HealthLink Consent for Treatment and Medical History

PATIENT NAME:____________________

DATE OF BIRTH:____________________

Patient Name:________________________________ Social Security #:________________________

Date of Birth (DOB):____________________________ Age:__________ Date of surgery/Injury:__________

Street Address:____

City:________________________ State:______________ Zip Code:____________________

Primary Phone:______________________________ Secondary Phone:______________________

E-mail:____

Primary Person on Insurance (If not patient):________________________________ DOB:____________

Referring Physician:____________________________ Primary Care Physician:____________________

Emergency Contact:____

Emergency Contact Phone:____________________________ Relationship:______________________

Is your injury/condition due to a car accident? ☐Yes ☐No Receiving Home Health? ☐Yes ☐No

Appointment Reminder Option (Check One): ________Call ________Text message

Consent to Medical and Related Health Care: I consent to the admission to Healthlink, an outpatient facility of Baptist Health System, referred to as "Facility", and consent to treatment and procedures that my doctor thinks are needed. I also understand that the delivery of health care services and treatment may involve risks of injury or even death. No guarantees are made to me regarding the result of examination or treatment at Healthlink.

Payment Agreement/Assignment of Benefits: I agree (on behalf of the patient, and, if I am the parent of a minor child, also on my own behalf) to pay all charges and expenses for services at the rates set by the Facility, unless a different rate is set by the Facility's contract with my managed care or insurance company. I understand that failure to pay these charges within 45 days after billing may result in referral to an agency or attorney for collection, in which case I agree to pay reasonable attorneys' fees and collection expenses in addition to the balance of the account. I agree that if the account results in a credit balance, this credit balance will be applied to any other debt I owe to the hospital and the balance refunded to me.

I assign to the Facility all (i) rights in benefits or compensation otherwise payable to me by any insurance company (this includes, but is not limited to, health or medical insurance coverage, auto or homeowners' insurance including uninsured motorist coverage and personal injury protection) and any other payor, and (ii) rights, claims and causes of action against anyone who may be financially responsible for the injury or illness which caused or contributed to my hospitalization, including funds from any settlement. I understand that it is not the Facility's responsibility to file claims or file suit on my behalf. It is my responsibility, within the applicable time limits, to seek all insurance reimbursement, obtain all proper pre-authorizations, file any lawsuits against any financially responsible parties, and appeal any denials. I understand that my failure to take these actions may result in a denial of reimbursement or money otherwise due me, in which case I would still be responsible for the full amount of the Facility bills.

PATIENT NAME:__________________

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Medicare/Medicaid Payment: If I have coverage through Medicare or Medicaid, I certify that the information given by me in assigning payment under Medicare or Medicaid is correct. I request that payment of authorized Medicare or Medicaid benefits be paid directly to this Facility on my behalf. I authorize this Facility to release any information about me that is necessary to act on this request for payment.

Attendance Policy: We respectfully request 24 hours advance notice of appointment cancellations. Consistent care is important for progress. If you have three (3) cancellations or two (2) no-shows, you will be discharged as a patient. Please speak to your therapist if extenuating circumstances arise.

Teaching: Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital or the Facility under appropriate supervision. Unless I notify the Facility that I do not want to participate in these educational programs, I agree that trainees may participate in and/or provide care to me while I am a patient at the Facility.

Personal Property: As a patient, I am encouraged to leave personal items at home. I have been informed by the Facility that the clinic maintains a place for personal effects. I understand that the Facility accepts no responsibility for loss of any personal effects that I or others bring to the clinic for me. I release this Facility and its agents for damage to or loss of my property.

Notice of Electronic Check Conversion: If I provide a check as payment, I authorize this Facility to use information from my check to make a one-time electronic funds transfer (EFT) from my account or to process the payment as a check transaction. If this Facility uses information from a check to make an EFT, the funds may be withdrawn from my checking account the same day.

Advanced Directives:

Patient has an advanced directive or living will: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has Medical Durable Power of Attorney: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Patient has designated a Health Care Surrogate: ☐No ☐Yes

If yes, copy provided? ☐No ☐Yes

Name of designated Health Care Surrogate: ______________________________

Phone Number: ____________________ Relationship to patient: _______________________

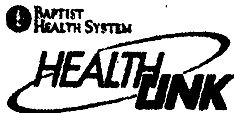
I would like to receive further information about Living Wills and other advanced directives: ☐No ☐Yes

Patient Rights and Responsibilities: I received Patient Rights and Responsibilities information explaining my rights and my responsibilities as a patient in this Facility, including how to file a complaint and grievance.

