Our primary care team

Thank you for choosing us. Our goal is to provide you with the best care possible. To do that, we have a primary care team dedicated to providing you with quality, coordinated care specific to your clinical needs and circumstances. The primary care team consists of doctors, advanced practice providers, clinical pharmacists, behavioral health providers, community health workers and RN care managers.

Each team member, including you, plays an important role in your health.

Chronic disease

- Our team will help you manage your chronic disease—such as diabetes, COPD, asthma and heart failure.
- We support and guide you through healthy eating, being active, monitoring and taking medication.

Medication management

- Pharmacists help find affordable medication options.
- Pharmacists answer any questions that you may have about your prescribed medication.

YOU

- Attend scheduled visits.
- Partner with your care team to improve your health.

Behavioral health

- Behavioral health providers offer emotional and social support.
- Depending on the need and availability, they help coordinate services like housing, transportation and meals.

Support services

- Have access to limited specialty services.
- Help with preventive care.
- Can assist with transportation to get you to and from your doctors' appointments.

Baylor Scott & White
COMMUNITY CARE

BSWHealth.com/CommunityCareClinics

Our patient-provider pledge

To meet your care goals, it's important for you and our care team to work together. In order to best partner with you, we have outlined expectations below that will help us care for you better.

What we ask from you:

- Treat your care team with courtesy, respect and dignity.
- Make your appointments:
  - Inform our office of any changes in your contact information, insurance and employment.
  - Arrive 15 - 20 minutes before scheduled appointments.
  - Notify us 24 hours in advance if you cannot keep an appointment. Missed appointments may affect your ability to schedule future visits.
- Engage in your care:
  - Be honest about your history, symptoms and medications.
  - Ask questions if you do not understand.
  - Follow your plan for care. Take medications as instructed.
  - Call your doctor first with any problems unless it is a medical emergency.

We pledge to:

- Treat you with courtesy, respect and dignity.
- Keep your healthcare affordable:
  - Low-cost visits with providers
  - Affordable medications
- Help you to reach your health goals:
  - Listen to your feelings and questions to help you make decisions about your care.
  - Explain diseases, treatments and results in an easy to understand way.
  - End every visit with clear instructions about expectations, treatment goals and future treatment plans.

Baylor Scott & White
COMMUNITY CARE

BSWHealth.com/CommunityCareClinics

GENERAL CONSENT TO TREAT

1. **General Consent** I consent to allowing the applicable Baylor Scott & White Health affiliated facilities listed below ("Facility") to provide me with necessary medical service, evaluation, diagnosis, treatment, and care (collectively, "care"). My consent includes any examinations, imaging, laboratory tests (including, but not limited to, tests to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), medications, medical treatment, and/or other services rendered by physicians, advance practice professionals, technical assistants, their associates, and other healthcare providers including nurses and other Facility staff (collectively, "providers"), which are advisable during the course of my evaluation, diagnosis, care, and treatment. Further, I agree and understand that care provided to me within the Emergency Department is considered an admission to the Facility even if I am not admitted to an inpatient bed. This consent is continuing in nature during the entire course of my care, unless specifically revoked by me.

Baylor Scott & White All Saints Medical Center - Ft. Worth
Baylor Scott & White Ambulatory Endoscopy Center
Baylor Scott & White Continuing Care Hospital
Baylor Scott & White Heart and Vascular Hospital - Dallas
Baylor Scott & White Heart and Vascular Hospital - Ft. Worth
Baylor Scott & White Heart and Vascular Hospital - Waxahachie
Baylor Scott & White McLane Children's Medical Hospital
Baylor Scott & White Medical Center - Austin
Baylor Scott & White Medical Center - Brenham
Baylor Scott & White Medical Center - Buda
Baylor Scott & White Medical Center - Centennial
Baylor Scott & White Medical Center - College Station
Baylor Scott & White Medical Center - Grapevine
Baylor Scott & White Medical Center - Hillcrest
Baylor Scott & White Medical Center - Irving
Baylor Scott & White Medical Center - Lake Pointe
Baylor Scott & White Medical Center - Lakeway
Baylor Scott & White Medical Center - Marble Falls
Baylor Scott & White Medical Center - McKinney
Baylor Scott & White Medical Center - Plano
Baylor Scott & White Medical Center - Pflugerville
Baylor Scott & White Medical Center - Round Rock
Baylor Scott & White Medical Center - Taylor
Baylor Scott & White Medical Center - Temple
Baylor Scott & White Medical Center - Waxahachie
Baylor Scott & White The Heart Hospital - Denton
Baylor Scott & White The Heart Hospital - McKinney
Baylor Scott & White The Heart Hospital - Plano
Baylor University Medical Center
HealthTexas Provider Network
Hillcrest Family Health Center
Hillcrest Physician Services
Scott & White Clinic

