for choosing Baylor Scott & White - HealthTexas Provider Network. We appreciate your assistance by completing this form, as it will help us better care for you.

Were you referred by another physician? If so, who?

_____

Reason for visit:

_____

Allergies:

List any significant reactions to food/meds ☐ No allergies

	Allergy	Reaction
1.		
2.		

Medications

List any medications you take, prescription and nonprescription and their dosage: ☐ No medications

	Medication	Dose	Refill needed (Y/N)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Local Pharmacy: _____ **Phone Number:** _____

Address: _____ **City:** _____

Mail order Pharmacy: _____

Past Medical History: Please check all that apply.

☐ No medical problems

	Abnormal pap smear
	Anemia
	Anxiety
	Asthma
	Atrial fibrillation
	Breast cancer
	Cervical cancer
	Chicken pox
	Chronic Back pain
	Colon cancer
	Deep Vein Thrombosis

	Depression
	GERD
	Gestational Diabetes
	GI bleed
	Gout
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Hypertension
	Hyperthyroidism

	Hypothyroidism
	Kidney Stone
	Heart attack
	Kidney Failure
	Kidney Disease
	Seizures
	Skin Cancer
	Stroke
	Substance Abuse
	Ulcers

Additional History

Surgical History: Please Check all that apply:

☐ No surgeries

	Abdominal aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Brain Surgery
	Breast Biopsy R/L
	Breast Enhancement
	Breast Surgery R/L
	CABG-Heart bypass
	Cardiac Catheterization
	Carotid Endarterectomy
	Carpal Tunnel surgery R/L
	Cataract Surgery R/L

	Cerebral Aneurysm
	Gall Bladder removal
	Colon Surgery
	Heart Transplant
	Hip Surgery R/L
	Hysterectomy
	Hysterectomy with ovaries removed
	Kidney removal R/L
	Kidney Transplant
	Knee arthroscopy
	Knee Surgery R/L

	Liver Transplant
	Lung Transplant
	Masectomy (breast removal) R/L
	Neck Surgery
	Previous C-section
	Shoulder Surgery R/L
	Sinus Surgery
	Tonsillectomy
	Tubal ligation (tubes tied)
	Valve replacement
	Other:

Family History: Please check all that apply:

	None	Alcohol abuse	Alzheimer's	Asthma	Autoimmune	Breast cancer	Cancer	Colon Cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

Alcohol Use: ☐ Yes ☐ No

Number of drinks/week: ____ glasses of wine ____ cans of beer ____ shots of liquor

Sexually Active: ☐ Yes ☐ Not currently ☐Never

Type of birth control: _____

Partners: ☐ Female ☐ Male ☐ Both

Drug Use: ☐ Yes ☐ No ☐ Former

Type of Drugs: : _____

Tobacco Use: ☐ Yes ☐ No

If so what type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes ☐ Snuff ☐ Chew

Year Started_____ Packs/day_____ Quit Date_____

Occupation:_____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children: _____

Years of education: _____

Who do you live with?_____

Immunizations: Please enter the dates of your most recent vaccinations

Tetanus/TdaP/Td: _____ **Human Papilloma Vaccination (HPV)/Gardasil:**_____

Prevnar:_____ **Pneumovax:**_____

Zostavax /Shingles Vaccination:_____ **Influenza Vaccination**_____

Preventative care: Please enter the dates of your most recent tests

	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
Osteoporosis Test/DEXA		
For Women Only		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		
Last Prostate exam		
PSA		

For Women Only

OB/Gyn History:

Last Menstrual period:

Duration of periods: Interval between periods: Heavy periods: : ☐ Yes ☐ No

# of pregnancies:_____ # of miscarriages:_____ # of abortions:_____

Have you had any of these symptoms in the last 2 weeks

Constitution

yes	Activity Charge	no
yes	Appetite Change	no
yes	Chills	no
yes	Diaphoresis	no
yes	Fatigue	no
yes	Fever	no
yes	Unexpected Weight Change	no

