BAPTIST HEALTH MEDICAL GROUP
Patient Demographic Information Form Date: _____
Please Print Legibly

Full Name: _____ Date of Birth: _____ SSN: _____
Age: _____Sex: _____Marital Status: _____ Email Address: _____

Address: _____
City: _____ State: _____ Zip Code: _____
Home Ph: _____Cell Ph: _____Work Ph: _____

Are you a Baptist Health Employee? *Circle One*: Yes No
If yes, please provide Employee ID: _____
Are you a Veteran? Yes / No

Race: (circle one) White – Black/African American – Asian – Native American/Alaska – Native Hawaiian /Pacific Islander

Ethnicity: (circle one) Hispanic/Latino OR Non- Hispanic/Latino

Preferred Language: _____Written Language: _____Needs Interpreter? Yes / No
Emergency Contact: _____ Relationship: _____ Ph: _____
Primary Physician: _____Ph: _____Referring Physician: _____
Employer: _____ Ph: _____
Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Pharmacy Name_____Location_____

Guarantor Information: (Information of person financially responsible for a minor under age 18)
Guarantor Name: _____ Relationship to Patient: _____
SSN: _____ Date of Birth: _____ Sex: _____
Home Ph: _____Cell Ph: _____Work Ph: _____
Guarantor Address: _____
City: _____ State: _____ Zip Code: _____

Employment Status(circle one): FT – PT – Not Employed – Military Duty – Self Employed – Disabled – Student FT – PT

Guarantor Employer: _____ Ph: _____

Insurance / Subscriber Information
Primary Insurance: _____ Policy ID#: _____
Group #: _____ Effective Date: _____
Subscriber Name: _____ Subscriber SSN: _____
Subscriber Date of Birth: _____ Relationship to Pt: _____
Subscriber Address: _____
City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____ Policy ID#: _____
Group #: _____ Effective Date: _____
Subscriber Name: _____ Subscriber SSN: _____
Subscriber Date of Birth: _____ Relationship to Pt: _____
Subscriber Address: _____
City: _____ State: _____ Zip Code: _____

BAPTIST HEALTH MEDICAL GROUP

PATIENT CONDITIONS AND CONSENTS

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, & MEDICAL TREATMENT:

I voluntarily consent to care involving routine diagnostic tests, procedures and medical treatment as ordered by my treating physician(s), including their assistants or designees. I consent to receive medical care through the use of telehealth and/or remote patient monitoring. I further consent to the interpretation of diagnostic studies from an off-site location using telehealth technologies. I consent to medical, nursing, allied health and other students observing and participating in my care under the supervision of a qualified professional. I consent to photographic recordings or reproducible images during the surgical, medical, and/or diagnostic procedure(s) and their use for scientific, educational, identification, or research purposes. I also consent to testing for communicable and blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV), if a provider orders testing for diagnostic purposes or if there has been an exposure to healthcare personnel. I have been given no guarantees about the results that may be obtained from my care.

2. PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT EMPLOYEES OF BAPTIST HEALTH MEDICAL GROUP:

In most situations, the medical treatment provided to patients by Baptist Health Medical Group ("Baptist") is provided by Baptist employed physicians and providers. However, there other providers who are not employees or agents of Baptist that may provide medical services or be involved in my care. Such providers include, but are not limited to radiologists, pathologists, and psychologists. These providers may be independent or may be employed by other health care organizations. You may receive a separate bill for the services of these providers or the bill you receive may have separate charges for services of such providers. Charges for such services are established by these providers.

3. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I agree that I am responsible for payment of my physician office bill. Payment of any portion of my bill not covered by a third party payor is due at the time of service unless Baptist has agreed to other arrangements.

I agree to the assignment of all third party payor benefits to Baptist and to any health care provider rendering services to me. I agree to pay Baptist and other health care providers for all charges for services that are not covered or paid by any third party payor regardless of the reason, including but not limited to a determination by any third party payor that such services are not covered services or medically necessary. I acknowledge and agree that Baptist is not required to accept assignment of any third party payer benefits, in which case, I may receive a bill from Baptist for the full amount of charges related to any care or treatment provided to me or my guarantor by Baptist and I agree to pay Baptist for such charges. Moreover, I understand that Baptist may accept payment from payers with whom it does not have a contract and that any acceptance of payment does not constitute acceptance by Baptist of any reimbursement rates established by such third party payers and that I may receive a bill from Baptist for the difference between the rate paid by such payers and Baptist's charges. To the extent I am a Medicare or Medicaid beneficiary, I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Baptist or to any health care provider rendering services to me by the Medicare or Medicaid program. I hereby irrevocably appoint Baptist as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of Baptist to pursue any such right of recovery. I agree to take all actions necessary to assist Baptist in collecting payment from any such third party payer.

After reasonable notice, any unpaid account may be turned over to a collection agency and/or attorney for collection. Should it be necessary for Baptist to pursue collection, I agree to pay all reasonable collection costs, including court costs and attorney's fees incurred by Baptist in collecting my account.

Pursuant to the Fair Credit Reporting Act (15 USC §1681b(a)(2)), I authorize any credit reporting agency engaged by Baptist to release to Baptist or any of its representatives or affiliates, my consumer report. I understand that the purpose of this authorization and request is to obtain my consumer report, which may be used to determine the availability of or the need for financial assistance, charity care, or insurance coverage for me and may be used for billing and collection purposes related to payment for services

PATIENT CONDITIONS AND CONSENTS

provided to me. I understand this authorization is valid until my Baptist account for all services is closed.