2. **Telemedicine** I consent to the Facility providing me with necessary care through telemedicine / telehealth, or through the use of electronic communications such as video or virtual communications, with providers who are located at a different site(s) ("off-site providers"). I agree and understand that I may be billed for any out of pocket costs such as co-pay, deductible, or coinsurance based on my health or insurance plans.
3. **Teaching Location** I agree and understand that the Facility may be a teaching Facility and residents, fellows, and students from various teaching programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my providers. I consent to allow residents, fellows, students, and authorized individuals to participate and observe the care provided to me as determined by my providers and as permitted by Facility policy.
4. **Independent Contractor** I agree and understand that the Facility may have one or more agreements with providers who are not employees of the Facility. I hereby consent to receive care from such providers and recognize that as independent contractors, the Facility is not responsible for the care or lack of care provided by these individuals. I understand that all such medical decisions regarding my care at the Facility are made by such providers and not by the Facility. **I also understand that I may receive a separate bill from these providers.** I may request a listing of the providers who have been granted medical staff privileges to provide medical services at the Facility.
5. **Control Over Decisions** I agree and understand that I have the right to make decisions about my care and that my providers and I will discuss and agree upon my care.
6. **Testing After Accidental Exposure** I consent to the testing for communicable diseases, in the event of an accidental exposure to a provider, healthcare worker, or other individual.
7. **State Reporting Requirements** I agree and understand that the Facility or provider is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or the Centers for Disease Control and Prevention. Also, I understand that the Facility is required by law to report certain activities including abuse or neglect.
8. **Personal Property** I agree and understand that I am responsible for my personal property. I understand that any and all valuables or other articles of personal property should be placed in the care of a family member or other authorized representatives. The Facility is not responsible for the safekeeping of these items. If available, I understand that the Facility maintains a safe or secure area for property and valuables, and that I may utilize this safe or secure area according to Facility policy; however, the Facility cannot guarantee the security of these items.
9. **Notice Regarding Physician Ownership** If I am receiving care at Baylor Scott & White Heart and Vascular Hospital – Dallas/Fort Worth/ Waxahachie, Baylor Scott & White The Heart Hospital – Plano/Denton/ McKinney, Baylor Scott & White Ambulatory Endoscopy Center, or an outpatient department of one of these facilities, I acknowledge that I am aware that one or more of the physicians providing my treatment at the Facility or one of its outpatient departments has an ownership interest in the Facility. A list of the physician owners is available to me upon request.
10. **Financial Responsibility** I agree and understand that regardless of any and all assigned benefits/monies, I am responsible for the total charges for services rendered. I further agree that all amounts are due upon request and are payable to the Facility and any provider providing me care. I agree to pay for any and all charges and expenses incurred or to be incurred. I understand that I will be provided with itemized statements regarding these charges through the MyBSWHealth web page and mobile application, and that I may also contact Customer Service at 1-800-994-0371 or billingquestions@bswhealth.org to request a paper copy. **I understand that independent providers (which could include, for example only, anesthesiologists, radiologists, pathologists, emergency medicine physicians, advance practice professionals, and other independent providers of health care services) providing me care may be considered out-of-network on my health or insurance plans although the Facility may be considered in network. I understand my insurance may not cover some services provided to me. I am responsible for asking about and understanding my insurance coverage for my providers and facilities. I understand if I desire additional information as to the providers who may be involved in providing my care, I can either ask my treating provider (who may know some of the specialists or groups who could be involved) or I can request a list of Facility-based physician groups by calling the following toll free number: (877) 810-0372. This list is updated annually and is subject to change without prior notice. Only my insurance carriers can confirm the nature and extent of my coverage and which facilities and providers will be considered in-network.** I further understand and agree that should my account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I shall pay all charges for reasonable attorneys' fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be

applied to any outstanding accounts, either current or bad debt. Further, I hereby consent to credit bureau inquiries for any and all permissible purposes. I understand that I may request information from the Facility on whether it has a contract with my health or insurance plans and under what circumstances I may be responsible for payment of amounts not paid by my health or insurance plans.

