Diagnostic Clinic of Houston
MODERN MEDICINE • SENSITIVE CARE

Locations
☐ Museum District ☐ Medical Center
☐ W. Houston ☐ Katy ☐ Pearland ☐ Pasadena
www.diagnosticclinic.com

Patient Information

Date________________________ **Patient Status**: ☐ New ☐ Established ☐ Consultation ☐ Referral

Patient Name (Last)__________________ (First)________________ (MI)______ Sex______
Date of Birth________________ SSN________________ Marital Status________________
Address__________________________ City ____________ State ______ Zip________
Phone______________ Cell______________ E-Mail__________________________
Primary Language______________________ Religion__________________________
Race__________________________ Ethnicity (*Hispanic or Latino*) ☐ Yes ☐ No ☐ Refuse to Report
Emergency Contact__________________ Relationship________________ Phone__________

In regards to your healthcare, would you like to receive (*to the information you provided above*):
Voicemails? ☐ Yes ☐ No **Texts?** ☐ Yes ☐ No **E-Mails?** ☐ Yes ☐ No **Portal Access?** ☐ Yes ☐ No

Employment

Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Military Active Duty ☐ Student ☐ Unemployed

Employer/School__________________________ Occupation/Degree Level__________________
Address__________________________ City ______________ State ______ Zip ________
Work Phone__________________________ May we contact you at work? ☐ Yes ☐ No

Insurance

Type of Medical Coverage? ☐ Medicare ☐ Private/Commercial ☐ Medicaid ☐ Self-Pay/Uninsured

Primary Insurance____________________ Effective Date________________ Type__________
Policy #__________________ Group #________________ Relation to Insured__________
Insured's Name__________________ Date of Birth__________ SS#________________
Billing Address____________________ City______________ State________ Zip________
Provider Services #____________________ Member Services #____________________

Secondary Insurance____________________ Effective Date________________ Type__________
Policy #__________________ Group #________________ Relation to Insured__________
Insured's Name__________________ Date of Birth__________ SS#________________
Billing Address____________________ City______________ State________ Zip________
Provider Services #____________________ Member Services #____________________

Please provide the receptionist your ID and Insurance cards

- I understand that I am required to give current insurance card(s), photo ID, and other billing information for claims to be filed to any contracted carriers on my behalf. I agree to notify Diagnostic Clinic of Houston of any changes in my insurance coverage or statement address and contact information as soon as possible.
- I understand that I am responsible for notifying the office of any recertification or referrals needed for my insurance.
- I authorize payment of medical benefits be made directly to Diagnostic Clinic of Houston for services rendered. This assignment covers any and all benefits under Medicare, private insurance, other government sponsored programs, and any other health plans.
- In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Diagnostic Clinic of Houston.
- I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf.
- I authorize Diagnostic Clinic of Houston to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

____ ____________________
Signature of Patient or Guardian **Date**

Patient Agreements and Rights

Consent to Treat

I hereby authorize Diagnostic Clinic of Houston to examine me / the patient and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate by today's standards. I authorize and give my consent to Diagnostic Clinic of Houston to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for the named patient. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

Assignment of Benefits

I hereby allow Diagnostic Clinic of Houston to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

Release of Information

I authorize release and disclosure of all or any part of my medical record to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not limited to any private insurer, government program, workers compensation payer, employer, or family member. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care. I also allow Diagnostic Clinic of Houston to obtain medical records from other sources if needed for my medical care. A photocopy of this release shall be considered valid. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release. This release may not be revoked as to any records relating to services provided during this course of treatment.

Advance Beneficiary Notice

Many insurance companies will ONLY pay for services that it determines to be "reasonable and necessary". Therefore, certain procedures are excluded from their program.

I accept personal responsibility for payment of charges for services rendered to me by Diagnostic Clinic of Houston.

I understand as a courtesy, Diagnostic Clinic of Houston does file insurance claims for hospital charges and special procedures. However, this does not alleviate my obligation to settle the account in full in the event my insurance company delays or denies the charges.

Statement of Ownership Disclosure

In order to allow you to make a fully informed decision about your health care, the physicians of Diagnostic Clinic of Houston would advise you, the patient, that he/she may have a financial interest or ownership in one or more of the following healthcare providers: Texas International Endoscopy Center, Epix Medical Services, Memorial Hermann Kingsland Surgery Center, Memorial Hermann Katy Surgery Center, Cinco Medical Anesthesia, Physicians Endoscopy Center, Gessner Anesthesia Associates, Rite Choice Pharmacy, GALA Histology Lab and/or United Pathology Associates. At some point during your care, medical services, laboratory, pathology, anesthesia or other treatment may be performed by one or more of the providers previously listed. These providers may or may not be in-network with your health plan.

You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare provider other than those listed above. You will not be treated differently by your physician if you choose to obtain healthcare services with another provider/facility.

Financial Responsibility

Diagnostic Clinic of Houston appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are rendered to me at the doctor's regular rates.

