Digestive & Liver Disease Consultants, P.A.

Comprehensive Gastrointestinal & Hepatology: Consultative, Endoscopy & Motility Services

PATIENT CONSENT FORM

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby authorize Digestive & Liver Disease Consultants, PA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand while this consent is voluntary, if I refuse to sign this consent, DLDC can refuse to treat me.

I have been informed that Digestive & Liver Disease Consultants, PA has prepared a notice ("Notice of Privacy Practices"), which more fully describes the uses, and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Digestive & Liver Disease Consultants, PA in writing; however, if I revoke my consent, such revocation will not affect any actions that Digestive & Liver Disease Consultants, PA took before receiving my revocation.

I understand that Digestive & Liver Disease Consultants, PA has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Digestive & Liver Disease Consultants, PA restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Digestive & Liver Disease Consultants, PA does not have to agree to such restrictions, but that once such restrictions are agreed to, Digestive & Liver Disease Consultants, PA must adhere to such restrictions.

NOTICE TO PATIENTS - PHYSICIAN ASSISTANT

This organization has on staff a Physician Assistant (PA) to assist in the delivery of medical care. A Physician Assistant is not a doctor; however, a PA is a graduate of a certified training program and is licensed by the state medical board. Under the supervision of a physician, a PA can diagnose, treat and monitor common acute and chronic diseases as well as provide routine health maintenance care. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities and accepting responsibility for the medical services provided.

_____ Initial: I have read the above and hereby consent to the services of a PA for my health care needs as deemed necessary. I understand that at any time, I can refuse to see the PA and request to see a physician.

PHYSICIAN OWNERSHIP DISCLOSURE

During the course of your physician / patient relationship with the physicians of Digestive & Liver Disease Consultants, PA: Guru N. Reddy, MD, FACP, FACG, FASGE, AGAF or Howard B. Hamat, MD, FRCP ("Physicians"), your physician may refer you to Memorial Hermann North Houston Endoscopy & Surgery, LLC ("Center"). The address of the Center is 275 Lantern Bend Dr. Suite 400, Houston, TX 77090.

In connection with any referral to the Center, you are hereby advised that the above listed Physicians have an investment interest in the Center. This information is being provided to you to help you make an informed decision regarding your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Memorial Hermann North Houston Endoscopy & Surgery, LLC. You will not be treated differently by your physician or Memorial Hermann North Houston Endoscopy & Surgery, LLC if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact the Business Office via phone at (281) 440-0101 ext 1126, by email at dwalters@gimed.net or by parcel post to 275 Lantern Bend Dr. Suite 200, Houston, TX 77090.

By signing below you acknowledge that should you be referred to the Center, your signature below evidences your informed decision to decline the option to have your health care provided at another healthcare facility. Lastly, you further acknowledge by signing below that you signed the Physician Ownership Disclosure Form prior to your Physician's referral of you to the Center.

Printed Name:_____ Signature: _____

ADVANCED BENEFICIARY NOTICE (ABN)

Thank you for choosing DLDC as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ABN Policy, which we require that you read and sign prior to your treatment. All patients must review and update their demographic information ("Patient Face Sheet") prior to seeing their physician. We accept cash, checks, Visa/MasterCard, Discover and American Express.

We accept assignment of insurance benefits; however, your insurance carrier / carriers may not cover office visits or procedures for screening purposes.

_____ Initial: I have been informed and understand that my insurance carrier may not cover these routine tests. I agree to pay for these services if they are denied. (Note: Self-Pay procedures paid in full at the time the appt is scheduled, will received a 20% discount off the cost of the procedure.)

All co-pays, deductible, coinsurance and out of pocket responsibilities are due at the time services are rendered. Prepayments resulting from deductible, coinsurance and out of pocket responsibilities as required by your insurance company, for the physician fees associated with procedures, are due 72 hours prior to procedure.

_____ Initial: I release Digestive & Liver Disease Consultants, PA of any financial responsibility for fees from any outpatient entity, laboratory, pathologist, anesthesiologist or hospital. I understand that these fees are separate from Digestive & Liver Disease Consultants, PA**.**

ADVANCED DIRECTIVES

- Do you have an Advance Directive to help you communicate your medical treatment wishes at some time in the future when or if you are unable to make your wishes known due to illness or injury?
  Circle one: **YES** **NO but I want to discuss** **NO and I DECLINED to discuss**
  ***If yes, please provide a copy of this legal document for your records. _____**

- Do you have a legal Medical Power of Attorney? Circle one: **YES** **NO**
  ***If yes, please provide a copy of this legal document for your records. _____**

CANCELLATION / NO-SHOW POLICY

A 24-hour notice is required if you are unable to keep your appointments. All no-shows or cancellations without 24-hour notice will result in a charge to your account of either $25 for office visits, $50 for ancillary testing, $50 for procedures.

I have read, understand and agree to Digestive & Liver Disease Consultants, PA's Patient Consent Form including the Consent for Release of Information for Treatment, Payment & Health Care Operations, Notice to Patients - Physician Assistant, Physician Ownership Disclosure, Advance Beneficiary Notice (ABN), Advanced Directives and Cancellation / No-Show Policy contained herein.

_____ _____

Signature of patient or patient's representative **Date**

_____

Printed name of patient or patient's representative

_____ _____

Relationship to the patient **Witness**