DHAT

Digestive Health Associates
of Texas, P.A.

Physician you are seeing: ________________________ Referred By: ____

Patient Name: ____
Last First Middle Initial

Address: ____
Street Apt# City State Zip

DOB: ______________ Age: ____ Sex: M / F Social Security # ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Primary #__________________ Cell # ____________________ Work # _________________

Patient Authorization for Communication via Alternative Means

I authorize **Digestive Health Associates of Texas, P.A.** (DHAT) to communicate my protected health information ("PHI") in the manner indicated below. I understand that it is my responsibility to notify the DHAT of any change in this manner of communications. I further understand that my PHI may be subject to redisclosure, as described on Page 7.

(Check the box that applies)

☐ Primary # ☐ Cell # ☐ Work # ☐ U.S. Mail ☐ E-Mail ☐ Fax #____________________

☐ Leave detailed messages on my answer machine/voicemail

☐ Leave brief message with only call back number, name and doctor's office on my answering machine/voicemail

Email: ____

Employer: ____________________________________ Address: ____

Patient Ethnicity: ____________________________ (Declined) ______

Patient Race: ____________________________ (Declined) ________ Language Spoken: _____________________

Name of Spouse: ______________________________ Spouse SS# __________________ Date of Birth ____________

Emergency Contact: ____ Relationship: ____________________

Primary #: ______________________________ Secondary #: __________________________________

Pharmacy Name & Address: ____ Phone # _______________________

How did you hear about us?
☐ Phone Book ☐ Website ☐ Primary Care Physician
☐ Referring Physician ☐ Health Fair ☐ Insurance Company
☐ Advertisement ☐ Friend/Family: ____________________________________
☐ Other: ____

Patient Initials: ____________________

Insurance/Financial Information

Patient Name: ______________________________ Date of Birth: ____________________

Primary Insurance:

Name of Insurance Provider: ______________________ Phone #: ____________________

Claim Form Address: ____________________ City ________________ State________ Zip__________

ID Number ______________________________ Group Number__________________________

Subscriber if other than patient: ________________________ His/Her Date of Birth ________________

Relationship ______________________

Secondary Insurance:

Name of Insurance Provider: ______________________ Phone #: ____________________

Claim Form Address: ____________________ City ________________ State________ Zip__________

ID Number ______________________________ Group Number____________________

Subscriber if other than patient: ________________________ His/Her Date of Birth ______________

Relationship ______________________

Assignment to Pay Insurance Benefits

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the facility of any changes to my contact and/or insurance information. I understand that I am responsible for payment of professional services at the time they are rendered and that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts determined by my insurance company to be my responsibility, and any collection/attorney fees incurred in collecting that balance. I assign to the provider all payment for medical services rendered to me or my dependents for services filed to insurance on my behalf. Balances that remain unpaid after 90 days from the date first billed may be referred to an outside collection agency for further collection efforts. I understand that if paying by check and it is dishonored, or paying by credit card and an invalid dispute leading to chargeback occurs, a processing fee of $30 will be assessed. DHAT may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Consent for Medical Treatment

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. I understand that the provider will discuss with me any proposed testing or surgical procedure prior to scheduling.

Notice of Privacy Practices

A copy of the DHAT Notice of Privacy Practices will be provided upon request.

Patient Signature: ______________________________ **Date:** ________________

Patient Name: ______________________________ Date of Birth: ____________________

Please print all information, then sign and date the form at the bottom

7.30 ***Patient Authorization for Personal Representative***

I authorize **Digestive Health Associates of Texas, P.A.** to disclose or provide my protected health information ("PHI") the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my PHI. They may also consent to authorize the use or disclosure of my PHI:

____

Name of Personal Representative and Relationship (i.e. Spouse, family member, etc)

____

Address

____

City, State, Zip

____

Phone Number

Description of Information to be Disclosed:

I authorize **Digestive Health Associates of Texas, P.A.** to disclose the following PHI to my designated personal representative.

Circle One: **Procedure & Biopsy** **Labs** **All Information**

Expiration or Termination of Authorization

This authorization will remain in effect until terminated by the patient, the patient's representative, or another individual or legal entity authorized to do so by a court of law.

