Patient's Communication Preferences Regarding Their PHI

TELEPHONE COMMUNICATION PREFERENCES

Home _____

Work _____

Mobile Phone _____

Other _____

EMAIL COMMUNICATION PREFERENCES

Email Address: _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that **Texas Interantional Endoscopy Center** or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, **Texas Interantional Endoscopy Center** or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

TEXT MESSAGE COMMUNICATION PREFERENCES

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update **Texas Interantional Endoscopy Center** when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient Signature for Consent to Text Message.

MAIL COMMUNICATION PREFERENCES

May we send mail to your home address? ❑ Yes ❑ No ***(If no, please provide an alternate mailing address below.)***

_____

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	**Telephone**
❑ Spouse	_____	_____
❑ Caretaker	_____	_____
❑ Child	_____	_____
❑ Parent	_____	_____
❑ Other	_____	_____

Do you have health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

I acknowledge that I have been given the opportunity to request restriction on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature — Date

_____ _____

Printed Name — Relationship to Patient

TEXAS INTERNATIONAL ENDOSCOPY CENTER

TIEC-PHI 11/15
ARMADILLO PRESS

Patient's Communication Preferences Regarding Their PHI

PATIENT INFORMATION

TEXAS INTERNATIONAL ENDOSCOPY CENTER

State Required Ethnicity and Race Questions

BACKGROUND INFORMATION

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.

If patients fail or refuse to identify their own race and ethnic backgrounds, facility staff will use its best judgment in making the identification.

QUESTIONS

Question #1: Nationality or Ethnic Background

(mark the box that most accurately identifies the patient's ethnic background)

Is the patient...?

- ❑ **(1) Hispanic/Latino** (21352)
- ❑ **(2) Not Hispanic/Latino** (21865)
- ❑ **I (patient or patient's legal guardian) refuse to answer the question.**

Question #2: Race

(mark the box that the patient believes most accurately identifies his/her race)

Is the patient...?

- ❑ **(1) American Indian/Eskimo/Aleut** (10025)
- ❑ **(2) Asian or Pacific Islander** (20289)
- ❑ **(3) Black** (20545)
- ❑ **(4) White** (21063)
- ❑ **(5) Other** *Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.* (21311)
- ❑ **I (patient or patient's legal guardian) refuse to answer the question.**

Patient or Legal Guardian Signature _____ Date _____