11. **Medicare and Medicaid** If I have Medicare or Medicaid, I acknowledge my financial obligations may be limited by law. Other insurance carriers may limit my obligations by contract or policy benefit guidelines. If I do not have insurance coverage, I may ask for help to determine my eligibility.
12. **Outpatient Department** Charges I agree and understand if I receive care in an outpatient department, I may receive two bills including a bill for Facility services (also known as a facility fee) and a separate bill for the physician or other provider services (also known as professional services).
13. **Assignment of Benefits** I hereby irrevocably assign, transfer and convey to the Facility and any provider providing care to me, any and all benefits, interests and rights (including, but not limited to, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third party reimbursement, or prepaid healthcare plan for services rendered or products that I receive from the Facility. Notwithstanding the foregoing, my assignment of benefits, interests, and rights is not effective if I have signed an agreement with the Facility assuming responsibility for paying for services rendered by the Facility providers as out-of-network and retaining the responsibility to bill my insurance company.
14. **Responsible Parties** Upon receiving any care from the Facility and any provider providing care to me, I have assigned my rights of recovery from any Responsible Party to the Facility and any provider providing care to me. I understand that I may not assign, waive, compromise or settle any rights or causes of action that I may have against any Responsible Party, person or entity who causes an injury or illness treated by a Facility provider, without the express prior written consent of the Facility. This right is independent, separate and apart from any other right acquired by the Facility. I also agree to reimburse, first, the Facility for services provided out of any claim made against a Responsible Party. I acknowledge that for any financial assistance, uninsured patient discount or any other discount from the Facility covering medical benefits for illness or injury caused by an act or omission of a Responsible Party, the Facility reserves the right to reconsider and reverse the financial assistance, uninsured patient discount, or any other discount. Financial assistance, uninsured patient discount, or any other discounts/adjustments are considered an action of last resort. Therefore, the Facility reserves the right to dismiss, or reverse any such adjustments or discount on any account at any time. For purposes of this document, a Responsible Party includes any of the following: a tortfeasor individually, a tortfeasor's insurance company, any underinsured / uninsured automobile insurance coverage that provides benefits to a patient, no fault insurance coverage, any award, settlement or benefit paid under any worker's compensation law, claim or award, any indemnity agreement or contract, and/or any other payment for a patient as compensation for injuries sustained or illness suffered as a result of the negligence or liability of any individual or entity.
15. **Release of Information** I agree and understand that the Facility may release my healthcare information for payment purposes and any other purpose permitted by law. Further, the Facility may release my information to other providers for my continued care. I also authorize the release of medical information to organ transplantation services should I be identified as a potential organ donor. I agree that any leftover specimens sent to the laboratory may be used for medical education, validation, and authorized research.
16. **Communication** I authorize the Facility and providers, along with any billing service and collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, digital voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.
17. **Retention of Records** I agree and understand that the Facility will retain my medical records for the required retention period. I acknowledge that the Facility may authorize the disposal of medical records at the end of this retention period.
18. **Notice of Privacy Practices** I acknowledge that I have received a copy of the Facility's "Notice of Privacy Practices." I acknowledge that I can obtain an additional copy of the "Notice of Privacy Practices" on the Facility's website.
19. **Patient Rights and Advance Directives** I acknowledge that I have received information about my right to accept or refuse care. I have the right to make an advance directive, or living will. I am not required to have an advance directive to receive care. If I give the Facility an advance directive, my provider will follow it to the extent permitted by law.
20. **Patient Representative** I acknowledge that I have the right to name a representative who will make decisions on my behalf in the event I am unable to. I may designate a representative in writing or by telling my provider. My representative will be involved in my care plan, unless I expressly withdraw this designation in writing or by telling my provider.
21. **Photography** I consent to the videotaping, photographing, and/or other recording of myself and/or the portion(s) of my body involved in my care for medical education, internal quality control, performance improvement, and/or other related uses. I understand that for the purposes listed above I have the right to request cessation of the recording or filming. I also understand that for those purposes I have the right to rescind consent for the use of the recordings, videotapes and/or photographs up until a reasonable time before the recording or film is used. I understand the recording or film is the property of the Facility.
22. **Warranty and Guarantee** I agree and understand that the practice of medicine is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care rendered by the Facility or providers.

