Office Policies

No Show Policy:

We ask you to be considerate of the medical needs of others and call our office promptly within 24 hours of your appointment if you are unable to make your appointment time. If you do not arrive for your appointment, or fail to cancel prior to 24 hours before your appointment time, there will be a **$35.00 no show fee** applied to your account that will need to be paid in full by the next scheduled appointment. This fee cannot be billed to your insurance company.

You will be reminded of your upcoming appointment by phone. If we are unable to confirm your appointment verbally, your appointment will be canceled.

Late Arrival Policy:

The doctor makes every effort to be respectful of our patients' time and to see our patient on time. Unfortunately, when even one patient arrives late, it can throw off the entire schedule. In addition, rushing or "squeezing in" an appointment shortchanges and contributes to decreased quality of care. Dr. Dave does not overbook patients and she provides ample time for each appointment. **Patients arriving more than 10 minutes after their appointment time will be asked to reschedule and pay the no show fee of $35.** Please consider traffic patterns and parking availability when planning for your child's appointment.

Southlake Appointments Policy:

If an appointment is canceled anytime after 12 noon on the Friday prior to a Monday Southlake appointment, the cancellation policy will be applied. We will be happy to reschedule for the Plano office in the future. We have limited availability in Southlake. We travel to Southlake on Mondays to serve our patients so that they do not have to travel to Plano.

After Hour Calls:

We return patient calls by the end of the business day. After hour calls are defined as calls received through the answering service. These calls will accrue a **$35.00 after hours call fee** applied to your account. This fee cannot be billed to your insurance.

Procedure Policy:

There is a **$75 cancellation fee** for not giving at least **48 hours** notice prior to canceling or rescheduling a procedure. Procedure payment is due 24 hours prior to the procedure to avoid the procedure being canceled.

Patients name:_____

Parents Signature:_____**Date:**_____

TDDC
Texas Digestive Disease Consultants

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information:

Texas Digestive Disease Consultants

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)**:**

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

TDDC
Texas Digestive Disease Consultants

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Form must be completed for all persons under the age of 18 years

The Texas Family Code allows only certain people to consent to medical treatment for minors if parental consent cannot be obtained. These are:

1. A grandparent
2. An adult sister or brother
3. An adult aunt or uncle
4. An educational institution in which your child is enrolled, which has written authorization to consent to treatment
5. Any adult who has care and control of the child and who has written authorization from the parent to consent to treatment.

I, _____, am

☐ the parent

☐ the guardian (specify relationship)

of the minor child, _____, and hereby authorize Texas Digestive Disease Consultants and/or its authorized agents, to consent to what ever medical treatment they may deem necessary while said minor is under their care in accordance with Texas Family Code Section 32.001.

Nature of expected medical treatment: Gastroenterology Specialist Care

Date treatment is expected to begin: _____

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

TDDC
Texas Digestive Disease Consultants

Today's date_____ Name of physician you are seeing today _____

Last name of patient _____ First _____ Middle initial _____

Street address _____

City _____ State _____ Zip _____

Home phone_____ Work phone _____

Mobile phone _____ E-mail address _____

Preferred method of contact (please circle one): home # work # cell # US mail

Date of birth_____ Age _____ Sex _____ Marital status _____

Social security number _____

Employed by _____ Occupation _____

Emergency contact _____ Relationship _____

Home phone_____ Work phone _____

Referred by _____ Primary care physician _____

Primary insurance _____ Insured name _____

DOB_____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

Secondary insurance _____ Insured name _____

DOB_____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

I authorize the person(s) below to receive information regarding my medical care:

_____

Name/Relationship Name/Relationship

Agreement/Authorization Release

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the doctor. If my insurance company does not pay, I understand that I will be responsible for payment. I agree to call my doctor's office if my test results have not been called to me within two weeks of completion of endoscopy/ scopes, blood tests, stool tests, biopsies/pathology and/or x-rays. I understand that my doctor may have a vested interest in the endoscopy center where my procedure may be performed.

_____ _____

Signature of Patient or Guardian Date