Consent to Contact:

I consent and authorize this Facility, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, debt collectors, and other contracted staff (any or all of these is referred to as "Provider") to use automated telephone dialing systems, text messaging systems and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to the health care law, health care coverage, care follow-up, and other healthcare information or (2) provide telemarketing messages (including pre-recorded messages) during a call or via text message that delivers a "health care" message made by, or on behalf of, a "covered entity" or its "business associate," as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103.

Telephone messages may be played by a machine automatically when the telephone is answered, whether answered by me or someone else. These messages may also be recorded by my answering machine. I give the Provider permission to call or send a text message to any telephone number. I give the Provider permission to play pre-recorded messages or send text messages with information about my transactions over the phone, and understand that such information may not be encrypted or secure.



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PATIENT NAME:____________________

DATE OF BIRTH:____________________

I promise that, unless I indicate otherwise, I own or customarily use the telephone numbers I give the Provider. I also promise to notify the Provider in writing within 30 days if I change phone number(s). I understand that Provider will continue to use the number I provide unless I provide notice of a change, and, therefore, failure to notify Provider may result in missed or delayed communications. I also give the Provider permission to communicate such information to me via electronic mail, and understand that such information may not be encrypted or secure.

I agree that the Provider will not be liable to me for any calls or electronic communications, even if information is communicated to an unintended recipient (including, for example, contacts to a previous number that I have not notified the Provider is no longer used by me).

I understand that, when I receive such calls or electronic communications, I may incur a charge from the company that provides me with telecommunications, wireless and/or Internet services. I agree that the Provider has no liability for such charges. I understand that consent to receive calls/messages is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt-out method that will be identified in the applicable communication.

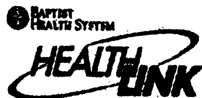
I have read and may request a copy of this form. I am the patient, the patient's legal representative, or am authorized by the patient as the patient's general agent to act on his or her behalf to accept the terms of this form. I understand and accept the terms of this Consent for Treatment form. If I have any questions, I have had an opportunity to ask questions about anything I don't understand.

____________________	____________________	__________	__________
Printed Name of Patient	Signature of Patient/Patient's Agent or Representative	Date	Time
____________________	____________________	__________	__________
Patient's DOB	Clinic Representative/Employee#	Date	Time

Translator: I have accurately and completely read the document to the patient or patient's representative in the language requested by the patient or patient's representative.

______________________________ ____________________
Translator Date / Time

______________________________ ____________________
Witness Date / Time



NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

PATIENT NAME:________________

DATE OF BIRTH:________________

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

________________________ Name of Patient

________________________ Signature of Patient

_______ / _______ / _______
Date Signed

________________________ Name Patient's Personal Representative

________________________ Signature of Patient's Personal Representative

_______ / _______ / _______
Date Signed

FOR INTERNAL USE ONLY

________________________ Name of Employee

________________________ Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other ________________________________

____ - ____ (Version: As noted on NPP)

____/____/____ (Date: As noted on NPP)

PATIENT NAME:__________________

DATE OF BIRTH:__________________

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to achknowledge that you authorize HEALTHLINK to disclose your PHI to the following individuals (check all that apply):

Name:______________________________ Relationship to Patient:______________________

Telephone:()__________________________ Email:______________________________

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

Name:______________________________ Relationship to Patient:______________________

Telephone:()__________________________ Email:______________________________

Types of Information: ☐ Appointment Reminders ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Secure Email ☐ Other:

Print Name of Patient	Signature of Patient/Patient's Agent or Representative	Date	Time
Patient's DOB	Clinic Representative/Employee #	Date	Time

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I hereby authorize HEALTHLINK CARDIAC REHAB (PHYSICIAN / HEALTH FACILITY) to release the information specified below relative to the following period of service: THROUGHOUT DURATION OF CARDIAC REHAB PROGRAM (MONTH / YEAR OF TREATMENT).

