



## HealthLink

### **Bitters**

288 Bitters Rd  
San Antonio, Texas 78216  
OFFICE: (210) 297-9906  
FAX: (210) 297-0982

### **Downtown**

311 Camden St #106  
San Antonio, Texas 78215  
OFFICE: (210) 297-7725  
FAX: (210) 297-0731

### **North Central**

525 Oak Centre, Suite #450  
San Antonio, Texas 78258  
OFFICE: (210) 297-4525  
FAX: (210) 297-0459

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#### **PATIENT INFORMATION**

NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ DATE OF SURGERY/INJURY: \_\_\_/\_\_\_/\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

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#### **RETIRED:** If yes skip this section

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

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#### **EMERGENCY CONTACT:**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
PHONE: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

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#### **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION DURING THIS ADMISSION**

Information about your health and health care treatment is filed in your medical record. This information is confidential and you control how the clinic releases this information during your stay. Therefore, please **CHECK ONE** of the following regarding how you wish to have information regarding your health and health care treatment released.

\_\_\_\_\_ **Privacy Code Choice A:**

I authorize the clinic to release the following:

1. Anyone who asks will be told I am in the clinic.
2. My immediate (which includes, husband/wife, parent, and child) will be told my diagnosis, medical history, treatment, and prognosis.
3. Those authorized by law will be told if I am being tested, examined, or treated for any of the following conditions:  
HIV, AIDS related conditions, psychiatric illness, drug/alcohol/chemical abuse.

\_\_\_\_\_ **Privacy Code Choice B:**

1. No one will be told I am in the clinic.
2. No one will be told my diagnosis, medical history, treatment, or prognosis.
3. No phone calls will be transferred to my room.
4. Those authorized by law will be told if I am being tested, examined, or treated for any of the following conditions:  
HIV, AIDS related conditions, psychiatric illness, drug/alcohol/chemical abuse.

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Patient Signature/Legally Authorized Representative

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DOB

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Clinic Representative/Witness

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Date





**NOTIFICATION of PATIENT RESPONSIBILITY**  
**For CO-PAYS and DEDUCTIBLES**

Your insurance policy requires the payment of co-payments, and/or deductible amounts from you at the time of service. Your insurance company also requires Baptist Health System to collect your co-payment or unmet deductible amount or we could be in violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

Baptist Health System has verified your insurance coverage. Based on the information your insurance company provided to us, the estimated amount that you are responsible for is:

Co-Payment amount: \_\_\_\_\_ per visit, then plan pays \_\_\_\_\_ %

Co-Insurance amount: \_\_\_\_\_ per visit, then plan pays \_\_\_\_\_ %

Deductible amount: \_\_\_\_\_

Deductible met: \_\_\_\_\_ for this year.

Patient has agreed to pay \$ \_\_\_\_\_ each visit to be applied towards deductible / co-ins.

We are required to collect the above amount prior to the start of each treatment session. Our front office staff can accept payment from you with a check, credit/debit card or cash. As a courtesy we will bill your insurance company for their portion of the bill.

Please verify that you understand your financial responsibility by signing and dating this form. Please let us know if we can assist you in any other way.

Thank you,

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Baptist Health System Representative: \_\_\_\_\_ Date: \_\_\_\_\_