Patient or Legally Authorized Representative / Responsible Adult	Date and Time	Relationship to Patient
	/ / :	

BSWH USE ONLY

☐ Patient Unable to Sign

BSWH Witness Attestation Confirming Patient's Inability to Sign	Date and Time
	/ / :

(Refer to Facility Informed Consent Policy for Legally Authorized Representative.)

GUIDE TO YOUR CARE AND PATIENT RIGHTS AND RESPONSIBILITIES

Important information about medical and ethical issues

Our goal while you are a patient is to help you experience the best possible outcome. For this to happen, everyone—you, your family and your health care team—must all work together and communicate clearly. This guide is provided to help you understand how you and your family can work with your health care team toward the goal of achieving the best possible outcome, as well as to help you understand your rights and responsibilities. We know that a facility can be a confusing place. You may have many different members of your health care team who visit when your family isn't nearby. Physicians and nurses may use words you don't understand. You may have questions about facility rules or your rights as a patient. You may be very sick and hard choices may need to be made about your treatment. Making those decisions can be difficult and emotions may be strong. We hope the information you find in this guide will ease your mind, make you feel comfortable communicating with your health care team about your treatment or any other issues, and enhance the experience of both you and your family.

The rights and responsibilities recognized at Baylor Scott & White Health ("BSWH") are as follows:

- BSWH is committed to respecting the rights of BSWH patients and their surrogate decision-makers, designated representatives, support persons, and families in accordance with ethical standards, federal and state law, and facility accreditation standards. Along with those rights, patients also have certain responsibilities.
- Patients are informed of their rights and responsibilities. Communication assistance is available to patients, through the services of a translator or interpreter, in order for patients to receive the information in a manner they understand.
- Patients have the right to have a family member, surrogate decision-maker, support person, or designated representative and the patient's physician promptly notified of their admission to a BSWH facility.
- BSWH will collaborate with patients and their surrogate decision-makers to promote patient health and welfare by recommending treatments based on medical science and health care professional judgment.
- We will treat all with dignity, compassion, and respect for personal values, including spiritual beliefs.
- Patients will not be discriminated against for any reason.
- Patients have the right to receive information in a language and form necessary for their understanding and agreement with, or refusal of, the treatment recommended. If patients are unable to receive this information, it is given to their surrogate decision-maker.
- Patients have the right to formulate advance directives such as living wills, and we will respect those directives within the law and facility policy.
- Patients have the right to receive information about our policies on advance directives and the initiation, maintenance or withdrawal of life sustaining treatments. Further, patients have the right to receive information about Cardiopulmonary Resuscitation ("CPR") and our policies on Code Status Orders including Full Code, Do Not Attempt Resuscitation ("DNAR"), and Limited Code ("LC") orders.
- Patients may request, or have their surrogate decision-maker, designated representative, support person, and/or physician request on their behalf, a discharge planning evaluation to be performed and to have that information given to the patient, surrogate decision-maker, designated representative, support person, and physician. When appropriate, a discharge planning evaluation is offered to outpatients.
- Patients have the right to accept or refuse visitors of their choosing except when such visitors might interfere with their medical treatment or the treatment of others.
- Patients have a right to privacy as outlined in law and regulation.
- Patients have a right to a copy of their medical records in accordance with law and facility policy.
- Patients have the right to consent or refuse to consent to participation in research and to the involvement of students and residents in their care.

Limitations on rights:

- Patients do not have a right to testing or treatments that are unavailable in our facilities.
- Patients do not have a right to testing or treatment which, in the treating physicians' judgment, is medically inappropriate for their condition.