Name of Patient: ______

Address: ______ (STREET / CITY / STATE / ZIP)

Date of Birth: ______ SS#: ______ Phone: ______

Release To: ______ (FACILITY / INDIVIDUAL TO RECEIVE INFORMATION) for the purpose of CARDIAC CARE.

THE FOLLOWING INFORMATION IS TO BE RELEASED:

- ☐ Admission Face Sheet
- ☑ Billing Records/Financial Information
- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History and Physical Exam
- ☐ Lab Results
- ☑ Medication Record
- ☐ Nurse's Notes
- ☐ Operative Report
- ☑ Outpatient Record
- ☐ Physician Orders
- ☐ Respiratory Treatment Notes
- ☐ Progress Notes
- ☐ PT/RT/OT Record
- ☐ X-Ray Reports
- ☑ Other, please specify: any and all cardiac rehab records

I understand that upon release of the selected information above, this information may be subject to redisclosure by the recipient and Baptist Health System is not liable for redisclosure. The records to be furnished or reviewed include information concerning my case history and the treatment, examinations, or hospitalization, including but not limited to, any and all information related to testing, diagnosis and treatment for acquired immune deficiency syndrome (AIDS) or related disorders, if any. I, the undersigned, understand this information may include reference to psychiatric treatment or testing, evaluation, or treatment for substance abuse. The hospital, employees, and physician are released from liability for release of these records.

IMPORTANT — If patient deceased, please check one box below:

- ☐ I am the Administrator/Executor for the deceased and have attached the Letters / Testamentary.
- ☐ There is no court appointed Administrator/ Executor and I am the next of kin.

______ SPECIFY RELATIONSHIP TO THE DECEASED

______ SIGNATURE OF PATIENT ______ DATE

______ SIGNATURE OF PATIENTS LEGALLY ASSIGNED REPRESENTATIVE (WHEN APPLICABLE) ______ DATE

______ RELATIONSHIP TO PATIENT (WHEN APPLICABLE)

This information has been released to you from records where confidentiality is protected by Federal Law. Federal Regulations (42 Code of Federal Regulations, Part 2) prohibits you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A photocopy shall have the same effect as an original.

This authorization is subject to revocation at any time except to the extent that action has been taken. All requests for revocation must be in writing to the Health Information Management Department. This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.

Internal Use Only: ☐ Records Reviewed ☐ Copies Provided

Name:

Date of Birth:

■ Evaluation
☐ 18th Session
☐ Discharge

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? *(Use "O" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______
=Total Score:______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
⑤	⑤	⑤	⑤

Patient Signature: ______________________ Date:__________ Time: _________

Clinical Staff Signature: ______________________ Date: __________ Time: _________

NAME:

D.O.B:

THE DUKE ACTIVITY STATUS INDEX

■ Evaluation ☐ 18th Session ☐ Discharge

Circle Y (yes) or N (no) to the following questions:	YES or NO	Weight
1. Are you able to take care of yourself,that is, eating, dressing, bathing, or using the toilet yet?	Y N	2.75
2. Are you able to walk indoors, such as around the house yet?	Y N	1.75
3. Are you able to walk a block or 2 on level ground yet?	Y N	2.75
4. Are you able to climb a flight of stairs or walk up a hill without stopping?	Y N	5.50
5. Are you able to run a short distance?	Y N	8.00
6. Are you able to do light work around the house like dusting or washing dishes yet?	Y N	2.70
7. Are you able to do moderate work around the house like vacuuming, sweeping floors, or carrying in the groceries yet?	Y N	3.50
8. Are you able to do heavy work around the house like scrubbing floors or lifting or moving heavy furniture yet?	Y N	8.00
9. Are you able to do yard work like raking leave, weeding or pushing a power mower yet?	Y N	4.50
10. Are you having sexual relations?	Y N	5.25
11. Are you able to participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football yet?	Y N	6.00
12. Are you able to participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing yet?	Y N	7.50
SCORE (Staff will calculate for you):		

Patient Signature: ______________________ Date: __________ Time: __________

Clinical Staff Signature: ______________________ Date: __________ Time: __________

Functional Capacity in METS = (DASI score) x 0.43 + 9.6 then divide by 3.5 = ____ METs 50% ____METs 70% ____METs

♥RATE YOUR PLATE♥

Think about the way you usually eat. For each food choice, put a check mark in column A, B or C.
Bring the completed form to your next clinic visit.

