Baylor Family Medicine at Frisco

Patient Demographic Information

TODAY'S DATE:__________________________ CHART #:________________________

PATIENT INFORMATION:

FULL NAME:____
LAST FIRST MI

SEX: MALE FEMALE

BIRTHDATE: ________/________/________

ADDRESS:____APT# __________

SOCIAL SECURITY:_______-________-_______

____
CITY STATE ZIP

PRIMARY(Best #) :_______________________

SECONDARY# : _________________________

EMPLOYER: __________________________________ EMPLOYER PH #:______________________OCCUPATION: ________________________

EMERGENCY CONTACT NOT LIVING AT SAME ADDRESS:_____________________________ CONTACT PH # :(____)________________

How did you learn of our practice? ____

Martial Status: S M D W

Do you have a living will on file? __________________________

Race (circle one) American Indian Asian Black Hispanic White Other

IF PATIENT IS MINOR: (RESPONSIBLE PARTY)

FULL NAME:____
LAST FIRST MI

SEX: MALE FEMALE

ADDRESS:____

BIRTHDATE: ________/________/________

SOCIAL SECURITY:_______-________-________

HOME PHONE # :(_____)___________________

____
CITY STATE ZIP

PATIENT RELATION TO GUARANTOR: SELF SPOUSE DEPENDENT

DRIVER LICENSE #:_______________________

EMPLOYER:______________________________OCCUPATION: ________________________ EMPLOYER PH # :(_____)___________________

INSURANCE INFORMATION: INSURANCE CARD REQUIRED TO FILE INSURANCE

PRIMARY INSURANCE:____

ID #:_________________________________

ADDRESS:____

GROUP #:____________________________

____
CITY STATE ZIP

INSURANCE PH. # (_______) ______________

INSURED'S NAME____

SOCIAL SECURITY #:______-________-________

INSURED'S BIRTHDATE:___________/________/__________

PT. RELATION TO INSURED________________

INSURED'S EMPLOYER:____

EMPLOYER PHONE # :(____) ______________

EMPLOYER ADDRESS:____

SECONDARY INSURANCE:____

ID #:_________________________________

ADDRESS:____

GROUP #:____________________________

____
CITY STATE ZIP

INSURANCE PH. # (_______) ______________

INSURED'S NAME____

SOCIAL SECURITY #:______-________-________

INSURED'S BIRTHDATE:___________/________/__________

PT. RELATION TO INSURED________________

INSURED'S EMPLOYER:____

EMPLOYER PHONE # :(____) ______________

EMPLOYER ADDRESS:____

HEALTHTEXAS PROVIDER NETWORK
NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/ Information

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians[1] with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at www.baylorhealth.edu.; and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to

[1] *Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.*

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 02/01/06
VERSION: 2

Patient Name:_______________________________ Patient Identifier:___________________________

ACKNOWLEDGMENT OF THE RECEIPT OF HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

____ ____________________

(Signature of Patient or Legal Representative) **(Date)**

February 1, 2006
(Effective Date of *Notice*)

[1]Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

Patient Name:____ Patient Identifier #:______________________________

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to ***(Baylor Family Medicine at Frisco)*** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

____________________________________	________________________
Name	Relationship
____________________________________	________________________
Name	Relationship
____________________________________	________________________
Name	Relationship

__________I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:
[ ] OK to leave message with detailed information [ ] Leave message with call-back number only	[ ] OK to leave message with detailed information [ ] Leave message with call-back number only

[ ] Written Communication

- [ ] OK to mail to my home address____
  ____
  ____
- [ ] OK to mail to my work/office address____________________________________
  ____
  ____
- [ ] OK to fax to this number____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

______________________________________ ______________________________________
Signature of Patient or Legal Representative Date

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for ________________________to authorize evaluation and treatment for my
(Minor's Name(s): First & Last)
child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____

Signature of Patient, Parent, or Legal Guardian **Date**
Please print name (if different from patient name below):___________________________

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HTPN") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HTPN. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HTPN, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

____

Signature of Patient, Parent, or Legal Guardian **Date**
Please print name (if different from patient name below):___________________________

PATIENT NAME:_____________________________________MR#________________

DEMOGRAPHIC INFORMATION

NAME_________________________________ BIRTH DATE_______________ SEX_______ TODAY'S DATE______________

MARRIED______ SINGLE______ DIVORCED______ WIDOWED______ NUMBER OF PREVIOUS MARRIAGES________

PROBLEM THAT BROUGHT YOU HERE TODAY____

PAST MEDICAL HISTORY (Please check if you have or have had any of the following conditions)