Patients have the responsibility to:

- Provide a complete and honest medical history.
- Cooperate with all necessary examination, testing and treatment recommended. If a patient is unwilling to do so, we will consider the patient responsible for the consequences and the patient should seek treatment elsewhere.
- To show respect at all times for our staff, other patients, and visitors.
- To pay for that portion of medical treatment not covered by insurance or to disclose to us any need for financial assistance.
- To speak up and ask questions if the patient or surrogate decision-maker does not understand or feels dissatisfied with the treatment and care we are providing, or if the patient or surrogate decision-maker feels the patient is unsafe while under our care.

A patient's guardian, next of kin, surrogate decision-maker, support person, or designated representative may exercise, to the extent permitted by law, the rights delineated on behalf of the patient and take on the responsibilities of the patient if a patient:

- Has been adjudicated incompetent in accordance with the law;
- Is found by their physician to lack decision-making capacity or to be mentally incapable of understanding the proposed treatment or procedure;
- Is unable to communicate their wishes regarding treatment; or
- Is a minor.

Who is on my health care team?

Throughout this guide we refer often to your health care team. Depending on many factors, your health care team may be made up of any number of individuals. Every team member brings special expertise. These individuals will identify themselves, their professional status, if applicable, their relationship to others on the team, and their role in your treatment and care.

Goals and types of treatment

The most basic goal of medicine is to fix or cure your health problem. If a complete cure is not possible, the goal of the health care team is to try to slow down the problem or make it go away for a while (remission). Perhaps the most important goal is to provide you with comfort and relief of suffering at all times. You will receive medically appropriate treatment to meet these goals and we hope that you will do well.

Communicating with your health care team

Good communication is essential to every part of medical treatment. It is important when things are going well. It may be even more important when things are not going well and the outcome you and your family expected is not being achieved. Either way, it is vital that you, your family and your health care team communicate clearly. You should feel free to discuss any topic associated with your care and treatment with members of your health care team. For example, you may want to discuss:

- Your diagnosis
- Goals of your treatment
- The types of treatment appropriate to meet those goals
- The benefits, burdens, and risks of treatment as well as the probability of success. It is important that you discuss your goals and the types of treatment with your physicians, nurses and your family while you are able to speak for yourself. How do you want to be treated if you have an accident or an illness and become so sick you can't speak for yourself? Who should speak for you and what should they say?
- The importance of advance care planning

The process of thinking about who should speak for you if you can no longer speak for yourself and considering the goals and intensity of your treatment is called advance care planning. When thinking about who should speak for you, consider how trustworthy that person is and how available they are. Think about what you would want them to say on your behalf. This is easy if you are only temporarily unable to speak for yourself and recovery is expected. But what if you become so sick that you can no longer communicate, and cure is no longer possible? If you make these decisions in advance, you will be relieving your family and loved ones from making these decisions for you. You should think about these questions:

- What physical, mental or financial burdens would you be willing to accept to temporarily stay alive longer (or prolong dying) in that circumstance?
- What quality of life would you want to have to make staying on a breathing machine or dialysis worthwhile?
- Would you be willing to live confined to a bed in a nursing home, unable to care for yourself?
- How important is pain control to you—not only physical, but mental and spiritual?
- What if you were permanently unconscious and could not feel pain, hunger, thirst, happiness, love or joy, but could be kept alive with a tube in the stomach to provide artificial nutrition and hydration?

GUIDE TO YOUR CARE AND PATIENT RIGHTS AND RESPONSIBILITIES

These are hard questions and they often have deeply personal answers. Whatever your answers are, the best way to communicate them is by completing an advance directive such as a Living Will and/or a Medical Power of Attorney.

Advance directives have been clearly shown to improve patient care in the setting of serious illness and to lessen family stress. If you do not have an advance directive at the time of admission, we hope you will complete one. It is never too late to do so, and a copy can be placed in your medical record. You are not required to complete an advance directive. Whether or not you choose to complete an advance directive, your care, treatment and services that you receive will not be affected, nor will your decision result in any discrimination against you. To help you face questions you may have about advance directives and to complete an advance directive, you may request the following additional resources from your nurse, social worker, chaplain or physician, or you may access advance directive resources online at BSWHealth.com

If I complete an advance directive, can I change my mind?

