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) 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.
- A claim will be sent to your insurance company for payment. If your insurance company remits the payment to you, please send the payment to our office, along with the Explanation of Benefits.
- 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)

No Show / Late Cancellations:

To provide the best possible service and availability to all patients, our practice has implemented the following fees:

- **Office visit** – We require a 1 business day notice for all office visit cancellations. If the required notice is not given, a $50.00 charge may be assessed to the patient account.
- **Procedure** – We require a 3 business day notice for all procedure cancellations. If the required notice is not given, a $100.00 charge may be assessed to the patient account.

The missed appointment payment may be required prior to, or upon the next scheduled procedure or office visit.

Ancillary Services:

Your physician may refer you to one or more "ancillary services" in connection with your medical care. An ancillary service is a service supplementing or supporting your medical treatment. The following are considered, but not limited to, possible ancillary services:

- Ambulatory Surgery Center
- Infusion Therapy
- Laboratory & Pathology Testing
- Nutritional Services
- Pharmacy Services
- Radiology/Imaging

Your physician may have an economic interest in or business relationship with the company or person who provides the ancillary service(s). You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

Research Programs:

Your physician may ask if you would like to participate in a clinical trial or research program. These programs may be sponsored by a drug company or may be a practice-sponsored research program. Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participation in a program that your physician believes may be appropriate for you.

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 incorrect 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.

Assignment of Benefits:

DHAT may file a claim for services rendered by the physician, facility, pathologist and or anesthesia provider. DHAT is authorized to transfer any patient overpayment to one of these associated entities if applicable. I hereby authorize DHAT to:

- Release any information necessary to the insurance company regarding my illness and treatments.
- Process claims generated for my examination/treatment.
- Allow a photocopy of my signature to be used to process insurance claims for a period of a lifetime.
- Keep this order in effect until it is revoked by me in writing.

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.

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

Signature _____ Date _____

Patient Information

DHAT Physician you are seeing today	Referring Physician	Primary Care Physician	
Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ☐ Primary Number	Mobile Phone ☐ Primary Number	Work Phone ☐ Primary Number	
Sex ☐ Male ☐ Female ☐ Transgender	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner		
Social Security Number	Employer Name	Occupation	
Emergency Contact Name	Emergency Contact Phone Number	Emergency Contact Relationship	
Email Address		☐ I consent for patient portal access	
Voicemail Messages on Home Phone ☐ Detailed ☐ Brief	Voicemail Messages on Mobile Phone ☐ Detailed ☐ Brief	Voicemail Messages on Work Phone ☐ Detailed ☐ Brief	
Which category best describes your race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White or Caucasian ☐ Hispanic or Latino ☐ Other Race ☐ Declines			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines	Preferred Language	Will a translator be required ☐ Yes ☐ No	
Pharmacy Name	Pharmacy Location	Pharmacy Phone Number	
How did you hear about Digestive Health Associates of Texas, P.A. ☐ Physician Referral ☐ Advertisement ☐ Website ☐ Health Fair ☐ Insurance Company ☐ Family/Friend			

Responsible Party

Complete this section if guarantor is someone other than the patient or a minor

Last name	First Name	MI	Relationship to Patient
Address	City	State	Zip
Home Phone	Work Phone	Mobile Phone	
Date of Birth	Social Security Number	Sex ☐ Male ☐ Female ☐ Transgender	

Insurance

Insurance card(s) must be presented at time of service

Primary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth
Secondary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth

General Consents

Consent for Medical Treatment

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 judgement of any 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.

Consent to Obtain External Prescription History

I understand Digestive Health Associates of Texas, P.A. utilizes electronic prescribing technology and participates with SureScripts. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. Detailed prescription history provides your provider valuable information and improves accuracy in your medication list.

Electronic Communication

As a service to our patients, we provide courtesy appointment reminder calls and when possible, text messages. We also may place other important calls and send text messages using a prerecorded or automated message.

Notice of Privacy Practices

I acknowledge that I have been given the opportunity to receive the Notice of Privacy Practices. This notice identifies how medical information about you may be used and disclosed, and how you can gain access to this information.

I understand that the duration of this authorization is indefinite unless otherwise revoked in writing.

Patient Name (please print)

Patient Signature Date

Patient Authorization for Personal Representative

I authorize Digestive Health Associates of Texas, P.A. to disclose or provide my protected health information to the following individual(s) 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.