____ ARTHRITIS	____ DIABETES	____ ASTHMA	____ HIGH BLOOD PRESSURE
____ STROKE	____ GERD/HRTBURN	____ MIGRAINE HA	____ HYPOTHYROIDISM
____ SKIN CANCER	____ HEART ATTACK	____ DEPRESSION	____ HIGH CHOLESTEROL
____ HEPATITIS ____ (Type)	____ OSTEOPOROSIS	____ ANXIETY	____ CANCER (Type) ________________________

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE (Please list here)_______________________________________

____

PREVIOUS SURGERY AND/OR HOSPITALIZATION (Please list here)

REASON	HOSPITAL	DOCTOR	YEAR
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________
______________________________	___________________	_________________	________

HISTORY OF SEXUALLY TRANSMITTED DISEASES (Please list) ____

HISTORY OF ALLERGY TO MEDICATIONS OR OTHER SUBSTANCES (Please list)________________________________

____

FAMILY HISTORY: Please indicate in the spaces below any family members with a history of **Tuberculosis, Diabetes, Heart Disease, Cancer (Type), Emphysema, Kidney Disease, Asthma, Bleeding Tendencies, Anemia, Seizure Disorders, Glaucoma, High Blood Pressure, Gout, Arthritis, Ulcers, Stroke, Anxiety or Depressive Disorders.**

	IF LIVING		**IF NOT LIVING**	
	AGE	HISTORY OF ILLNESS	AGE AT DEATH	CAUSE
FATHER	_________	_________________________	______________	__________________
PATERNAL GRANDFATHER	_________	_________________________	______________	__________________
PATERNAL GRANDMOTHER	_________	_________________________	______________	__________________
MOTHER	_________	_________________________	______________	__________________
MATERNAL GRANDFATHER	_________	_________________________	______________	__________________
MATERNAL GRANDMOTHER	_________	_________________________	______________	__________________
BROTHERS	_________	_________________________	______________	__________________
	_________	_________________________	______________	__________________
SISTERS	_________	_________________________	______________	__________________
	_________	_________________________	______________	__________________
SONS	_________	_________________________	______________	__________________
DAUGHTERS	_________	_________________________	______________	__________________

SOCIAL HISTORY:

OCCUPATION (Current or previous if retired) ____RECENT CHANGE? Y / N

EDUCATIONAL LEVEL, DEGREES, OTHER TRAINING____

RELIGIOUS PREFERENCE ____

DO YOU EXERCISE REGULARLY? Y / N HOW OFTEN?________________ TYPE___________________________

TOBACCO USE? (SMOKE OR CHEW) Y / N IF YES, AMOUNT DAILY __________NUMBER OF YEARS USE_____

ALCOHOL USE? Y / N IF YES, AMOUNT OF ALCOHOL IN AN AVERAGE: DAY____ WEEK____ MONTH____

AMOUNT OF CAFFEINE DAILY ____

HIV RISK FACTORS (Circle) UNPROTECTED SEX IV DRUG USE TRANSFUSION (Before 1980) OTHER STD
EXPOSURE TO HIV+ PERSON HEALTHCARE WORKER PROMISCUITY

MEDICINE LIST:

DRUG	STRENGTH	USAGE

SPECIALISTS: Please list any specialists that you are seeing and the medical problem you are seeing them for.

DOCTOR	SPECIALTY	MEDICAL PROBLEM

FEMALES ONLY:

AGE AT ONSET OF PERIODS ______

DURATION OF PERIODS ______

INTERVAL BETWEEN PERIODS ______

REGULAR ______ IRREGULAR ______

LAST MENSTRUAL PERIOD __________

AGE WHEN PERIODS CEASED ______

NUMBER OF PREGNANCIES ______

NUMBER OF MISCARRIAGES ______

PRESENT BIRTH CONTROL METHOD______________________________

HAVE YOU HAD AN ABORTION? Y / N IF SO, NUMBER? __________

DO YOU DO SELF BREAST EXAMS? Y / N CONCERNS? Y / N

IF MENOPAUSAL, VAGINAL BLEEDING SINCE? Y / N

VAGINAL DISCHARGE? Y / N PAINFUL PERIODS? Y / N

PAIN WITH INTERCOURSE? Y / N HEAVY PERIODS? Y / N

BLOATED AND IRRITABLE BEFORE PERIODS? Y / N

OTHER CONCERNS? ____

DO YOU HAVE NOW, OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING?

