Open Access Colonoscopy
Dr. J. George Sun

Today's Date:	**PLEASE PRINT**	Primary Care or Referring Physician:	
PATIENT INFORMATION			
Legal Name Last:	First:	Middle Initial:	
Social Security No.:	Birth Date:	Sex: ☐ F ☐ M	
Mailing Address:	City:	State:	Zip Code:
Home Phone No.:	Cell Phone No.:	Work Phone No.:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Not Employed Occupation:			
Student Status (if applicable): ☐ Full Time ☐ Part Time ☐ Not a Student			
EMERGENCY CONTACT			
Name:	Relationship to patient:	Phone No.:	
INSURANCE INFORMATION			
Is this patient covered by insurance? ☐ Yes ☐ No	Is this an Employer Plan: ☐ Yes ☐ No		
Primary Insurance Name:	**ID:**		
Subscriber's Name: ☐ Self ☐ Other (please specify)	Birth date (for other than self):		
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify):			
Secondary Insurance Name:	**ID:**		
Subscriber's Name: ☐ Self ☐ Other (please specify)	Birth date (for other than self):		
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify):			
GUARANTOR INFORMATION			
Person responsible for bill: ☐ Self ☐ Other (specify if other)	Address (if different):	Phone No.:	
CONTACT PREFERENCE			
Detailed messages with test results may be left on: ☐ Cell Phone ☐ Home Phone			
Only provide an e-mail if you consent to sign up for the Patient Portal Patient Portal ☐ Accept ☐ Decline Email:			
PHARMACY INFORMATION			
Pharmacy Name:	Pharmacy Phone No. or cross streets:		
I allow Digestive Health Associates to view my prescription history from an external source due to continuing patient care. **Patient's Initials:**			
GOVERNMENT MANDATED INFORMATION			
Preferred Language: ☐ English ☐ Spanish ☐ Other:			
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Decline to provide			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide			

Medical Information

Name: ______________________________
Date of birth: ________________________ Height: _____________ Weight: _____________

What is the date of your last colonoscopy? What were the findings of your last colonoscopy?

____

Medications-Please list all current medications with dosage that you are taking.

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________
9. ______________________________ 10. ______________________________

Check any illness or conditions you have/had:

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Sexually Transmitted Disease
☐ Cancer ☐ Liver Disease ☐ Jaundice ☐ Kidney Disease
☐ Asthma ☐ Arthritis ☐ Vein Trouble ☐ Bleeding Tendencies
☐ Heartburn ☐ Stomach Ulcer ☐ TB ☐ Hepatitis

Other:

____

Are you allergic or sensitive to medications or other substance:
☐ Yes ☐ No
List: ____

Please list all surgical and procedure history and date of surgery/procedure:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________
9. ______________________________ 10. ______________________________

Please identify any significant medical history for the following family members:

Family	Alive	Deceased	Present Health or cause of death
Mother	☐	☐	______________________
Father	☐	☐	______________________
Paternal Grandfather	☐	☐	______________________
Paternal Grandmother	☐	☐	______________________
Maternal Grandfather	☐	☐	______________________
Maternal Grandmother	☐	☐	______________________
Siblings	☐	☐	______________________
Children	☐	☐	______________________

Social History:

Do you consume alcoholic beverages?: ☐ Yes ☐ No
Type and Amount: ____________________________ How Long? _______________________

☐ Current Tobacco Use Type: _____________ Frequency/Amount: ___________ How Long? _______________
☐ History of Tobacco Usage ☐ No Tobacco Use History

Do you use/have used illicit drugs?: ☐ Yes ☐ No
Type and Amount: _______________________ How Long? ___________________________

Welcome to Digestive Health Associates, our main goal is to provide the best quality of care for our patients. The doctors and staff will strive to perform the most necessary and reasonable services required for your well-being and care. We want your visits to our offices to be as comfortable as possible. Please read these policies prior to your treatment so that you will have a better understanding of our office policies. Sign the acknowledgements on this page and take a copy of both our office policy statements and the HIPPA policy.

ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read, understand, and agree to abide by the policies stated on the office policy form.

