

PATIENT RELATIONSHIP AGREEMENT

Treatment Relationship: I agree to medical care, treatment and diagnostic testing as directed by the treating physician or his/her designee. Baylor College of Medicine (BCM) is a teaching institution and may have students and residents involved in my care. I may request and receive information on the specific affiliation of any healthcare provider involved in my care.

Sharing Health Information for Treatment and Continuity of Care: BCM may share my medical information for treatment, payment and health care operations and as outlined in the BCM Notice of Privacy Practices. I understand that BCM may utilize health information exchange (HIE) systems to electronically share my protected health information for treatment purposes with other providers involved in my care. This may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, billing information, sensitive information (HIV, genetic counseling/testing, mental health and drug/alcohol abuse information) and other protected health information.

I may “opt-out” and not have my protected health information disclosed through the HIE systems by providing and signing the Baylor College of Medicine Opt-Out Form. If you have questions about how we share records electronically, or if you want to opt-out of the HIE, please see a BCM representative for more information.

Assignment of Insurance Benefits/Patient Financial Responsibility: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by BCM. I assign all rights, title and interest in payments from third parties and authorize payments to Baylor College of Medicine. I understand my insurance carrier may not approve or reimburse my medical services in full due to rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for fees not paid in full, co-payments, deductibles, and co-insurance except where my liability is limited by contract, or State or Federal law.

Accidental Exposure of Health Care Worker: I understand that Texas law provides that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Notice of Privacy Practices Acknowledgment: I acknowledge receipt of BCM’s Notice of Privacy Practices, which explains how BCM may use and disclose my protected health information. If you have questions about our Notice, please contact the BCM Privacy Office; their contact information is in the Notice.

Patient Name (Printed): _____

Legal Representative’s Name* (Printed): _____

Relationship of Legal Representative to Patient: _____

***Attach documents demonstrating legal authority to act on behalf of the patient**

Signature: _____ Date: _____