Right to Revoke or Terminate

As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

Digestive Health Associates of Texas, P.A.
8220 Walnut Hill Lane, Suite 214
Dallas, Texas 75231
Attn: Rose Swanson/Office Manager

Redisclosure Statement

I understand that the practice has no control regarding persons who may have access to the mailing address, telephone, cell, or fax number I have designated to receive my PHI. I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Patient Signature: ______________________ **Date:** ______________

8220 Walnut Hill Lane, Suite 214, Dallas, TX 75231 (214) 368-6707
7501 Lakeview Parkway, Suite 260, Rowlett, TX 75088 (972) 475-8183

John W. Secor, M.D. James D. Hakert, M.D. John C. Lee, M.D. Sami N. Arslanlar, M.D. Viralkumar Patel, M.D. Lisa Alvarez, M.D.

CANCELLATION POLICY

Our office charges the following cancellation fees for failure to notify of cancellation in a timely manner:

Office Visits—If not cancelled within 24 hours (1 business day) of appointment date, a fee of $25.00 will be assessed.

Procedures—If not cancelled within 72 hours (3 business days) of scheduled date, a fee of $75.00 will be assessed.

It is very important to notify our office of any cancellations as early as possible so your time slot can be offered to another patient. Your cooperation is appreciated.

Appointment reminders are sent out as a courtesy, it is the patient's responsibility to keep all appointments that they have scheduled.

I have read and understand the Cancellation Policy for Digestive Health Associates of Texas.

____
Patient Name (Printed)

____
Patient Signature

____
Date

Notice of Privacy Practices

This notice describes how DIGESTIVE HEALTH ASSSOCIATES OF TEXAS, P.A.'S medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. **DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.** is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your rights under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request an disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

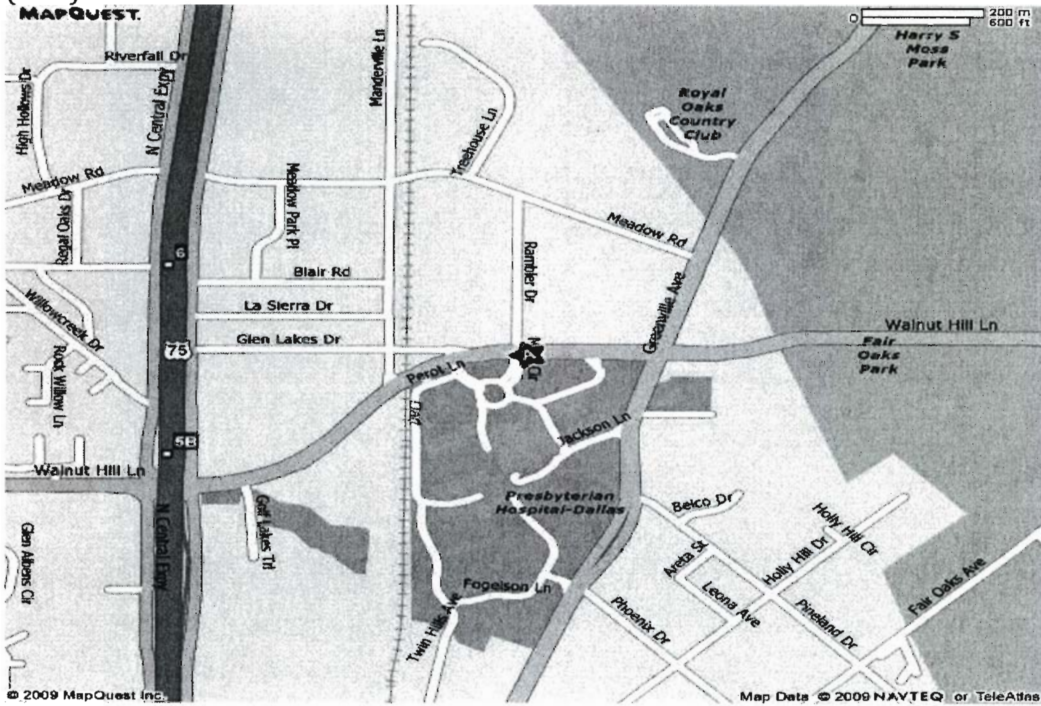
Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

214-689-5960

We will not retaliate against you for filing a complaint

Dallas Office—Presbyterian Professional Building II
8220 Walnut Hill Lane, Suite 214, Dallas, TX 75231
(214) 368-6707



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Rowlett Office—Lake Pointe Medical Arts Building
7501 Lakeview Parkway, Suite 260
Rowlett, TX 75088
(972) 475-8183