

PATIENT'S FULL NAME		NICKNAME	
DATE OF BIRTH	MALE FEMALE	SS NUMBER	
STREET ADDRESS			APT. NUMBER
CITY	STATE	ZIP CODE	
CUSTODIAL PARENT MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> BOTH <input type="checkbox"/>			

MOTHER'S FULL NAME		DATE OF BIRTH	SS NUMBER
STREET ADDRESS			APT. NUMBER
CITY	STATE	ZIP CODE	
EMPLOYER		OCCUPATION	
HOME PHONE	WORK PHONE	CELL PHONE	

FATHER'S FULL NAME		DATE OF BIRTH	SS NUMBER
STREET ADDRESS			APT. NUMBER
CITY	STATE	ZIP CODE	
EMPLOYER		OCCUPATION	
HOME PHONE	WORK PHONE	CELL PHONE	

EMERGENCY CONTACT NAME		RELATION TO PATIENT	
HOME PHONE	WORK PHONE	CELL PHONE	

PRIMARY INSURANCE COMPANY		GROUP NUMBER	
ADDRESS			
PHONE NUMBER	POLICYHOLDER NAME	POLICYHOLDER ID #	

REFERRING PHYSICIAN'S NAME	
ADDRESS	
PHONE NUMBER	FAX NUMBER

PEDIATRICIAN'S NAME (IF DIFFERENT FROM REFERRING DOCTOR)	PHONE NUMBER
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I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all physician charges and non-covered medical services.

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to DIGESTIVE ASSOCIATES OF TEXAS, PA. 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.

I have received the notice of Privacy Practices.

Signature of responsible party \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. This information is called protected health information. Specifically, "Protected Health Information" 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 health care services.

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 214-689-6960

### Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. 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. If needed, new versions of this notice will be effective for all protected health information that we maintain at that 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.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to designate a personal representative** - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

**You have the right to inspect and copy your protected health information** - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

**You have the right to request a restriction of your protected health information** - 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. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

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

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

### Complaints

You may complain to us or to the Secretary 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 our Privacy Manager of your complaint.

### How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, 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. And, we may contact you to provide information about health related benefits and services offered by our office.

**For Payment** - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**For Healthcare Operations** - We may use or disclose, as needed, your protected health information 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, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating deidentified information.

### Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

**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, you identify, your protected health information that directly relates to that person's involvement in your health care. 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 protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**As Required By Law** - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

**For Public Health** - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

**For Communicable Diseases** - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**For Health Oversight** - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

**In Cases of Abuse or Neglect** - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**To The Food and Drug Administration** - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**For Legal Proceedings** - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**To Law Enforcement** - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

**To Coroners, Funeral Directors, and Organ Donation** - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**In Cases of Criminal Activity** - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**For Military Activity and National Security** - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

**For Workers' Compensation** - Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**When an Inmate** - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures** - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

# DHAT

## Digestive Health Associates of Texas, P.A.

### Patient History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_\_ Female

Social Security #: \_\_\_\_\_ Referring Dr: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Completed by: \_\_\_\_\_

Please answer the following questions as completely as possible. If there is not enough room on the front of the page use the back.

### Past Medical History

#### Childs Birth History

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Discharge Date \_\_\_\_\_

Length of Pregnancy \_\_\_\_\_ Type of Delivery \_\_\_\_\_

Complications \_\_\_\_\_

Breastfed? \_\_\_\_\_ months Bottled? \_\_\_\_\_ months Formula? \_\_\_\_\_ months

#### Hospitalizations Since Birth(\_\_\_\_\_ None)

Date	Hospital Name	Location	Doctor's Name	Reason for Hospitalization	What was done
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

#### Current Medications(\_\_\_\_\_ None)

Date

_____
_____
_____

#### Drug or Food Allergies (\_\_\_\_\_ None)

_____
_____
_____

Patient \_\_\_\_\_ Date \_\_\_\_\_

Are your child's immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No

**OTHER INFORMATION**

Please list any medical or other information you feel is pertinent or helpful.

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**FAMILY HISTORY**

	<b>Alive (Y/N)</b>	<b>Age</b>	<b>Health Status</b>	<b>Significant Med. Conditions</b>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

**Significant medical illness in grandparents, aunt, uncles, or cousins.**

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**Is there any history of the following in your family: (Circle the correct response)**

High Blood Pressure	Yes	No	Heart Disease	Yes	No	Tuberculosis	Yes	No
Ulcer Disease	Yes	No	Colon Disease	Yes	No	Liver Disease	Yes	No
Constipation	Yes	No	Irritable Bowel	Yes	No	Slow Growth	Yes	No
Birth Defects	Yes	No	Migraines	Yes	No	Gallstones	Yes	No
Kidney Stones	Yes	No	Thyroid Disease	Yes	No			

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

### SYSTEM REVIEW

Please CIRCLE any problems that your child has ever been treated for or presently suffer from:

- |                                  |                       |                            |
|----------------------------------|-----------------------|----------------------------|
| EYE DISORDER                     | DIFFICULTY SWALLOWING | BREAST DISORDER            |
| EAR DISORDER                     | HEARTBURN             | MENSTRUAL DISORDER         |
| THROAT DISORDER                  | VOMITING OF BLOOD     |                            |
| CAVITIES                         | REGURGITATION         | EASY BRUISING              |
| SINUS DISORDER                   | INDIGESTION           | ANEMIA                     |
|                                  |                       | BLOOD DISORDER             |
| THYROID DISORDER                 | ABDOMINAL PAINS       | DIABETES                   |
| RHEUMATIC FEVER                  | STOMACH DISORDERS     |                            |
| CHEST PAIN                       | HERNIA                | ARTHRITIS                  |
| HEART DISORDERS                  | ULCER                 | SCOLIOSIS                  |
| HIGH BLOOD PRESSURE              | INTESTINAL DISORDERS  | BONE/JOINT DISORDERS       |
| HEART VALVE DISEASE              | COLITIS               |                            |
| HEART MURMUR                     | RECTAL DISORDERS      | CANCER                     |
|                                  | HEMORRHOIDS           | TUMOR(S)                   |
| COUGH                            | RECTAL BLEEDING       | CYST                       |
| COUGHING OF BLOOD                | DIARRHEA              | LYMPH GLAND ENLARGEMENT    |
| ASTHMA                           | SPLEEN DISORDERS      | IMMUNE DEFICIENCY          |
| BRONCHITIS                       | PANCREATIC DISORDERS  |                            |
| EMPHYSEMA                        | LIVER DISORDERS       | FAINTING                   |
| TUBERCULOSIS                     | YELLOW SKIN           | CONVULSIONS                |
| PNEUMONIA                        | YELLOW EYES           | EPILEPSY                   |
| LUNG DISEASES                    | GALLBLADDER DISORDERS | MIGRAINE HEADACHES         |
|                                  |                       | NERVOUS DISORDERS          |
| DIFFICULTY OR PAIN IN URINATION  |                       | ATTENTION DEFICIT DISORDER |
| SUGAR,PROTEIN,BLOOD,PUS IN URINE |                       |                            |
| KIDNEY DISORDERS                 |                       |                            |
| BEDWETTING                       |                       |                            |
| BLADDER DISORDERS                |                       |                            |
| DAYTIME WETTING                  |                       |                            |

Physician Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



**7.34 Patient Authorization for Disclosure of Protected Health Information via Telephone, Facsimile and E-Mail**

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

**Practice Name:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Purpose of request** - I authorize the practice to disclose or provide protected health information (as described below) directly to me at the telephone numbers I have indicated. I understand that it is my responsibility to notify the practice of any change in these numbers and that any disclosure left on voice mail or an answering machine, indicated by me, is subject to the redisclosure statement within this authorization.

**For the Telephone:**

Please list numbers in order of priority and specify whether the number is home, mobile or work.

**Telephone:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**For the Facsimile:**

Please list facsimile number

**Facsimile Number:** \_\_\_\_\_

**For the E-Mail:**

**E-Mail Address:** \_\_\_\_\_

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the telephone numbers I have indicated (*please provide a written description of the information to be disclosed, such as results of exams, appointment reminders, laboratory tests, procedures, and other healthcare services*):  
\_\_\_\_\_

**Purpose of disclosure** – I am authorizing the disclosure of my protected health information to the specified telephone, facsimile numbers and E-Mail address as a means of enhancing communication with my healthcare provider and the practice.

**Expirations or termination of authorization** – This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): \_\_\_\_\_

**Right to revoke or terminate** – As stated in the practice’s Notice of Privacy Practice, I have the right to revoke or terminate this authorization by submitting a written request to the practice’s Privacy Manager. This can be done in-person or by mailing a request to the practice, Attn Privacy Manager.

**Re-disclosure** – I understand that the practice has no control regarding persons who may have access to the telephone numbers I have listed to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Dear Patient,

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective, medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

**Payment Guidelines:**

- We must collect any co-payments, co-insurance, and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders & Credit Cards** (Visa, Mastercard, American Express).
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If, by mistake, your insurance company remits this payment back to you, please send it to us along with all paperwork sent to you. **Please do not send payment back to the insurance company.**

**When to Present Insurance Card?**

Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group #, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

**Insurance Company Denies Payment?**

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

1. This is a pre-existing illness or condition that they do not cover.
2. You have not met your full calendar year deductible.
3. The type of medical service required is not covered.
4. The insurance was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You have exceeded your maximum dollar/visit amount.
7. You did not have a referral # for your visit/service.

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at (214) 689-3829 or (800) 425-3759.

Sincerely,

**Digestive Health Associates of Texas, P.A. (DHAT)**

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. I assign the proceeds of such insurance claim to DHAT. Both DHAT and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions, and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**



**Consent for Medical Minor (age) 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 guaranties have been made to me as to the result of treatment or examinations performed.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, the parent or authorized guardian, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Parent or Guardian's signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Digestive Health Associates of Texas**

Medicaid Waiver for Non-PAR Physicians

I understand that \_\_\_\_\_ is not a provider for Medicaid and will not file a claim to Medicaid for any services provided. I will be responsible for any balances. This waiver is valid for one year from date of signature.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please sign even if your child does not have Medicaid**