Yes, you may cancel, or revoke any advance directive simply by destroying the document, signing and dating a written statement that states your desire to cancel the directive, or telling your doctor or nurse. You may also review and revise your advance directive. If you choose to change an advance directive, you must execute a new one.

If you are admitted within the facility where else can I get help?

If you are admitted within the facility there are specially trained social workers, nurses, and chaplains who can help you with advance care planning concerns. You may also have ethical concerns as you consider potentially serious issues. All Baylor Scott & White facilities have access to ethics committees and ethics consultants who may offer counsel and assist in resolving ethical issues that might arise. These services are provided free of charge. You, your family or health care decision maker, your physician or any member of your health care team may request guidance from a Baylor Scott & White facility ethics committee. For further information, your physician, nurse, social worker or chaplain can help you reach the ethics committee at your facility or you may call one of the phone numbers at the end of this handout. You may also wish to consult your personal or family lawyer if you have questions about advance care planning.

What if there is disagreement about ethical issues?

On rare occasions there may be ethical disagreements between you, your family and/or health care providers. We believe good communication can prevent most ethical disagreements. It is also worth remembering the following:

- We will make every reasonable attempt to honor your treatment preferences within the mission, philosophy and capabilities of the facilities and the accepted standards of medical practice. This includes those expressed by an advance directive or by others on your behalf if you lack an advance directive and are unable to make decisions.
- We respect your right to reject treatments offered.
- We do not recognize an unlimited right to receive treatments that are medically inappropriate.
- Texas law, specifically Chapter 166 of the Texas Health & Safety Code, provides a process for resolving ethical disagreements between you, your family, and/or health care providers in those rare cases where further communication does not resolve the disagreement. This process relies on ethics consultants and ethics committees available at each facility to help as needed.

At some point, you may be asked to make hard choices about treatment when cure of your illness is no longer possible, and emotions may be strong. We have provided this information in hopes of helping you better understand your rights, responsibilities and ethical issues associated with being in the facility. We hope a better understanding will improve communication, treatment and lessen stress for all.

Complaints

We welcome your feedback at all times, both positive and negative. If you have any complaints, we hope you will:

- First report your complaint to the clinical manager for the unit or facility involved. The bedside nurse will help you identify the clinical manager.
- We will investigate your complaint through our formal complaint process, and we will give you a response. Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services and/or the Joint Commission by e-mail, fax, letter or phone at the contact numbers and addresses listed below.

Grievance Process Information

We will investigate your complaint through our formal complaint process, and we will give you a response.

Patient Privacy or Confidentiality Complaints: (866) 245-0815
Billing Concerns: (800) 994-0371
Patient Relations: (866) 218-6919

Although we encourage you to bring your concerns directly to us, you always have the right to take any complaint to the Texas Department of State Health Services by email, fax, letter or phone at the contact numbers and addresses listed below.

Medicare Beneficiaries

Texas Department of State Health Services
Health and Human Services Commission
Complaint and Incident Intake Mail Code E-249
P.O. Box 149030
Austin, Texas 78714-9030
Email: hfc.complaints@hhsc.state.tx.us
Complaint hotline: 888-973-0022
Fax: 833-709-5735

The Joint Commission
Office of Quality and Patient Safety
One Renaissance Blvd.
Oakbrook Terrace, IL. 60181
www.jointcommission.org
Phone: 1-800-994-6610
Fax: 630-792-5636

Have a right to take complaints including quality of care, disagreement with a coverage decision, or wishes to appeal a premature discharge to the Quality Improvement Organization ("QIO") for Texas Medicare beneficiaries at the contact number and address listed below.

KEPRO
Rock Run Center
5700 Lombardo Center, Suite 100 Seven Hills, OH 44131
(888) 315-0636
Fax (844) 878-7921
KEPRO.Communications@hcqis.org

HMO Patient's Right to File a Complaint:

You may send a complaint to your HMO if you are not happy with your HMO's operations, procedures, or the health care services you received from your doctors. HMOs must meet required deadlines to resolve your complaint and must give you a written answer. If you are not happy with the HMO's decision, you can appeal the decision to the HMO's appeal panel. The appeal panel members cannot be the same individuals who reviewed or decided your complaint. Call or write to your HMO to find out more about the HMO's complaint and appeal process. You may also contact the Texas department of insurance for more information about your rights and about HMO requirements at the following address and telephone numbers:

Texas Department of Insurance
HMO complaint helpline 1-800-252-3439
In Austin, call 512-463-6515 Servicio en español

X_____

Notice of Privacy Practices

OCTOBER 2022

Your Information. Your Rights. Our Responsibilities.