CONSTITUTIONAL	YES	NO
FEVER/CHILLS	____	____
WT. GAIN	____	____
WT. LOSS	____	____
FATIGUE	____	____
NIGHT SWEATS	____	____
INSOMNIA	____	____
SNORING	____	____
SKIN		
RASH	____	____
NONHEALING WOUNDS	____	____
SUSPICIOUS MOLES	____	____
ITCHING	____	____
DRY SKIN	____	____
HEAD		
CONCUSSION	____	____
HAIR LOSS	____	____
SCALP PROBLEMS	____	____
EYES		
VISION CHANGES	____	____
DOUBLE VISION	____	____
BLURRED VISION	____	____
NIGHT BLINDNESS	____	____
ITCHY EYES	____	____
MATTERING	____	____
EARS		
HEARING LOSS	____	____
RINGING IN EARS	____	____
DIZZINESS	____	____
EXCESSIVE WAX	____	____
NOSE		
RUNNY NOSE	____	____
CONGESTION	____	____
SNEEZING	____	____
NOSE BLEEDS	____	____
MOUTH/THROAT		
PAIN	____	____
PROBLEMS SWALLOWING	____	____
HOARSENESS	____	____
CAVITIES	____	____
NECK		
PAIN/STIFFNESS	____	____
SWOLLEN GLANDS	____	____
RESPIRATORY		
COUGH	____	____
SHORTNESS OF BREATH	____	____
SOB WITH EXERCISE	____	____
WHEEZING	____	____
NIGHT PROBLEMS	____	____
CARDIOVASCULAR		
CHEST PAIN/PRESSURE	____	____
PALPITATIONS	____	____
SWELLING OF ANKLES	____	____
EXERCISE INTOLERANCE	____	____
GASTROINTESTINAL		
ABDOMINAL PAIN	____	____
NAUSEA/VOMITING	____	____
DIARRHEA	____	____

	YES	NO
CONSTIPATION	____	____
HEARTBURN	____	____
TARRY STOOLS	____	____
BLOODY STOOLS	____	____
OTHER STOOL CHANGES	____	____
BREAST		
PAIN	____	____
MASS	____	____
NIPPLE DISCHARGE	____	____
DO YOU DO SELF EXAMS?	____	____
GENTOURINARY (MALE)		
BURNING WITH URINATION	____	____
FREQUENT URINATION	____	____
BLOOD IN URINE	____	____
URINATION AT NIGHT (____ TIMES)	____	____
PROBLEM INITIATING STREAM	____	____
DISCHARGE	____	____
INCONTINENCE (URINE LEAKAGE)	____	____
ERECTILE DYSFUNCTION	____	____
LACK OF SEX DRIVE	____	____
GENITOURINARY (FEMALE)		
BURNING WITH URINATION	____	____
FREQUENT URINATION	____	____
BLOOD IN URINE	____	____
URINATION AT NIGHT (____ TIMES)	____	____
DISCHARGE	____	____
ODOR	____	____
ITCHING	____	____
INCONTINENCE (URINE LEAKAGE)	____	____
PAINFUL INTERCOURSE	____	____
LACK OF SEX DRIVE	____	____
MUSCULOSKELETAL (MUSCLE AND JOINT)		
PAIN	____	____
STIFFNESS	____	____
SWELLING	____	____
LOSS OR DECREASE OF MOVEMENT	____	____
HEMATOLOGIC (BLOOD)		
EASY BRUISING	____	____
EASY BLEEDING/POOR CLOTTING	____	____
SWOLLEN GLANDS	____	____
ENDOCRINE (HORMONES)		
HEAT INTOLERANCE	____	____
COLD INTOLERANCE	____	____
EXCESSIVE HUNGER	____	____
EXCESSIVE THIRST	____	____
EXCESSIVE URINATION	____	____
HAIR LOSS	____	____
NEUROLOGIC (NERVOUS SYSTEM)		
HEADACHE	____	____
NUMBNESS	____	____
WEAKNESS	____	____
TINGLING	____	____
TREMOR	____	____
FAINTING	____	____
PSYCHIATRIC (MENTAL HEALTH)		
DEPRESSION	____	____
ANXIETY	____	____
MEMORY LOSS/PROBLEMS	____	____
IRRITABILITY	____	____

FEMALES

***Please list the DATE (month and year) of the studies or shots that you have had for your CURRENT age**

Age	18-24	25-39	40-49	50-64	65+
Flu Shot (yearly)					
Tetanus (every 10 years)					
Cholesterol (every five years)					
Cervical CA Screen (yearly pap smear)					
Breast Examination (yearly by doctor)					
Breast CA Screen (yearly mammogram)					
Colon CA Screen (yearly fecal occult blood test)					
Colon CA Screen (colonoscopy at least every ten years)					
Pneumonia Vaccine (one time)					
Bone Scan (yearly osteoporosis screen)					

