

# TDDC

Texas Digestive Disease Consultants

Today's date \_\_\_\_\_ Name of physician you are seeing today \_\_\_\_\_

Last name of patient \_\_\_\_\_ First name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_

Social security number \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_

Preferred method of contact (please circle one) Home phone Cell Work Portal Letter Declines to specify

Emergency contact \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Referred by \_\_\_\_\_ Referring physician phone \_\_\_\_\_

Primary insurance \_\_\_\_\_ Insured name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insured DOB \_\_\_\_\_ Insured SSN \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Insurance phone \_\_\_\_\_

Employer name \_\_\_\_\_

Secondary insurance \_\_\_\_\_ Insured name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insured DOB \_\_\_\_\_ Insured SSN \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Insurance phone \_\_\_\_\_

Employer name \_\_\_\_\_

I authorize the insurance listed above to pay directly to Texas Digestive Disease Consultants all benefits due me, as provided for in the above policy contract with the aforementioned company(ies). I will pay for all such charges that may be denied by the insurance company(ies) above mentioned. I hereby consent to receiving calls or texts on my mobile device.

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.

I hereby consent to treatment rendered by Texas Digestive Disease Consultants, which could include in office procedures and injections.

\_\_\_\_\_  
Signature of Patient/Guardian/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Guardian/Personal Representative (please print)

\_\_\_\_\_  
Relationship to patient

# Patient Authorization for Disclosure of Protected Health Information via Alternative Means

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

**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, electronically 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 your protected health information, including medical and personal information pertaining to your condition and treatment (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 and payment information to me via the means described below. I also approve of making a payment via the below means. 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 redisclosure statement within this authorization.

text message       email address:       US Mail:       fax number:       phone:

**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: Practice Manager.

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

**Redisclosure Statement** – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell 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 and electronic communications are 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.

\_\_\_\_\_  
Authorized Signature (patient, parent, or legal guardian)

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

\_\_\_\_\_  
Description of Authorized Representative's Authority (as applicable)

\_\_\_\_\_  
Authorized Representative's Printed Name

\_\_\_\_\_  
Minor's Signature (as applicable)

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



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

**Notice of Privacy Practices**  
**Texas Digestive Disease Consultants**

**Form 7.20**

**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 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 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 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 a 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) 424-2200

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We will not retaliate against you for filing a complaint.

Effective Date 9/23/2013

Publication Date 9/23/2013

**Communication of Protected Health Information  
Release Form**

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Date: \_\_\_\_\_ GI Physician: \_\_\_\_\_

By signing this release, I authorize GI Alliance on behalf of itself and the other companies/components, which have been designated as a HIPAA Affiliated Covered Entity to discuss my health information and payment information to me via text message or telephone, or in person or by telephone, with the individual(s) and/or organization(s) listed below.

I acknowledge that this release is for verbal or written communication only and does not allow for copies of my medical records to be released. This release will expire when I am no longer receiving care from GI Alliance.

(PLEASE PRINT NAMES)

Physician: \_\_\_\_\_ Physician: \_\_\_\_\_

Spouse: \_\_\_\_\_ Mother: \_\_\_\_\_

Father: \_\_\_\_\_ Guardian: \_\_\_\_\_

Brother: \_\_\_\_\_ Sister: \_\_\_\_\_

Son: \_\_\_\_\_ Daughter: \_\_\_\_\_

Other Individual: \_\_\_\_\_ Individual's Relationship to Patient: \_\_\_\_\_

Other Individual: \_\_\_\_\_ Individual's Relationship to Patient: \_\_\_\_\_

I authorize that my health information may be disclosed as well as information relating to the following items that I have initialed below:

\_\_\_\_\_ Mental Health \_\_\_\_\_ Genetics

\_\_\_\_\_ Drug, Alcohol, or Substance Abuse \_\_\_\_\_ HIV/AIDS

I understand that this authorization may authorize the communication of all medical records including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any disclosure by the recipients is prohibited.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I acknowledge that I have the right to revoke this release, in writing, prior to its expiration. I further acknowledge that the written revocation will not affect any communication of my medical information to the individual(s) and/or organization(s) listed on this form prior to the time that it is revoked.

\_\_\_\_\_  
Authorized Signature (patient, parent, or legal guardian) Date Signed

\_\_\_\_\_  
Description of Authorized Representative's Authority (as applicable) Authorized Representative's Printed Name

\_\_\_\_\_  
Minor's Signature (as applicable) Date Signed

# 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 **\$50.00 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. **If you arrive after your scheduled appointment time you will be asked to reschedule and the no show fee of \$50 will be applied.** Please consider traffic patterns and parking availability when planning for your child's appointment.

## 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 **\$50.00 after hours call fee** applied to your account. This fee cannot be billed to your insurance.

## Procedure Policy:

There is a **\$100 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.

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

Parent  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_