DHAT
Digestive Health Associates
of Texas, P.A.

Dear Patient,

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 physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

**Payment Guidelines:**

- We must collect any co-payments, co-insurance, and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders and Credit Cards** (Visa, MasterCard, American Express and Discover).
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. **Please do not send the payment back to the insurance company.**
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment in full is due upon receipt of your first statement.

**When to Present Insurance Card**

Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group #, etc) since your last visit. This protects you from paying a bill because we had the wrong insurance 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. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

**Insurance Company Denies Payment?**

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

1. This is a pre-existing illness or condition that they do not cover.
2. You have not met your full calendar year deductible.
3. The type of medical services required is not covered.
4. The insurance was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You did not have a referral # for your visit/service.
7. You have exceeded your maximum dollar/visit amount.

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full at the time of billing.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at 214-689-3829 or 800-425-3759.

**Sincerely,**
**Digestive Health Associates of Texas, P.A. (DHAT)**

I have read and understand my financial obligations. DHAT/DHM may file a claim for services rendered by the physician, facility, pathology, and/or anesthesia. DHAT/DHM is authorized to transfer any patient overpayment to one of these associated facilities if applicable.

I understand that I will be fully responsible for payment in full at the time of billing of any and all medical services denied by my insurance company or determined to be my portion of the billed charges.

_____ _____

**Patient Signature** **Date**

DHAT
Digestive Health Associates of Texas, P.A.

Physician you are seeing: _____ Referred By: _____

Patient Name: _____
Last First Middle Initial

Address: _____
Street Apt# City State Zip

DOB: _____ Age: ____ Sex: M ○ F ○ Social Security # _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner

Primary #_____ Cell # _____ Work # _____

***Patient Authorization for Communication via Alternative Means***

I authorize **Digestive Health Associates of Texas, P.A.** (DHAT) to communicate my protected health information ("PHI") in the manner indicated below. I understand that it is my responsibility to notify the DHAT of any change in this manner of communications. I further understand that my PHI may be subject to redisclosure, as described on Page 7.

**(Check all that apply)**

☐ Primary # ☐ Cell # ☐ Work # ☐ U.S. Mail ☐ E-Mail ☐ Fax #_____
☐ Leave detailed messages on my answer machine/voicemail
☐ Leave brief message with only call back number, name and doctor's office on my answering machine/voicemail

Email: _____

Employer: _____ Address: _____

Patient Ethnicity: _____ (Declined) ☐

Patient Race: _____ (Declined) ☐ Language Spoken: _____

Name of Spouse: _____ Spouse SS# _____ Date of Birth _____

Emergency Contact: _____ Relationship: _____

Primary #: _____ Secondary #: _____

Pharmacy Name & Address: _____ Phone # _____

How did you hear about us?
☐ Phone Book ☐ Website ☐ Primary Care Physician
☐ Referring Physician ☐ Health Fair ☐ Insurance Company
☐ Advertisement ☐ Friend/Family: _____
☐ Other: _____

**Patient Initials: _____**

**Insurance/Financial Information**

Patient Name: _____ Date of Birth: _____

**Primary Insurance:**

Name of Insurance Provider: _____ Phone #: _____

Claim Form Address: _____ City _____State_____Zip_____

ID Number _____ Group Number_____

Subscriber if other than patient: _____ His/Her Date of Birth _____

Relationship _____

**Secondary Insurance:**

Name of Insurance Provider: _____ Phone #: _____

Claim Form Address: _____ City _____State_____Zip_____

ID Number _____ Group Number_____

Subscriber if other than patient: _____ His/Her Date of Birth _____

Relationship _____

**Assignment to Pay Insurance Benefits**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the facility of any changes to my contact and/or insurance information. I understand that I am responsible for payment of professional services at the time they are rendered and that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts determined by my insurance company to be my responsibility, and any collection/attorney fees incurred in collecting that balance. I assign to the provider all payment for medical services rendered to me or my dependents for services filed to insurance on my behalf. Balances that remain unpaid after 90 days from the date first billed may be referred to an outside collection agency for further collection efforts. I understand that if paying by check and it is dishonored, or paying by credit card and an invalid dispute leading to chargeback occurs, a processing fee of $30 will be assessed. DHAT may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

**Consent for Medical Treatment**

I, the undersigned, 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 judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. I understand that the provider will discuss with me any proposed testing or surgical procedure prior to scheduling.