HENT

yes	Congestion	no
yes	Dental Problem	no
yes	Drooling	no
yes	Ear Discharge	no
yes	Ear Pain	no
yes	Facial Swelling	no
yes	Hearing Loss	no
yes	Mouth Sores	no
yes	Nosebleeds	no
yes	Postnasal Drip	no
yes	Rhinorrhea	no
yes	Sinus Pressure	no
yes	Sneezing	no
yes	Sore Throat	no
yes	Tinnitus	no
yes	Trouble Swallowing	no
yes	Voice Change	no

Eyes

yes	Eye Discharge	no
yes	Eye Itching	no
yes	Eye Pain	no
yes	Eye Redness	no
yes	Photophobia	no
yes	Visual Disturbance	no

Respiratory

yes	Apnea	no
yes	Chest Tightness	no
yes	Choking	no
yes	Cough	no
yes	Shortness of Breath	no
yes	Stridor	no
yes	Wheezing	no

Cardiovascular

yes	Chest Pain	no
yes	Leg Swelling	no
yes	Palitations	no

GI

yes	Abdominal Distention	no
yes	Abdominal Pain	no
yes	Anal Bleeding	no
yes	Blood in Stool	no
yes	Constipations	no
yes	Diarrhea	no
yes	Nausea	no
yes	Rectal Pain	no
yes	Vomiting	no

Endocrine

yes	Cold Intolerance	no
yes	Heat Intolerance	no
yes	Polydipsia	no
yes	Polyphagia	no
yes	Polyuria	no

GU

yes	Difficulty Urinating	no
yes	Dyspareunia	no
yes	Dysuria	no
yes	Enuresis	no
yes	Flank Pain	no
yes	Frequency	no
yes	Gential Sore	no
yes	Hematuria	no
yes	Menstrual Problem	no
yes	Pelvic Pain	no
yes	Urgency	no
yes	Urine Decreased	no
yes	Vaginal Bleeding	no
yes	Vaginal Discharge	no
yes	Vaginal Pain	no

Muscular

yes	Arthralgias	no
yes	Back Pain	no
yes	Gait Problem	no
yes	Joint Swelling	no
yes	Myalgias	no
yes	Neck Pain	no
yes	Neck Stiffness	no

SKIN

yes	Color change	no
yes	Pallor	no
yes	Rash	no
yes	Wound	no

Allergy/Immunology

yes	Environmental Allergies	no
yes	Food Allergies	no
yes	Immunocompromised	no

Neurological

yes	Dizziness	no
yes	Facial Asymmetry	no
yes	Headaches	no
yes	Light-Headedness	no
yes	Numbness	no
yes	Seizures	no
yes	Speech Difficulty	no
yes	Syncope	no
yes	Tremors	no
yes	Weakness	no

Hematologic

yes	Adenopathy	no
yes	Bruises easily	no

Psychiatric

yes	Agitation	no
yes	Behavior Problem	no
yes	Confusion	no
yes	Decreased Concentration	no
yes	Dysphoric Mood	no
yes	Hallucinations	no
yes	Hyperactive	no
yes	Nervous/anxious	no
yes	Self-injury	no
yes	Sleep Disturbance	no
yes	Suicidal Ideas	no

Race, Ethnicity & Language

Acct #

HealthTexas PROVIDER NETWORK
A member of Baylor Scott & White Health System

HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Race

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Some Other Race
- ☐ Unknown
- ☐ Patient Declined

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White or Caucasian:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Ethnicity

Which category best describes your ethnicity?

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

Language

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Chinese
- ☐ Dutch
- ☐ Hindi
- ☐ Other_____

_____ _____

Patient Name (please print) **Date**

Acknowledgement of The Receipt of HealthTexas Provider Network (HTPN) Notice of Health Information Practices

HealthTexas PROVIDER NETWORK
A member of Baylor Scott & White Health System

Acct #

Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's Notice of Health Information Practices.**

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Effective Date of this Notice: **09-23-2013**

[1] ***Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.***

Baylor Scott & White HEALTH

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/ Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This Notice of Privacy Practices ("Notice") describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members. An Affiliated Covered Entity ("ACE") is a group of Covered Entities, Health Care Providers and Health Plan under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the BSWH ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the BSWH ACE and as permitted by HIPAA and this Notice. As an ACE, BSWH may add or remove Covered Entities as part of the BSWH ACE. For a complete current list of the members of the BSWH ACE, please visit our website at www.BSWHealth.com/PrivacyMatters. The list will also be made available upon request either at our facilities or by contacting us toll-free at 1-866-218-6920.

