Digestive & Liver Disease Consultants, P.A.

Comprehensive Gastrointestinal & Hepatology: Consultative, Endoscopy & Motility Services

PATIENT CONSENT FORM

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby authorize Digestive & Liver Disease Consultants, PA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand while this consent is voluntary, if I refuse to sign this consent, DLDC can refuse to treat me.

I have been informed that Digestive & Liver Disease Consultants, PA has prepared a notice ("Notice of Privacy Practices"), which more fully describes the uses, and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Digestive & Liver Disease Consultants, PA in writing; however, if I revoke my consent, such revocation will not affect any actions that Digestive & Liver Disease Consultants, PA took before receiving my revocation.

I understand that Digestive & Liver Disease Consultants, PA has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Digestive & Liver Disease Consultants, PA restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Digestive & Liver Disease Consultants, PA does not have to agree to such restrictions, but that once such restrictions are agreed to, Digestive & Liver Disease Consultants, PA must adhere to such restrictions.

NOTICE TO PATIENTS - COVID-19

During this COVID-19 Pandemic, I have come to the clinic by myself for a consultation and treatment. If I am an asymptomatic carrier or an undiagnosed patient with COVID19, I suspect that I may put at risk doctors and staff; it is my responsibility to take appropriate precautions and to follow all the Protocols during my visit as instituted by the practice. I also know that I may get an infection from the office or from a doctor or any other healthcare provider and I will take all precautions during this visit. I will not hold doctors and hospital staff in the event I / my accompainent(s) are tested positive for COVID-19 in the future.

_____ Initial: I have read the above and hereby consent

NOTICE TO PATIENTS - PHYSICIAN ASSISTANT

This organization has on staff a Physician Assistant (PA) to assist in the delivery of medical care. A Physician Assistant is not a doctor; however, a PA is a graduate of a certified training program and is licensed by the state medical board. Under the supervision of a physician, a PA can diagnose, treat and monitor common acute and chronic diseases as well as provide routine health maintenance care. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities and accepting responsibility for the medical services provided.

_____ Initial: I have read the above and hereby consent to the services of a PA for my health care needs as deemed necessary. I understand that at any time, I can refuse to see the PA and request to see a physician.

PHYSICIAN OWNERSHIP DISCLOSURE

During the course of your physician / patient relationship with the physicians of Digestive & Liver Disease Consultants, PA: Guru N. Reddy, MD, FACP, FACG, FASGE, AGAF or Howard B. Hamat, MD, FRCP ("Physicians"), your physician may refer you to Memorial Hermann North Houston Endoscopy & Surgery, LLC ("Center"). The address of the Center is 275 Lantern Bend Dr. Suite 400, Houston, TX 77090.

In connection with any referral to the Center, you are hereby advised that the above listed Physicians have an investment interest in the Center. This information is being provided to you to help you make an informed decision regarding your health care. You have the right to choose your healthcare provider. You have the option of obtaining health care ordered by your physician at a different facility other than Memorial Hermann North Houston Endoscopy & Surgery, LLC. You will not be treated differently by your physician or Memorial Hermann North Houston Endoscopy & Surgery, LLC if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact the Business Office via phone at (281) 440-0101 ext 1126, by email at destes@gimed.net or by parcel post to 275 Lantern Bend Dr. Suite 200, Houston, TX 77090.
By signing below you acknowledge that should you be referred to the Center, your signature below evidences your informed decision to decline the option to have your health care provided at another healthcare facility. Lastly, you further acknowledge by signing below that you signed the Physician Ownership Disclosure Form prior to your Physician's referral of you to the Center.

Printed Name:_____ Signature: _____

ADVANCED BENEFICIARY NOTICE (ABN)

Thank you for choosing DLDC as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ABN Policy, which we require that you read and sign prior to your treatment. All patients must review and update their demographic information ("Patient Face Sheet") prior to seeing their physician. We accept cash, checks, Visa/MasterCard, Discover and American Express.

We accept assignment of insurance benefits; however, your insurance carrier / carriers may not cover office visits or procedures for screening purposes.

_____ Initial: I have been informed and understand that my insurance carrier may not cover these routine tests. I agree to pay for these services if they are denied. (Note: Self-Pay procedures paid in full at the time the appt is scheduled, will receive a 20% discount off the cost of the procedure.)

