DHAT Pediatrics

a division of Digestive Health Associates of Texas, P.A.

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 your healthcare team physicians) are trying to adapt to the changing ways that healthcare is financed and delivered. The following guidelines were developed to help you through the process:

Payment Guidelines:

- We collect co-payments, co-insurance, and/or deductibles at the time of service, unless other written arrangements have been made in advance with our office.
- We accept: **Cash, Checks, Money Orders, and Credit Cards** (Visa, MasterCard, American Express and Discover).
- If your check is returned, a processing fee of $30 will be assessed in addition to the amount of the check.
- Please note that any payments to your physician will be listed as Digestive Health Associates of Texas on your statement.
- A claim will be sent to your insurance company for payment.
- If your insurance company remits the payment to you, please send it to our office, along with the Explanation of Benefits. **Please DO NOT send the payment back to the insurance company.**
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment is due in full upon receipt of your statement. Balances that remain unpaid after 90 days may be referred to an outside collection agency for further collection efforts. _____ initial

When to present your insurance card:

Please present your insurance card at **EACH VISIT**. Specifically bring to our attention any changes (new card, new subscriber or group number, etc.) since your last visit. This protects you from paying a bill due to providing wrong 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. If you have a secondary insurance, it will be filed as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Why insurance companies may deny payment for services:

- You have not met your full calendar year deductible.
- The type of medical service required is not covered.
- The insurance was not in effect at the time of service.
- You have other insurance that must be filed first.
- You did not have the referral number for your visit/service.
- You have exceeded your maximum dollar/visit amount.

Assignments of Benefits

I warrant that I am the party responsible for making the medical decisions for the child represented in the medical record. I acknowledge that the payment is due at the time of service. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that the provider of service will not get involved in matters involving third party personal billing whether a result of custody, court order, or personal circumstances. **The parent/guardian who is accompanying the child to the visit is responsible for any payment due at the time the services are rendered and any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, and other amounts determined by my insurance company to be my responsibility along with any collection/attorney fees incurred in collecting the balance.** I understand that it is my responsibility to inform the office/facility of any changes to my contact and/or my child's insurance information. I assign the provider all payments for medical services rendered to my child, filed to the 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 returned, or paying by credit/debit card and an invalid dispute leading to a charge back occurs, a processing fee of $30.00 will be assessed. DHAT/DHM may use my child's healthcare information and may disclose such information to the above-named insurance company and/or their agents for the purposes of obtaining payment for services and determining benefits for related services. This agreement will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as an original.

We value you as a patient and we are eager to serve you! Our priority is to provide you with the best possible care. If you would like to contact our Central Business Office, you may do so at 214-689-3829 or 1-800-425-3759.

Sincerely,

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

I have read and understand the guidelines and financial obligations as stated above.

_____ _____

Signature Date

☐ **An** ☐ **Baker** ☐ **Brown** ☐ **Chan** ☐ **Russo** ☐ **Whitney**

Pediatric Patient Information

Date:_____

Who referred you to us? _____Primary Care Physician: _____

Patient Name: _____ Date of Birth _____Age: _____Sex: M or F

Address: _____ _____ _____ _____
Street City State Zip Code

Primary Phone #: _____ Custodial Parent:_____ Mother ☐ Father ☐ Both ☐

Patient Social Security #: _____ Ethnicity: _____ Decline: ☐

Language Spoken: _____ Patients Race: _____ Decline: ☐

Mother's Information

Name: _____ Date of Birth: _____Email Address:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Primary #: _____ Cell #: _____ Work #: _____

Social Security #: _____Occupation: _____

Father's Information

Date of Birth:

Name: _____ _____Email Address:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Primary #: _____ Cell #: _____ Work #: _____

Social Security #: _____Occupation: _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Primary #: _____ Cell #: _____ Work #: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____ Consent for External Rx History: ☐ Yes ☐ No

Insurance/Financial Information

Primary Insurance:

Name of Insurance: _____ Phone #: _____

Claims
Address: _____ _____ _____ _____
Street City State Zip Code

Subscriber #: _____ Group #: _____

Subscriber Name If
Other Than Patient: _____ Date of Birth: _____

Relationship to the Patient: _____

Secondary Insurance:

Name of Insurance: _____ Phone #: _____

Claims
Address: _____ _____ _____ _____
Street City State Zip Code

Subscriber #: _____ Group #: _____

Subscriber Name If
Other Than Patient: _____ Date of Birth: _____

Relationship to the Patient: _____

Consent for Medical Treatment of a Minor

I, the undersigned, as 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. All medical care and treatments will be discussed with me, by the physician prior to any proposed treatments, testing, or medical procedures being scheduled. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed. This has been fully explained to me. I understand and accept these terms, as indicated by my signature below.

This form has been fully explained to me and I understand and accept the contents with my signature below.

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

Medicaid Waiver for Non-Par-Physicians

I understand that the providers with ***Digestive Health Associates of Texas P.A.*** (DHAT) are not Medicaid providers, therefore DHAT 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 the date of signature.

Fee Policies

Form Fees:

- **Letters:** If the office is required to compose a letter on behalf of the patient, a $10.00 fee will be assessed.
- **Forms:** If the office is required to fill out a form on behalf of the patient, a $25.00 fee will be assessed.

Cancellations Fees:

- **Office Visits:** If not cancelled within 24 hours (1 business day) of the appointment date, a $25.00 fee will be assessed.
- **Procedures:** If not cancelled within 48 hours (2 business days) of the procedure date, a $50.00 fee will be assessed.

It is very important to notify our office of any cancellations as early as possible, so that your appointment can be offered to another patient. Your cooperation is appreciated in this matter.

My signature below indicates that I have read and understand the Consent for Treatment of a Minor, the Medicaid Waiver, and the Fee policies of ***Digestive Health Associates of Texas P.A.*** It also indicates that I have received a copy of the Notice of Privacy Practices.

Patient Name (Printed) _____ Date _____

Parent/Guardian Signature _____ Relationship to Patient _____

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Patient Authorization for Personal Representative

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

Name of Practice: _____

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Representative: _____ Phone #: _____

Address: _____ _____ _____ _____
Street City State Zip Code

- Description of information to be disclosed: I authorize the practice to disclose all my protected health information to my designated personal representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or 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:

Your DHAT Provider's Office

Attn: Privacy Officer

Re-disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your 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. Copies of signed authorizations are available upon request.

_____ _____
Parent/Guardian Signature Date

Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Patient Name: _____ Date of Birth: _____

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the re-disclosure statement within this authorization.

☐ Primary Phone ☐ Cell phone ☐ email address ☐ US Mail ☐ Fax number ☐ Patient Portal

☐ Leave a detailed message on my answering machine/voice-mail.
☐ Leave a brief message with only a call back number, the staff member's name and the name of the office on my answering machine/voice-mail

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

Please list desired expiration date: _____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Re-disclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell phone or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.
Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____
Signature Date

Notice of Privacy Practices

This notice describes how 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.

Our practice 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 regarding 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, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice 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 in the practice, and if such is maintained, on the practice's web site. **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 described 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, fax, telephone), and/or 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 obtain a copy your PHI - This means you may submit a written request to 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, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

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

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

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 or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided below on the Section: 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.

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 the determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose your PHI, for the 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.

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, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office. We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

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 PHI (e.g., in a disaster relief situation), 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, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; 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 Officer

We will not retaliate against you for filing a complaint.

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Patient Name: _____ Date of Birth: _____

Patient History

Current Medication – Please list any medications you are CURRENTLY taking. Please include Vitamins and Alternative Medications and Herbs.