4. SMOKE-FREE ENVIRONMENT:

Baptist maintains a smoke-free environment at each of its locations. Smoking is prohibited by health care personnel, patients, and visitors.

5. NOTICE OF NONDISCRIMINATION:

Baptist services, programs and activities are available regardless of race, color, national origin, religion, sex, disability or any other status protected by federal, state or local law.

6. LATEX ALLERGIES: I have a latex allergy ___ Yes ___ No

7. ADVANCE DIRECTIVES:

- I acknowledge that I have received a copy of a brochure describing my rights to make decisions about my medical care and advance directives or have reviewed this information at https://www.baptisthealth.com/patients-and-visitors/advance-care-planning/advance-directives.

- I have an advance directive (e.g., living will, durable power of attorney, healthcare surrogate)
  ___ Yes ___ No

  If **Yes**:
  - ☐ I have presented a copy to my physician office.

    OR
  - ☐ I do not have a copy, but I have been advised to bring a copy to be placed in my chart.

    I understand that it is my responsibility to provide the physician's office with a copy of my advance directive.

  If **No**:

  Would you like more information about advance directives? ___Yes ____No

8. PRIVACY NOTICE AND RIGHTS:

☐ I acknowledge that I have received a copy of Baptist's Notice of Privacy Practices or have the notice at https://www.baptisthealth.com/patients-and-visitors/website-and-privacy-information/baptist-health-medical-group-privacy-notice.

OR

☐ I have previously received a copy of Baptist's Notice of Privacy Practices.

9. CONSENT TO WIRELESS TELEPHONE CALLS:

I hereby authorize Baptist and all third parties, including clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys, business associates making appointment and exam confirmation and reminders, third parties who perform quality surveys, or other agents who may work on their behalf (including their successors, assigns, affiliates, or agents), to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that may result in charges to me. I agree that methods of contact may include using automatic telephone dialing systems or other computer assisted technology**.**

10. CONSENT TO EMAIL OR TEXT USAGE FOR HEALTHCARE COMMUNICATIONS:

If at any time I provide an email address at which I may be contacted, I consent to receiving healthcare communication at that email from Baptist. I further consent to Baptist communicating healthcare information, such as appointment reminders, to me on my

PATIENT CONDITIONS AND CONSENTS

wireless telephone through text. Baptist participates in Care Everywhere, an electronic exchange of patient data for continuity of care. You may choose to opt out of Care Everywhere by providing a written request to the Health Information Management Department.

The undersigned agrees that a copy of this consent, release and assignment of benefits may be used in place of the original copy. The undersigned authorizes Baptist to appeal on patient's behalf any adverse coverage determinations for treatment or services rendered at Baptist and further authorizes Baptist or its designee to represent patient during any appeal process. The undersigned certifies that he/she has read and agrees to this form and has received a copy.

If the patient is unable to sign, the undersigned Legal Authority certifies that the patient is _____ and the undersigned certifies he/she has read and agrees to this consent, release and assignment as a guardian, parent, next of kin, designated surrogate or as a power of attorney (as noted below) and has received a copy. (To the extent that the patient is unable to consent and has been appointed a legal guardian, please provide the name of the guardian and seek the guardian's consent for treatment.)

Patient Name (print): _____

Signature _____ Date: _____

Relationship to patient: _____ Print Name: _____

BAPTIST HEALTH®
MEDICAL GROUP

Curbside Flu Vaccine

I agree to wait the recommended 15-minutes after receiving my flu injection per BHMG policy and recommendation of the Immunization Action Coalition (IAC). I agree that I will wait this 15 minute period at the office of the BHMG location where I receive my flu injection. I understand that I may be asked to wait this 15 minute period in the vehicle in which I arrived.

I agree to notify the provider or staff **immediately** if I experience dizziness, lightheadedness, vision changes, and/or any other symptoms outlined in Vaccine Information Statement provided to me prior to receiving my flu injection.

I understand if I refuse to wait 15 minutes after receiving my flu injection and also choose to operate a motor vehicle that it could result in bodily harm and/or loss of life to myself and others.

_____ _____

Printed Name Date of Birth

_____ _____

Patient Signature (or Legal Guardian Signature) Date

BAPTIST HEALTH®
MEDICAL GROUP

Curbside Flu Consent 2024-2025

Patient Name: _____ **DOB:** _____

1. Is the person to be vaccinated sick today or had a fever of greater than 100.4°F in the last 24 hrs? ☐Y ☐N
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components? ☐Y ☐N
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐Y ☐N
4. Has the person to be vaccinated ever had Guillain-Barre syndrome or any other neurological diseases? ☐Y ☐N

I have been given a copy and have read or have had explained to me the U.S. Public Health Service important information statement about influenza vaccine dated 8/06/21. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of the vaccine and agree to receive the vaccination.

Patient/Guardian Signature: _____ **Date**: _____

Guardian Printed Name: _____

If any above questions are answered "yes", must have provider approval and documentation

Internal Use Only

Vaccine Manufacturer: Sanofi

NDC#: _____ **Exp:** _____

Vaccine Type: ☐Fluzone 65+ ☐Fluzone 6mos+

Administered by: _____

Administration Site: ☐ LD ☐ RD ☐ LT ☐ RT

Date: _____

Time Administered: _____ **Parking Space/Car Number (if applicable):** _____

Time Vehicle Departed: _____ **Patient waited 15 minutes after vaccine administration:** ☐ Yes ☐ No