**Notice of Privacy Practices**

A copy of the DHAT Notice of Privacy Practices will be provided upon request.

**Patient Signature**: _____ **Date**: _____

Patient Name: _____ Date of Birth: _____

***Reason(s) for your visit***:

***Current Medications*** – Please list any medications you are CURRENTLY taking including Vitamins and Alternative Medicines/Herbs:
Name of Medication and Dose:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

***Medical History*** – Check conditions that you have, had or are having:

| | | |
|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Emphysema | ☐ Migraine Headaches |
| ☐ Alcoholism | ☐ Epilepsy/Seizures | ☐ Pacemaker |
| ☐ Anemia | ☐ Glaucoma | ☐ Prostate Problems |
| ☐ Arthritis | ☐ Gout | ☐ Psychiatric Care |
| ☐ Asthma | ☐ Heart Disease | ☐ Rheumatic Fever |
| ☐ Bronchitis | ☐ Hepatitis Type _____ | ☐ Stroke |
| ☐ Cancer (type) _____ | ☐ Hernia: Hiatal | ☐ Thyroid Problems |
| ☐ Chemical Dependency | ☐ Hernia: Inguinal | ☐ Herpes |
| ☐ Tuberculosis | ☐ Defibrillator/ICD | ☐ High Blood Pressure |
| ☐ Ulcers | ☐ Depression | ☐ Kidney Disease |
| ☐ Sexually Transmitted Disease | ☐ Diabetes | ☐ Liver Disease |

☐ Others: _____

Have you ever had a colonoscopy: ○ Never ○ Yes_____ Polyps: ○ Yes ○ No
mm/dd/yyyy

***Allergies/Adverse Reactions*:**

***Surgical History*** – List any surgeries.

Date Hospital/Location Doctor Reason for Hospitalization

***Hospitalizations/Major Diagnostic Procedure:***

Patient Name: _____ Date of Birth: _____

***Family History:***

| **List any Significant Medical Conditions** | **Date of Birth** | **Medical Conditions or Cause of Death** |
|---|---|---|
| Father: ◯ Alive ◯ Deceased | _____ | _____ |
| Mother: ◯ Alive ◯ Deceased | _____ | _____ |
| How many siblings? Sisters ___ Brothers____ | | _____ |

Children: How many sons? _____ How many daughters? _____

**Is there any history of the following in your family? Also list family member.**

☐ Celiac Disease _____ ☐ Pancreatic Disease _____

☐ Colon Cancer _____ ☐ Ulcerative Colitis/Crohn's _____

☐ Colon Polyps _____ ☐ Liver/Gallbladder Disease _____

☐ Diabetes _____ ☐ Heart Disease _____

☐ Female Cancer (Breast, Ovarian, Endometrial or Uterine) _____

***Social* History:**

**Tobacco**

Are you a: ◯ Current Smoker ◯ Former Smoker ◯ Never Smoked

If you are a current smoker, how often do you smoke cigarettes?

◯ Every day ◯ Some days, but not every day

If you are a current smoker, how many cigarettes a day do you smoke?

◯ 5 or less ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31 or more

If you are a current smoker, how soon after you wake up do you smoke your first cigarette?

◯ Within 5 minutes ◯ 6-30 minutes ◯ 31-60 minutes ◯ after 60 minutes

If you are a current smoker, are you interested in quitting?

◯ Ready to quit ◯ Thinking about quitting ◯ not ready to quit

If you are a former smoker, how long has it been since you last smoked?

◯ 1-3 Months ◯ < 1 month ◯ 3-6 months ◯ 6-12 months

◯ 1-5 years ◯ 5-10 years ◯ > 10 years

**Alcohol**

Did you have a drink containing alcohol in the past year? ◯ Yes ◯ No

If yes, how often did you have a drink containing alcohol in the past year?

◯ Never ◯ Monthly or less ◯ Two to four times a month

◯ Two to three times per week ◯ Four or more times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more

If yes, how often did you have six or more drinks on one occasion in the past year?

◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily

History of Any Blood Transfusion & Date: _____ _____

Do you have any tattoos? Yes ◯ No ◯ Do you have piercings? Yes ◯ No ◯

Have you recently traveled outside the US? Yes ◯ No ◯ If yes, where? _____

| | None? | How much? | How often? | How long? | When Quit? |
|---|---|---|---|---|---|
| Illicit Drugs | ☐ | | | | |
| Caffeine | ☐ | | | | |

Hobbies: _____ Occupation:_____

Patient Name: _____ Date of Birth: _____

***Current Symptoms:*** (Please check **all** that apply)

**General**
- ☐ Chills/Fever
- ☐ Decreased Energy
- ☐ Difficulty sleeping
- ☐ Fainting/Dizziness
- ☐ Loss of weight

**Eyes/Ears/Nose/Throat**
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Runny nose
- ☐ Sinus problems
- ☐ Mouth ulcers

**Cardiovascular**
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Irregular heartbeats
- ☐ Palpitation
- ☐ Swollen ankles
- ☐ Leg cramps
- ☐ Heart murmur
- ☐ Heart problem

**Respiratory**
- ☐ Coughing
- ☐ Coughing blood
- ☐ Tuberculosis
- ☐ Positive TB skin test
- ☐ Asthma

**Gastrointestinal**
- ☐ Poor appetite
- ☐ Trouble swallowing
- ☐ Pain with swallowing
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Ulcer disease
- ☐ Liver disease
- ☐ Hepatitis history
- ☐ Hemorrhoids history
- ☐ Bloody bowel movements
- ☐ Abdominal swelling
- ☐ Jaundice (yellow eyes)
- ☐ Gallbladder disease
- ☐ Lactose intolerance
- ☐ Celiac Disease
- ☐ Constipated
- ☐ Using laxatives
- ☐ Loss of bowel control

**Genitourinary**
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Loss of bladder control
- ☐ Sexual problems

**Musculoskeletal**
- ☐ Swollen Joints
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Arthritis
- ☐ Back pain

**Neurological**
- ☐ Numbness or tingling
- ☐ Part of body paralyzed
- ☐ Seizure history
- ☐ Severe headaches

**Psychiatric**
- ☐ Feeling depressed
- ☐ Crying often
- ☐ Easily upset/irritated
- ☐ Frequent nightmares
- ☐ Frequently nervous
- ☐ Thinking of suicide

**Endocrine**
- ☐ Diabetes
- ☐ Thyroid problems

**Hematologic/Lymphatic**
- ☐ History of anemia
- ☐ History of tumor/cancer
- ☐ Bruise easily
- ☐ Bleed excessively

**Allergic/Hematologic**
- ☐ Hayfever
- ☐ Hives frequently
- ☐ Allergies to food

_____
Patient Initials

Patient Name: _____ Date of Birth: _____

***Please print all information, then sign and date the form at the bottom***

**7.30** ***Patient Authorization for Personal Representative***

I authorize **Digestive Health Associates of Texas, P.A.** to disclose or provide my protected health information ("PHI") the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my PHI. They may also consent to authorize the use or disclosure of my PHI:

_____
Name of Personal Representative and Relationship (i.e. Spouse, family member, etc)

_____
Address

_____
City, State, Zip

_____
Phone Number

***Description of Information to be Disclosed:***

I authorize **Digestive Health Associates of Texas, P.A.** to disclose the following PHI to my designated personal representative.

**Select One:** ○ **Procedure & Biopsy** ○ **Labs** ○ **All Information**

---

***Expiration or Termination of Authorization***

This authorization will remain in effect until terminated by the patient, the patient's representative, or another individual or legal entity authorized to do so by a court of law.

---

***Right to Revoke or Terminate***

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:

**Digestive Health Associates of Texas, P.A.**

**_____**

**_____**

**Attn: _____**

---

***Redisclosure Statement***

I understand that the practice has no control regarding persons who may have access to the mailing address, telephone, cell, or fax number I have designated to receive my PHI. I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

**Patient Signature**: _____ **Date**: _____



Reset Form