Name, Dose and Frequency of Medication: ☐ **None**

_____ _____

_____ _____

_____ _____

_____ _____

Drug or Food Allergies/Intolerance and Reactions: ☐ **None**

_____ _____

_____ _____

Are your child's immunizations up to date? ☐ **Yes** ☐ **No**

Has your Child ever had a blood transfusion? ☐ **Yes** ☐ **No** **Date:** _____

Birth History

_____ Birth Weight _____ Birth Length _____ Length of Pregnancy _____ Delivery Type

Complications _____

☐ Breast Fed _____ Months ☐ Bottle Fed _____ Months

Surgical/Hospitalizations (since birth):

Date	Hospital Name/Location	Doctor's Name	Reason

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Patient Name: _____ Date of Birth: _____

Family History

	Alive	Age	Health Status	Significant Medical Condition/s
Father	☐	_____	_____	_____
Mother	☐	_____	_____	_____
Sibling	☐	_____	_____	_____
Sibling	☐	_____	_____	_____
Grand Parents	☐	_____	_____	_____
Aunts/Uncles	☐	_____	_____	_____
Cousin	☐	_____	_____	_____
Cousin	☐	_____	_____	_____
Cousin	☐	_____	_____	_____

Is there any family history of the following?

- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Colon Disease
- ☐ Slow Growth
- ☐ Migraines
- ☐ Kidney Stones
- ☐ Heart Disease
- ☐ Ulcer Disease
- ☐ Liver Disease
- ☐ Irritable Bowel
- ☐ Birth Defects
- ☐ Gall Stones
- ☐ Thyroid Disease

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Patient Name: _____ Date of Birth: _____

Medical History- Check all conditions that the patient has had or is currently having:

Gastrointestinal
- ☐ Poor Appetite
- ☐ Regurgitation
- ☐ Trouble or Pain Swallowing
- ☐ Hernia
- ☐ Colitis
- ☐ Spleen Disorders
- ☐ Pancreatic Disorders
- ☐ Intestinal Disorders
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Diarrhea
- ☐ Ulcer Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Hemorrhoid History
- ☐ Bloody Bowel Movements
- ☐ Jaundice (yellow eye/skin)
- ☐ Gall Bladder Disease
- ☐ Lactose Intolerance
- ☐ Celiac Disease
- ☐ Constipated/Using laxatives
- ☐ Loss of Bowel Control

General
- ☐ Chills/Fever
- ☐ Decreased Energy
- ☐ Difficulty Sleeping
- ☐ Fainting/Dizziness
- ☐ Weight Loss

Eyes/Ears/Nose/Throat
- ☐ Blurred or Doubled Vision
- ☐ Eye Pain
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Chronic Earaches
- ☐ Runny Nose
- ☐ Sinus Problems

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Shortness of Breath
- ☐ Irregular Heartbeats
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Leg Cramps
- ☐ Heart Murmur
- ☐ Heart Problems

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Lung Disease
- ☐ Asthma

Allergic
- ☐ Hay-Fever
- ☐ Hives
- ☐ Allergies to Foods

Musculoskeletal
- ☐ Swollen Joints
- ☐ Scoliosis
- ☐ Joint/Bone Disorders
- ☐ Arthritis

Neurological
- ☐ Fainting
- ☐ Epilepsy
- ☐ Migraine Headaches
- ☐ Convulsions
- ☐ Nervous Disorders
- ☐ ADD/ADHD

Endocrine
- ☐ Diabetes
- ☐ Thyroid Problems

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Tumor/Cancer
- ☐ Bruise Easily
- ☐ Bleeds Easily
- ☐ Immune Deficiency
- ☐ Lymph Gland
- ☐ Enlargement Breast
- ☐ Disorder

Genitourinary
- ☐ Trouble Urinating
- ☐ Kidney Disorders
- ☐ Bed Wetting
- ☐ Sugar/Protein/Blood/Pus in urine
- ☐ Frequent Urination
- ☐ Loss of Bladder Control
- ☐ Menstrual Disorder

_____ _____
Patient Name (Printed) Date

_____ _____
Parent/Guardian Signature Relationship to Patient