This Notice will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you by:
  - Contacting the Health Information Management Department at the hospital or the outpatient clinic directly where you received care; or
  - Calling the Scott & White Health Plan ("SWHP") Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947 or writing to 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy, if you are a member of the health plan.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request an Amendment:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- We will not ask you the reason for your request.
- You may request a confidential communication by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- You may request this restriction by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request a list of those with whom we've shared information:
  - Contact us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may also view a copy of this Notice on our BSWH and SWHP member websites.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your privacy rights have been violated

- You can complain if you feel we have violated your privacy rights by:
  - Contacting us toll-free at 1-866-218-6920, by visiting www.BSWHealth.com/PrivacyMatters or in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling toll-free at 1-877-696-6775,

or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- For questions or other complaints, you may also contact:
  - The outpatient clinic directly or the Patient Relations Department at the hospital where you received care toll-free at 1-866-218-6919.
- For questions or other complaints relating to Health Plan Coverage:
  - SWHP members contact the Customer Advocacy line at 254-298-3000 or toll-free at 1-800-321-7947.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again by letting us know you wish to opt-out of any further fundraising communications.
- Information on how to opt-out will be included in any fundraising communications you may receive.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We may use your health information to give you information about treatment alternatives or health related benefits/services that may be of interest to you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- We can use and share your health information as necessary to operate and manage our business activities related to providing and managing your health care insurance.

Example: We might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

Communications regarding treatment alternatives and appointment reminders

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Bill for our services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for our services.

For payment

- We can use and share your health information for payment of premiums due to us, to determine your coverage, and for payment of health care services you receive.

Example: We might tell a doctor if you are eligible for coverage and what percentage of the bill might be covered.

For underwriting purposes

- We may use or share your health information for underwriting purposes; however, we will not use or share your genetic information for such purposes.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as the ways mentioned below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Student immunizations to schools

- We may disclose proof of your child's immunizations to their school based on your verbal or written permission.

Do research

- We can use or share your information for health research.

Food and Drug Administration (FDA)

- We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests

We can use or share health information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Electronic Health Information Exchange (HIE)

- We maintain electronic health information about you from other health care providers or entities that are not part of our healthcare system who have treated you or who are treating you and this information is also stored in the HIE.
- Our healthcare system and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law.
- We monitor who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.
- You may opt-out of the HIE by providing a written request to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201. If you opt-out, your information will still be stored in the HIE, but your information will not be viewable through the HIE.
- You may opt back in to the HIE at any time.
- You do not have to participate in the HIE to receive care.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our BSWH and SWHP member websites.

Effective Date: December 2018

Consent to Treat & Financial Responsibility

Acct #

HealthTexas PROVIDER NETWORK
A member of Baylor Scott & White Health System

Consent to Treat

I hereby authorize employees and agents of HealthTexas Provider Network (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Preferences Regarding Communication of PHI (Patient Health Information)

HealthTexas PROVIDER NETWORK
A member of Baylor Scott & White Health System

Acct #

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Mailed Letter ☐ Guardian ☐ MyBSWHealth (Patient Portal)

If the above method of communication is by phone, please check the appropriate box below **(check one):**

☐ Leave a message with detailed information.

☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian.**

If you would like to add additional contacts (other than the patient or legal guardian) that HealthTexas is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like HealthTexas to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

1 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

2 Contact Name _____ Relationship to Patient _____ Contact Phone Number _____

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian **Date**

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

Student ID: _____

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____ When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP___/___ (___/___, ___/___)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

Baylor Scott & White
HEALTHTEXAS PROVIDER NETWORK

Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) | Social Security Number

Patient Address | City | State | Zip Code

Marital Status: O Married O Single O Widowed O Separated O Divorced

Birth Date (Month/Date/Year) | Telephone Number

Spouse's Name

Employed O Yes O No

Patient's Employer

Telephone #

Employed O Yes O No

Spouse's Employer

Telephone #

Other Baylor Scott & White HealthTexas Provider Network accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)