All co-pays, deductible, coinsurance and out of pocket responsibilities are due at the time services are rendered. Prepayments resulting from deductible, coinsurance and out of pocket responsibilities as required by your insurance company, for the physician fees associated with procedures, are due 72 hours prior to procedure.

_____ Initial: I release Digestive & Liver Disease Consultants, PA of any financial responsibility for fees from any outpatient entity, laboratory, pathologist, anesthesiologist or hospital. I understand that these fees are separate from Digestive & Liver Disease Consultants, PA.

ADVANCED DIRECTIVES

- Do you have an Advance Directive to help you communicate your medical treatment wishes at some time in the future when or if you are unable to make your wishes known due to illness or injury?

  Circle one: **YES** **NO but I want to discuss** **NO and I DECLINED to discuss**

***If yes, please provide a copy of this legal document for your records.** _____

- Do you have a legal Medical Power of Attorney? Circle one: **YES** **NO**

***If yes, please provide a copy of this legal document for your records.** _____

CANCELLATION / NO-SHOW POLICY

A 24-hour notice is required if you are unable to keep your appointments. All no-shows or cancellations without 24-hour notice will result in a charge to your account of either $25 for office visits, $50 for ancillary testing, $50 for procedures.

I have read, understand and agree to Digestive & Liver Disease Consultants, PA's Patient Consent Form including the Consent for Release of Information for Treatment, Payment & Health Care Operations, Notice to Patients - Physician Assistant, Physician Ownership Disclosure, Advance Beneficiary Notice (ABN), Advanced Directives and Cancellation / No-Show Policy contained herein.

_____ _____

Signature of patient or patient's representative **Date**

_____

Printed name of patient or patient's representative

_____ _____

Relationship to the patient **Witness**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan & direct my treatment & follow-up among the Office of DLDC, & their employees.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the opportunity to read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Office of Digestive & Liver Disease Consultants, PA has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time at the address below to obtain a current copy of this notice.

Attn: Privacy Compliance Officer
Digestive & Liver Disease Consultants,
275 Lantern Bend, Suite 200
Houston, TX 77090

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand this office is not required to agree to my restrictions, but if they do agree then they are bound to abide by such. I also understand that I can designate persons other than myself to receive information about me.

Those persons and relationship to myself are as follows:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____
(If patient is a minor, otherwise leave blank)

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Acknowledgement, but was unable to do so as documented below.

DATE _____ INITIALS _____

REASON _____

Financial Policy and Patient Consent Form

Digestive & Liver Disease Consultants, PA (DLDC) recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstandings concerning protected health information and payment for professional services.

For the safety and protection of our patients and DLDC, we ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay).

1. **PAYMENT: Payment is expected at the time of service**. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though Insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $35 charge for returned checks. If not paid within 60 days, DLDC will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

2. **SELF PAYMENT (PRIVATE PAY, CASH PAYMENT)**: If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

3. **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit without a referral authorization your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. By signing below, the patient acknowledges that it is the patient's responsibility to be aware of what services are covered, and agrees to pay for any service deemed to be non-covered or not authorized by the plan.

4. **MEDICARE**: DLDC physicians are participating providers with the Medicare program and accept as payment: the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You will be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

5. SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify the provider in the future, immediately, of any additions, changes or deletions in primary or secondary insurance coverage. Initial/complete as applicable.

_____ I have no secondary insurance coverage.

_____ I have secondary insurance coverage as described on the attached Patient Demographic form.

6. OUTSTANDING BALANCES: After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility. All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

7. NO-SHOWS: If you miss your appointment or do not give at least 24 hours notice, you will be charged a 25.00 fee for a missed appointment, a $50.00 fee for a missed procedure or outpatient surgery, and a $50.00 fee for any in office testing/ancillary services. This cannot be billed to insurance. This fee will need to be paid before you are allowed to schedule another appointment.

DLDC firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions, or need clarification regarding these policies, please call us at (281) 440-0101.

_____

Patient Name (Please Print) **Patient Date of Birth**

_____

Signature (Insured/ Guardian) **Date**