This Notice describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members, including how we may use and disclose medical information about you and how you can access your medical information. An ACE is a group of Covered Entities, Health Care Providers and Health Plans 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. Please visit our website at BSWHealth.com/PrivacyMatters for a current list of the members of the BSWH ACE. The list will also be made available upon request either at our facilities or by contacting us toll-free at 1.866.218.6920.

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 medical record

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. **See page 2 for how to do this.**
- 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. **See page 2 for how to do this.**

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. **See page 2 for how to do this.**
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, mobile, home or office phone) or send mail to a different address. **See page 2 for how to do this.**
- We will say "yes" to all reasonable requests.

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. For example, we may say "no" if it would affect your care. **See page 2 for how to do this.**
- 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 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. **See page 2 for how to do this.**
- 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.

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.
- You may also view a copy of this Notice on our **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 using the Office of HIPAA Compliance contact information below.
- 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 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Hospital or Clinic To get an electronic or paper copy of your medical records, contact the **Health Information Management Department** at the **hospital** or the outpatient clinic directly where you received care.	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.**
Office of HIPAA Compliance For requests relating to an authorization, amendment, confidential communication, restriction, list of those with whom we've shared information, revocation of an authorization, opting in or out of the HIE, or to file a complaint, contact us at:	**1.866.218.6920 (toll-free)**; or **BSWHealth.com/PrivacyMatters**; or BSWH Office of HIPAA Compliance 301 N. Washington Ave., Dallas, TX 75246.
Health Plan To get an electronic or paper copy of the health information we have about you, or for questions or other complaints relating to your Health Plan Coverage, contact the Customer Advocacy line:	**1.800.321.7947 Scott and White Health Plan ("SWHP")** and also doing business as **Baylor Scott & White Health Plan**, and **Baylor Scott & White Insurance Company**; or **1.800.884.4901 FirstCare**; or **1.855.897.4448 RightCare**; or 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy.

For certain health information, you may tell us your choices about what we share.

You have the right 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 **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.**
We never share your information unless you give us written permission to do so for:	• Marketing purposes • Sale of your information, as this activity is defined under HIPAA • In most instances, sharing of psychotherapy notes
Fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures	**How do we typically use or share your health information? We typically use or share your health information in the following ways:**
Treat	• We can use your health information and share it with other professionals who are treating you, and for purposes of recommending treatment alternatives, care coordination, and alternative settings of care.
Run our organization	• We can use and share your health information to run our organization and improve patient/ member care **Example:** We can use and share your health information to support programs and activities to improve the quality of treatment services and provide customer service. For example, we may combine health information about many patients to evaluate the need for new services or treatments to improve the quality of patient care.
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 your 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	• 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 certain conditions in the law before we can share your information for these purposes. For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Public health and safety	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	• We may disclose proof of your child's immunizations to their school based on your verbal or written permission.
Research	• We can use or share your information for health research under certain circumstances.
Compliance with the law	• We will share information about you if federal, state, or local law or regulations require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.
Organ and tissue donation	• We can share health information about you with organ procurement organizations.
Medical examiners or funeral directors	• We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Workers' compensation, law enforcement and other governmental entities	We can use or share health information about you: • For workers' 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
Service provider	• We can share health information about you with service providers that assist us and who have the same contractual obligation to safeguard the information.
De-identified information	• We may use health information about you to create de-identified information. This is information that has gone through a rigorous process so that the risk that the information can identify you is very small. Once health information is de-identified in compliance with HIPAA, we may use or disclose it for various purposes, such as research or development of new health care technologies, and the de-identified information will no longer be subject to this Notice or your rights described herein. We may receive payment for the de-identified information.
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 use HIEs to exchange electronic health information about you with other health care providers or entities that are not part of our health care system. Information exchanged between providers or entities may be stored in their own systems. • Our health care system and these other providers or entities can use the HIEs 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 within our health care system, but other individuals and entities who use the HIEs may disclose your information to others subject to each HIE's rules. • You may opt-out of all HIEs by providing a written request to the BSWH Office of HIPAA Compliance. If you opt-out, others may still request your information through the HIEs, but your information will not be viewable through the HIEs. You may opt back in to the HIEs at any time. **See page 2 for how to do this.** • You do not have to participate in any 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: 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, in our office, and on our websites.