Patient/Guarantor Signature ___________________________________ Date __________________

ACKNOWLEDGMENT OF TRUE AND ACCURATE INFORMATION

The information reported on this document is true to the best of my knowledge. I hereby authorize the physicians and staff of Digestive Health Associates to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health. I authorize direct payment to be made to the physicians of Digestive Health Associates for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Digestive Health Associates is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

Patient/Guarantor Signature ___________________________________ Date __________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________, have received a copy of Digestive Health Associates Notice of Privacy Practices.
(Patient's Name)

Patient Signature ___________________________ Date ____________ Date of Birth: _________

RELEASE OF INFORMATION

Patients frequently request that their medical treatment be discussed with family members or other parties. If there is anyone with whom you would like to authorize the doctor to discuss your treatment, please indicate that person's name and relationship, as well as any limiting circumstances (Example: lab results, medications or emergency situations)

Please Print Name: _____________________________ Relationship: __________________________________
Please Print Name: _____________________________ Relationship: __________________________________
Limiting Circumstances: ____

Patient/Guarantor Signature ___________________________________ Date __________________

I understand that these instructions can be revoked at any time upon my written request. ___________________
Please initial

Office and Financial Policies

General Office Policy: Prescriptions are issued during office hours only. Due to HIPAA guidelines and to protect your confidentiality, we no longer refill medications by phone or fax. If you take medication for a chronic condition you are required to see the physician on a regular basis. It is your responsibility to plan ahead so that you do not run out of your medications.

You may be assessed a **$25.00 no-show fee** for select appointments that are not cancelled at least 24 hours before the appointment time.
This office has established an **Email policy** to better serve our patients. If you provide us with your Email address, you are giving us permission to email your test results or other personal health information. You will need to contact this office or schedule an appointment if you have questions about any information contained in the email. Although this office is dedicated to keeping your medical record information confidential, third parties may have access to email messages despite our best efforts. You should be aware that some companies consider email corporate property and your messages may be monitored if you communicate from work. This office is not responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

If you have **Lab Tests or Imaging,** the "Normal" results of these will be posted in the patient portal within 10-12 business days. Please allow two weeks from the date your tests were performed to phone our office for results. Normally within this time frame we have notified you of the results. There are times when the results notice may ask you to make an appointment. Please do not be alarmed, this typically means that the provider wants to speak to you in person for clarification or educational reasons. Please be assured that if your results are of an urgent nature the physician or nurse will call you immediately to discuss or give you further directions.

We will fax, mail or electronically send copies of your M**edical records** to other physicians with a signed authorization to release health information form, as a professional courtesy. Medical records are available to our patients with a signed authorization to release health information form and a fee of **$25.00** for the first 20 pages and $.50 for each additional page payable prior to or at time of pickup. Medical records requested by insurance companies or attorneys must be requested by those entities.

Financial Policy: We consider all charges to be reasonable and customary for this geographical area. ***Payment is due in full at the time services are rendered***. For your convenience we accept cash, check and credit cards (MasterCard, Visa, American Express and Discover). There is a **$30.00 charge** on all **Returned Checks** and we do not accept post-dated checks. It is our policy to report past due balances over 120 days to the credit bureau unless special arrangements have been made through the billing office. While we understand and respect that you have every intention of paying your bills, we have thousands of accounts that we report to the credit bureau as delinquent every year and as such must request a social security number from everyone. All non-cash transactions and/or services that are to be filed to insurance require a legal form of picture identification (Driver's license, State issued I.D. card, Passport). This picture identification will be scanned into our computer system and maintained as a part of your permanent record for both medical and financial purposes. This is for your protection as well as ours. With both financial and health identity theft taking place in this country every year, we feel that we must be able to verify your identity. Everyone has the right to refuse to provide the requested information. Your refusal will require payment in full in ***cash*** and we will ***not*** file insurance claims on your behalf. Please notify the front desk if you are unwilling to provide the requested identification information.