- You authorize the practice to disclose all your protected health information to your designated personal representative.
- 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.
- 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 Manager

Name of Personal Representative	Relationship	Phone Number
Name of Personal Representative	Relationship	Phone Number
Name of Personal Representative	Relationship	Phone Number

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 requirements of the Privacy Rule and will no longer be the responsibility of this practice. Copies of signed authorizations are available upon request

Patient Signature Date

Patient Name:_____ Date of Birth:_____

Medical History:

- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Cancer: _____
- ☐ Celiac Disease
- ☐ Colon Polyps
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Diverticulosis/Diverticulitis
- ☐ Epilepsy/Seizure Disorder
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Hernia: ☐ Inguinal ☐ Hiatal
- ☐ HIV positive/AIDS
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker/Defibrillator
- ☐ Pancreatitis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Medications: List any medications, vitamins, and herbs you are currently taking.

☐ I am not currently taking any medications

Name	Dose	Frequency

Allergies: ☐ No Known Drug Allergies

Medication/Food	Reaction

Surgical History: ☐ Denies Past Surgical History

Year	Surgery	Year	Surgery

Hospitalizations: ☐ Denies Past Hospitalization

Year	Reason	Year	Reason

Colonoscopy: ☐ Denies Prior Colonoscopy

When was your last colonoscopy? _____ Did you have polyps: ☐ Yes ☐ No

Who performed your last colonoscopy? _____

Patient Name:_____ Date of Birth:_____

Family History:

		Year of Birth	Illness/Condition
Father	☐ Alive ☐ Deceased		
Mother	☐ Alive ☐ Deceased		

Is there any family history of the following? Please list the family member.

Colon Cancer	☐ Yes ☐ No	
Cancer: _____	☐ Yes ☐ No	
Celiac Disease	☐ Yes ☐ No	
Crohn's/Ulcerative Colitis	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Liver and/or Gallbladder Disease	☐ Yes ☐ No	
Pancreatic Disease	☐ Yes ☐ No	

Number of Siblings: _____ Brothers _____ Sisters Number of Children: _____ Sons _____ Daughters

Social History:

Tobacco Use: ☐ Current Smoker ☐ Some Day Smoker ☐ Former Smoker ☐ Non-Smoker

Alcohol Use: Do you consume alcohol? ☐ Yes ☐ No
How many drinks per week? ☐ Less than 7 ☐ More than 7

Tattoos/Piercings: Do you have any tattoos? ☐ Yes ☐ No If yes, where: _____
Do you have any piercings? ☐ Yes ☐ No

Drug Use: ☐ None ☐ I used recreational drugs in the past
☐ I currently use recreational drugs ☐ Treated for substance abuse

Caffeine Use: Do you drink caffeine? ☐ Yes ☐ No
If yes, what type: _____ How many per day? _____

Blood Transfusions: Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, what year: _____

Recent Travel: Have your recently traveled outside the United States? ☐ Yes ☐ No
If yes, where: _____

Current Symptoms:

General
☐ Difficulty Sleeping
☐ Fever
☐ Weight Loss

Allergic
☐ Allergies to food
☐ Seasonal Allergies

Cardiovascular
☐ Chest Pain
☐ High Blood Pressure
☐ Irregular Heart Rhythm
☐ Swollen ankles

Dermatology
☐ Hives
☐ Itching
☐ Rash

Endocrine
☐ Diabetes Mellitus
☐ Thyroid Problems

Eyes/Ears/Nose/Throat
☐ Blurred Vision
☐ Mouth Ulcers
☐ Ringing in Ears
☐ Sore Throat

Hematologic/Lymphatic
☐ Anemia
☐ Bleeding Easily
☐ Swollen Lymph Nodes

Gastrointestinal
☐ Abdominal Pain
☐ Bloody Bowel Movements
☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Heartburn
☐ Hemorrhoids
☐ Jaundice
☐ Loss of Bowel Control
☐ Nausea
☐ Using Laxatives
☐ Vomiting

Genitourinary
☐ Blood in Urine
☐ Trouble Urinating

Musculoskeletal
☐ Arthritic Pain
☐ Joint Pain
☐ Muscle Pain

Neurological
☐ Seizures
☐ Severe Headaches

Psychiatric
☐ Anxiety
☐ Depression

Respiratory
☐ Asthma
☐ Cough
☐ Shortness of Breath