	A	B	C
1. **MEAT CUTS*** *fresh beef, pork, lamb, veal*	☐ **Usually eat:** lean cuts from the round, loin or leg; ham Or, **seldom eat meat.**	☐ **Sometimes eat:** higher-fat cuts, such as chuck, ribs, brisket, Tbone steak, prime rib	☐ **Usually/often eat:** higher-fat cuts
2. **CHICKEN, TURKEY***	☐ **Usually eat:** **without** skin	☐ **Sometimes eat:** **with** skin	☐ **Usually eat:** **with** skin
3. **GROUND MEAT & POULTRY***	☐ **Usually eat:** 5-7% fat (93-95% lean); ground turkey breast Or, **seldom eat.**	☐ **Usually eat:** 10-15% fat; ground turkey (dark & white meat)	☐ **Usually/often eat:** regular ground meat, with 20% fat or more
4. **PROCESSED MEAT & POULTRY*** *cold cuts, hot dogs, sausage, breakfast meats*	☐ **Usually eat:** lower-fat choices from lean meat or poultry; veggie breakfast links Or, **seldom eat.**	☐ **Sometimes eat:** higher-fat choices, such as salami, bologna, hot dogs, bacon, sausage	☐ **Usually/often eat:** higher-fat choices
5. **PORTION SIZE OF MEAT & POULTRY*** *cooked or processed*	☐ **Usually eat:** small portions ($\leq$ 3 oz.) deck of cards size	☐ **Usually eat:** medium portions (4-6 oz.)	☐ **Usually/often eat:** large portions (7 oz. or more)
6. **FISH, SHELLFISH***	☐ **Usually eat:** twice a week or more, especially oily fish like salmon, herring or sardines	☐ **Usually eat:** any type once a week	☐ **Usually eat:** any type less than once a week
7. **COOKING METHOD*** *for poultry, fish, meat*	☐ **Usually:** cook without added fat or use vegetable oil spray	☐ **Sometimes:** cook with added fat or deep fry	☐ **Usually/often:** cook with added fat or deep fry
8. **MEATLESS MEALS** *veggie burgers, vegetable or bean soups, meatless spaghetti sauce, tofu, rice & beans*	☐ **Usually eat:** twice a week or more	☐ **Usually eat:** less than twice a week	☐ **Rarely eat:** meatless meals
9. **WHOLE EGGS***	☐ **Usually eat:** 3 or less a week OR egg substitutes OR egg whites only	☐ **Sometimes eat:** 4 or more a week	☐ **Usually eat:** 4 or more a week
10. **MILK** *includes yogurt, cream*	☐ **Usually use:** 1% or skim milk, fat-free or low-fat yogurt, fat-free ½ & ½	☐ **Sometimes use:** 2% or whole milk, fullfat yogurt, regular ½ & ½	☐ **Usually use:** 2% or whole milk, fullfat yogurt, light cream
11. **CHEESE*** *includes cheese for pizza, sandwiches, snacks, mixed dishes, etc.*	☐ **Usually eat:** reduced-fat or part-skim Or, **seldom eat.**	☐ **Sometimes eat:** regular cheese, such as cheddar, Swiss, and American	☐ **Usually eat:** regular cheese
12. **DAIRY FOODS** *1 serving = 1 c. milk or yogurt, 1½ oz. cheese*	☐ **Usually eat or drink** 2 or more servings a day	☐ **Usually eat or drink:** 1 serving a day	☐ **Rarely eat or drink**

*If you are a vegetarian, check column A for these (*) topics.