Insurance Contracts: Digestive Health Associates will file your claim to those insurance companies with whom we have current contracts. As a courtesy, this office attempts to verify your insurance benefits prior to any services you may receive but the information we receive is not a guarantee of payment and you are ultimately responsible for knowing your plan benefits and requirements and therefore responsible for any and all co-pays, deductibles, co-insurance and non-covered services as identified on the explanation of benefits we receive from your insurance plan. All insurance contracts obligate your physician to collect any and all copays, deductibles, or co-insurance amounts from you. It is your responsibility to notify Digestive Health Associates of any change in insurance coverage. Failure to provide this office with current insurance information at the time of service may result in you being held responsible for the full amount of the charges because of claim filing deadlines required by your insurance which are typically 90-days or less. Many insurance plans require prior-authorizations for certain tests, referrals, ER visits, and/or treatment. These must be obtained prior to treatment. Without the proper authorization, your insurance may refuse to pay, and you will be responsible for all charges. It is the patient's responsibility to obtain referrals prior to their office visit from their referring physician (if required by insurance).

HIPPA Notice of Privacy Practices

This notice if Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or heath care operations (TPO) and for the purposes that are permitted or required by law. It also described your rights to access and control your protected health information, that may identify you and that related to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be released to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activates include, but are not limited to. Quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician in 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 use or disclose your protected health information in the following situations without your authorization. There situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to 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 section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatments, 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 the notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use anther Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative, i.e. electronically.

You have the right to have your physician ament your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail or posting within the office of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or 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 contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance Officer in person or by phone at 713-468-2030.

Procedure Disclosure

The goal at Digestive Health Associates is to provide quality gastrointestinal endoscopies in a comfortable, safe, and convenient environment.

While having a procedure with a physician of Digestive Health Associates, you may incur separate charges related to your procedure:

- Physician Fee
- Facility Fee
- Anesthesia Fee
- Histology Lab & Pathology Fees (if polyp(s) are removed and/or tissue(s) biopsied)

<u>Physician Fee</u>

Physician fees are all in network and will be billed to your insurance, if a balance is due it will be the patient's responsibility and a bill will be sent from our office to you.
*Cancellation Policy- A $150 fee will be charged for cancellations called into the office with less than 72 hours' notice.
*Rescheduling Policy- A $50 fee will be charged for procedures which are rescheduled with less than 48 hour notice.

<u>Facility Fee</u>

The facilities used by the physicians at Digestive Health Associates are in network with your insurance. The facility will call prior to your procedure date to provide you an estimate of your financial responsibility.
For questions about the facility fee, call
Memorial Endoscopy Center at 713-468-9200
Memorial Hermann Memorial City Hospital at 832-658-6325

<u>Anesthesia Fee</u>

Anesthesia services are considered <u>out-of-network</u> by some insurance plans regardless of location of service. However, you may still receive these services at affordable rates. Please call the rendering providers directly for more information and check with your medical insurance.
For questions about the anesthesia fee, call
Campbell Anesthesia Group, PLLC at 713-464-1650.
Memorial Hermann Memorial City Hospital (U.S. Anesthesia Partners) at 713-242-3439

<u>Histology & Pathology Fee</u>

Memorial Endoscopy Center and the physicians of Digestive Heath Associates have teamed up with specialist in GI pathology services to ensure that biopsy specimens are processed and diagnosed by some of the top gastrointestinal pathologists. GALA Histology Lab prepares specimens and United Pathology Associates' pathologists read the specimens. Both are in network with your insurance.
For questions about the histology lab & pathologist fees, call: 281-974-2038.

Procedures performed at Digestive Health Center located at Memorial Hermann Memorial City Hospital will have all polyp(s) and/or tissue(s) biopsies processed by the respective hospital.
For questions about the pathologist fees, call: Memorial Hermann Memorial City Hospital at 713-242-3776

By signing below, I understand that exact coverage or charges for a procedure will be determined after services are rendered and my insurance has processed the claims. I understand that I may receive a bill for any charges not paid by my insurance carrier and am financially responsible for the balance as determined by my insurance.
I also understand I have a right to refuse this procedure or discuss other available test options as the physician determines suitable in my diagnosis and treatment.

_______________________________________ ______________
Patient Signature Date

_______________________________________ ______________
In office Witness Signature Date