BAYLOR SCOTT & WHITE HEALTH
PERMISSION FOR VERBAL COMMUNICATION

Patient Name **Date of Birth** **Phone Number(s)**

Full Address (City, State, and Zip Code)

I permit Baylor Scott & White Health to discuss my personal medical health information, in person and/or by telephone, with the following persons involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments;**
- **To discuss my care including the results of diagnostic tests, diagnosis, prognosis, and treatment plans that may include mental health records, psychotherapy notes, AIDS/HIV test results, substance abuse treatment records, blood bank records, and/or genetic information; or**
- **To discuss billing and payment for medical services.**

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	Relationship	Phone Number
1.			
2.			
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508. This document of Permission for Verbal Communication is valid until revoked by the patient or patient's representative.

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

Signature of Patient or Legal Representative (electronic signatures not acceptable) **Date**

Print Name of Patient or Legal Representative **Relationship to Patient**

Representative's Authority to Act for Patient (attach supporting documentation)

Scan doc type: Consent-Verbal Communication

Financial assistance program

As part of its commitment to serve the community and provide quality medical care to all of our patients, Baylor Scott & White Health provides a Financial Assistance Program to patients who satisfy certain requirements. This includes patients who don't have health insurance and can't pay their bill.

If you believe you qualify for financial assistance, then you should complete Baylor Scott & White's Financial Assistance Application, provide Proof of Income, Proof of Address and Photo identification.

All documents must be received before we can process your application. If patient is under 18, we will need their birth certificate , vaccine records and social security (if available)

1. Proof of Address (submit one)

- Government ID or Driver's License with current address
- Utility bill in your name or spouse's name – light, water or gas ONLY
- Rent/Lease agreement with address under your name
- If the bills are not under your name or your spouse, then the person who the bill is under will have to fill out a letter of support and provide their proof of address (government ID or utility bill). **Ask our staff for a copy of the letter.**

2. Proof of Household Income (submit all that apply for you and your spouse)

- Tax return for the current tax return year (please sign tax return on pg 2)
- Paycheck remittance/stubs (last 4 checks stubs if paid weekly or 2 check stubs if paid bi-weekly). Need one month's worth of income.
- IRS Form W-2 or 1099 for the current tax return year
- Employer verification (dated, signed and applicant verified) – if you get paid in cash by an individual, then your employer will have to fill out the Employer Statement of Income letter. **Ask our staff for a copy of the letter.**
- Proof of participation in Government Assistance (food stamps, CDIC, Medicaid, TANF, etc)
- Benefit award letters from Social Security, Workers Compensation, or Unemployment Compensation Determination
- If you do not have income but get support from a family member or friend, then they will need to fill out a Letter of Support. **Ask our staff for a copy of the letter.**

Baylor Scott & White HEALTH

3. Photo Identification (not required)

- Government issued ID
- Picture ID (can be Matricula or other foreign expired ID)
- If you provided a letter of support for your proof of address, then the person whose utility bill is under must provide a picture ID

Application will not be complete until all required documents are received. If application is not complete, then it can cause delays in your referrals, orders and discounts for your medication. You will also be considered self-pay and responsible for paying for your visits.

The application and all documents can be brought into the clinic, uploaded via MyChart, faxed or emailed. All documents must be easy to read.

Financial Assistance Disqualification

Financial Assistance will be denied if the patient or responsible party provides false information regarding income, household size, assets or other resources available that might indicate financial means to pay for care.

You may be asked for some of this information again to qualify for other programs.

Copay fee

If you qualify for financial assistance, there is still a $10 copay fee to see our providers in person, via mybswhealth app or by phone. Failure to pay can cause interruptions to your care.

Copays help support our other programs, including preventive services, chronic disease, behavioral health, medication management, and pharmacy benefits.