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13. WHOLE GRAINS *1 serving = 1 oz slice bread; ½ English muffin; 1 c. cereal; ½ c. rice, pasta; 5 crackers; tortilla; mini bagel, 3 c. light popcorn*	☐ **Usually eat:** **3 or more servings a day**, 100% whole wheat bread & pasta, brown rice, whole grain cereals, i.e., oatmeal, raisin bran, Wheaties□	☐ **Sometimes eat:** 1 or 2 servings a day	☐ **Usually eat:** mostly refined grains, i.e., white bread, white rice, saltine crackers, corn flakes, Rice Krispies□, Special K□
14. FRUITS & VEGETABLES *includes legumes* *1 c. = medium whole fruit or potato, large tomato or ear corn, 2 c. raw leafy greens*	☐ **Usually eat:** 4-5 cups a day	☐ **Usually eat:** 2-3 cups a day	☐ **Usually eat:** 0-1 cup a day
15. COOKING METHOD *for vegetables, pasta, rice*	☐ **Usually prepare:** without fat & sauces OR use vegetable oil spray	☐ **Sometimes prepare:** with sauce, butter, margarine, oil	☐ **Usually prepare:** with sauce, butter, margarine, oil
16. FAT TYPE IN COOKING *includes baking*	☐ **Usually use:** olive or Canola oil Or, usually cook **without** added fat.	☐ **Usually use:** other oils, tub margarine	☐ **Usually use:** butter, bacon drippings, stick margarine, lard, shortening
17. SALT FROM PROCESSED FOODS	☐ **Always/usually:** *compare and choose lower-sodium options*	☐ **Sometimes:** *consider sodium content*	☐ **Rarely/never:** *consider sodium content*
18. SPREADS *added at the table on bread, potatoes, vegetables, pancakes, sandwiches, etc.*	☐ **Usually use:** spray or light tub margarine Or, **seldom use.**	☐ **Usually use:** regular tub margarine	☐ **Usually use:** butter or stick margarine
19. SALAD DRESSINGS, MAYONNAISE	☐ **Usually use:** fat-free or low-fat salad dressings & mayonnaise Or, **seldom use.**	☐ **Usually use:** light salad dressings & mayonnaise	☐ **Usually use:** regular salad dressings & mayonnaise
20. SNACK FOODS	☐ **Usually eat:** plain pretzels, light popcorn, baked chips Or, **seldom eat.**	☐ **Sometimes eat:** regular chips & popcorn, flavored pretzels	☐ **Usually/often eat:** regular chips & popcorn
21. NUTS, SEEDS *includes nut butters* *serving size =1/4 c. nuts, 2 T. peanut butter*	☐ **Usually eat:** 3 servings or more a week	☐ **Usually eat:** 1-2 servings a week	☐ **Usually eat:** 1 or less serving a week Or, **seldom eat.**
22. FROZEN DESSERTS	☐ **Usually eat:** sherbet, sorbet, fruit juice bars, low-fat ice cream or frozen yogurt Or, **seldom eat.**	☐ **Sometimes eat:** regular ice cream, ice cream bars/sandwiches	☐ **Usually eat:** regular ice cream, ice cream bars/sandwiches
23. SWEETS, PASTRIES, CANDY	☐ **Usually eat:** angel food cake, low-fat or fat-free products Or, **seldom eat.**	☐ **Sometimes eat:** donuts, cookies, cake, pie, pastry, or chocolate candy	☐ **Usually/often eat:** donuts, cookies, cake, pie, pastry or chocolate candy

24. EATING OUT *eat in or take out, any meal*	☐ **Seldom eat out** Or, **usually choose lower-fat menu items**	☐ **Usually eat:** 1-2 times a week	☐ **Usually eat:** 3 times a week or more

Find your Rate Your Plate score:

Total checks in column A =_______________ x 3 = ____________
Total checks in column B =_______________ x 2 = ____________
Total checks in column C =_______________ x 1 = ____________

TOTAL __________

If your score is:

58 - 72: You are making many healthy choices.

41 - 57: There are some ways you can make your eating habits healthier.

24 - 40: There are many ways you can make your eating habits healthier.

Look at your Rate Your Plate responses.

Do you have any responses in Column A? If you do, great! You are already making some heart healthy choices. Look at your responses in Columns B and C. Where you checked Column C, can you start eating more like Column B? Over time, move toward Column A.

Think about changes. Write down eating changes you are **ready to consider**.

Change #1: ____

Change #2: ____

Change #3: ____

Begin today. Make changes a little at a time. Let your new way of eating become a healthy habit.

Set goals. After discussion with your doctor, write down eating changes you are **ready to work on.**

Goal 1: ____

Goal 2: ____

Goal 3: ____

Patient Signature: ________________________ Date: __________ Time: __________

Clinical Staff Signature: ________________________ Date: __________ Time: __________

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