MALES

Age	18-24	25-39	40-49	50-64	65+
Flu Shot (yearly)					
Tetanus (every 10 years)					
Cholesterol (every 5 years)					
Colon CA Screen (yearly fecal occult blood test)					
Colon CA Screen (colonoscopy at least every ten years)					
Prostate CA Screen (yearly)					
Pneumonia Vaccine (one time)					

Electronic Communications to Patients

Baylor Office EHR is a joint effort of HealthTexas Physician Network physicians and other physicians aligned with Baylor Health Care System to fully support an electronic patient care experience through implementation of a common electronic health record platform. HealthTexas Physician Network ("HTPN") is pleased to offer Baylor Office EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

Use of Electronic Communication from HTPN to the Patient

Please check the appropriate box below:

☐ Yes, I want HTPN to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

E-mail address (please print):

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

☐ No, I do not want HTPN to use electronic communication as a way to communicate my information to me.

HTPN E-mail Guidelines

- At this time, HTPN can only send e-mails *to* patients. Currently, HTPN is not able to *accept* patient e-mails.
- All e-mail you receive from HTPN is sent under the name and e-mail account of DFW Centricity.
- The patient is responsible to notify HTPN promptly of any changes to his/her e-mail address.
- All of HTPN's electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- HTPN will not share your e-mail address with anyone unauthorized to view your medical record.

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from HTPN. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

______________________________ ____________________

Name *Date*

Patient Instructions for Secure Messages

1. You will receive an email in your Inbox from BaylorofficeEHR@BaylorHealth.edu or name@BaylorHealth.edu (the name may be the physician or nurse). Note: please make sure you have your email set up to accept emails with the domain BaylorHealth.edu so it will not be discarded as SPAM mail.

2. Open the email and **click** on the link in the message.

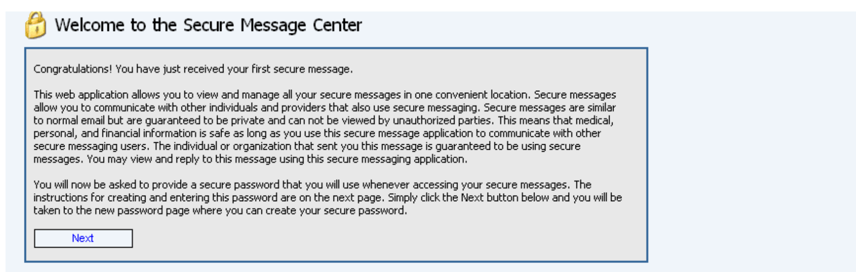
BAYLOR Office EHR

Secure Message

You have received a secure message from Marek, Deirdre [DeirdreM@BaylorHealth.edu] .

To retrieve this message click on the following link
https://tst.baylorpatient.com/mc10/ViewMessage.aspx?key=4aadbwb8iESUQH_48Q5s75-G5GcnYw

3. A welcome greeting will appear that describes Secure Messaging. **Click** Next Next.



Welcome to the Secure Message Center

Congratulations! You have just received your first secure message.

This web application allows you to view and manage all your secure messages in one convenient location. Secure messages allow you to communicate with other individuals and providers that also use secure messaging. Secure messages are similar to normal email but are guaranteed to be private and can not be viewed by unauthorized parties. This means that medical, personal, and financial information is safe as long as you use this secure message application to communicate with other secure messaging users. The individual or organization that sent you this message is guaranteed to be using secure messages. You may view and reply to this message using this secure messaging application.

You will now be asked to provide a secure password that you will use whenever accessing your secure messages. The instructions for creating and entering this password are on the next page. Simply click the Next button below and you will be taken to the new password page where you can create your secure password.

Next

4. On the initial log-in, you will need to create a password. **It is important that you write down your password and put it in a secure location** because this same password will be used with any future messages received from your provider. **Type** in the information and **click** set password Set Password.

Please create a password that will be used to access all your secure messages.
Passwords must contain a combination of letters and numbers and be between 6 and 15 characters long.

New Password

••••••••

Confirm Password

••••••••

Please select a hint question that will be used in case you forget your password.
Hint Question

What is your favorite pet's name?

You will be asked for the answer to your hint question if you forget your password.
Hint Answer

lady

Set Password Cancel

5. If you forget your password and attempt to enter the system, you will get locked out after three bad password attempts to enter your account. You will be locked out for 20 minutes before you can try again. Please make a note of your password and put it in a secure location. If you are still unable to get into the system, please contact BHNI@BaylorHealth.edu for help.

6. You will be able to **view the secure message but will not have the option to reply**.