If unemployed, please include the previous employer's name and telephone number*

A. Income: Please provide the income for each of the following persons in your household.

Patient O Full Time O Part Time - Hours/Week = _____
$_____ O Hr O Wk O Bi-Wk O Month O Year

$_____ **Additional Income**

Spouse O Full Time O Part Time - Hours/Week = _____
$_____ O Hr O Wk O Bi-Wk O Month O Year

$_____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father O Full Time O Part Time - Hours/Week = _____
$_____ O Hr O Wk O Bi-Wk O Month O Year

$_____ **Additional Income**

Patient's Mother O Full Time O Part Time - Hours/Week = _____
$_____ O Hr O Wk O Bi-Wk O Month O Year

$_____ **Additional Income**

Total Household Income $ _____

B. Income Verification: Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

O Paycheck Remittance O Employer Verification)
O IRS Form W-2 O Tax Return O Governmental Assistance (food stamps, CDIC, Medicaid,
O Bank Statements O Other (describe below) O Social Security, Workers Compensation or Unemployment Compensation Determination

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

C. Family Members: **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. Assets and Other Resources:

Do you have any assets or other resources available to you? *(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)*	☐ Yes	☐ No	If Yes, current amount available: $_____
Do you have medical insurance?	☐ Yes	☐ No	If Yes, please list provider name: _____
Do you have a Health Savings Account or Flexible Spending Account?	☐ Yes	☐ No	If Yes, current amount available: $_____

I understand Baylor Scott & White HealthTexas Provider Network may verify the financial information contained in this Financial Assistance Application ("Application") in connection with their evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize Baylor Scott & White HealthTexas Provider Network to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of Baylor Scott & White HealthTexas Provider Network. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party | **Printed Name** | **Date**

For Office Use Only

☐ Application information obtained by Baylor Scott & White HealthTexas employee in person or over the phone, no patient signature required.

Electronic Signature of Employee or Representative | Date

Notes Regarding Income Verification/Number in the Household:

O Patient is part of community care program

Program Name: _____

BaylorScott&White
HEALTHTEXAS PROVIDER NETWORK

Dear Patient/Guarantor:

As part of our commitment to serve the community, Baylor Scott & White Health provides financial assistance to individuals who satisfy certain income requirements. Your cooperation will provide us with the information to process your request. To determine if you qualify for financial assistance, we require the following:

☐ **Proof of Income**
Verification of income is required for patient and spouse (if applicable), or patient's parent(s) if the patient is a minor. Please provide the following (listed in order of preference): an IRS Form W-2, Wage and Tax Statement; paycheck stub remittance (past 2 months); individual tax return (most current); proof of participation in a governmental assistance program such as food stamps, CDIC, Medicaid or TANF; letter from employer confirming employment and income, Social Security Statement of Benefits, workers' compensation or unemployment compensation determination letters, or past three bank statements. If you are unable to provide one of the sources of income documentation listed above, please explain on the application why this information is not available.

☐ **Completed Financial Assistance Application**
A completed Financial Assistance Application is required for consideration to receive financial assistance. Please ensure the entire form is complete, including "Section C: Family Members" as follows:

- If patient is a minor: Include patient, patient's mother and father, and dependents of the patient's mother and father.
- If patient is an adult: Include patient, patient's spouse (if applicable) and any dependents.

This is your only notice. You must return the information outlined above or we cannot consider your account for financial assistance and payment is required. If the requested financial assistance information or payment is not received, we will evaluate your account for placement with a collection agency or if your account is already with a collection agency, it will remain with the collection agency. This could include reporting this debt to the credit bureaus. Prompt action will protect your credit rating.

For any questions, please refer to the clinic at 469-800-3166 or the Customer Service number listed on your statement.

Please return your completed Financial Assistance Application and required supporting documentation to the clinic at the following address:

Baylor Scott & White HealthTexas Provider Network
200 N VIRGINIA
TERRELL, TX 75160

Thank you for your prompt attention to this matter. Submission of the above documentation does not guarantee approval for financial assistance.

Sincerely,

Baylor Scott & White HealthTexas Provider Network
Financial Assistance