If any charges are submitted to my insurance carrier by Diagnostic Clinic of Houston or by a provider of healthcare services/products/equipment which are ordered by Diagnostic Clinic of Houston for treatment, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I understand and agree that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage.

Most health insurance carriers require the patient to pay a co-pay for services rendered. It is expected of me to pay the co-pay at the time the service is rendered at EACH VISIT.

Co-Insurance and Deductibles can be applied after a visit. Additionally, some services may not be covered by insurance. I agree to pay for any balance deemed my responsibility as per my insurance policy. I agree that all charges are due upon billing.

If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made.

I agree that if referred to a collection agency or legal action is necessary to collect my balance, I will pay the doctors' reasonable attorney fees and costs of collection. No extension or forbearance, and no attempt to obtain payment from insurance or other sources, shall waive or release my financial obligations under this agreement.

In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I agree that Diagnostic Clinic of Houston may at its discretion attempt to process the charge again and agree to an additional **25.00** charge for each attempt returned NSF.

Procedure Payments Agreement

As a courtesy, Diagnostic Clinic of Houston will contact you no later than 3 days prior to your scheduled procedure to collect on your insurance deductible or coinsurance if it applies to your insurance benefits. It is highly suggested that you contact your insurance company to make yourself aware of your insurance deductible and out of pocket benefits.

If we are not able to collect your deductible or coinsurance at least 3 days prior to your procedure, your procedure will automatically be canceled and you will have to contact the office to reschedule unless other payment arrangements have been made.

Pathology Lab Service Agreement

I have been made aware that Diagnostic Clinic of Houston may in the course of my endoscopic exam perform biopsies and further, that those tissue samples may be processed (technical component) in the Diagnostic Clinic of Houston office based histology lab. These services are independent of the actual endoscopic procedure and thus are billed and payable separately. These services will be billed to my health insurance provider and I am responsible for all remaining co-pay, coinsurance, deductible and non-covered services. I agree to make payment for these services in accordance with standard billing policy.

Cancellation Policy

At Diagnostic Clinic of Houston we are reserving a time just for you. It is important that you arrive on time and be prepared for your visit or to have your procedure done on the day and time scheduled. If you are unable to keep your appointment, please let us know at least 24 hours in advance for office visits and at least 48 hours in advance for procedures.

If you do not let us know in advance you will be assessed a $25 fee for office visits and / or a $50 fee for procedures. The fee will be your responsibility and will not be billed to your insurance.

Thank you for your understanding and assistance in assuring your care is provided timely and as scheduled.

I acknowledge that I will be responsible for payment of the missed appointment fee that will be charged in the event I do not keep or cancel my appointment with in the above allotted time. I understand that because this is a missed appointment fee it will be my financial responsibility, and it will not be billed to my insurance on my behalf.

Notice of Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present this document is to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The right to expect reasonable safety regarding the practice's procedures and environment
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments or canceling within the cancellation guidelines.
- Ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you, including demographic information, past, present or future may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

We may contact you by (telephone, mail, text message, email or a combination) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Our Promise to You
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 and to abide by the terms of the notice of privacy practices in effect.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically).

If you have any questions or objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact the Privacy Officer/Administrator:

Museum District
1200 Binz St.
Suite 1100
Houston, TX 77004
713-797-9191

West Houston
3030 S Gessner Rd.
Suite 120
Houston, TX 77063
713-777-9995

Pearland
10970 Shadow Creek Pkwy.
Suite 260
Pearland, TX 77584
713-840-5210

Medical Center
6560 Fannin St.
Suite 1008
Houston, TX 77030
713-795-0464

Katy
1331 W Grand Parkway N.
Suite 350
Katy, TX 77493
281-395-8688

Pasadena
5150 Crenshaw
Suite A100
Pasadena, TX 77505
713-585-6347

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Patient Acknowledgement

Date____________ Date of Birth____________

Patient Name (Last)__________________________________ (First)_________________________________ (MI)________ Sex_________

Please initial next to each acknowledgement and sign at the bottom

______ **Consent to Treat:** I hereby authorize Diagnostic Clinic of Houston to examine____ and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate by today's standards. I authorize and give my consent to Diagnostic Clinic of Houston to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for the named patient. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

______ **Assignment of Benefits:** I hereby allow Diagnostic Clinic of Houston to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

______ **Release of Information:** I authorize release and disclosure of all or any part of my medical record to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not limited to any private insurer, government program, workers compensation payer, employer, or family member. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care. I also allow Diagnostic Clinic of Houston to obtain medical records from other sources if needed for my medical care.

______ **Advance Beneficiary Notice:** I accept personal responsibility for payment of charges for services rendered to me by Diagnostic Clinic of Houston. I understand as a courtesy, Diagnostic Clinic of Houston does file insurance claims for hospital charges and special procedures. However, this does not alleviate my obligation to settle the account in full in the event my insurance company delays or denies the charges.

______ **Statement of Disclosure:** I have read and understand the statement of disclosure.

______ **Financial Responsibility:** I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are rendered to me at the doctor's regular rates.

I understand it is expected of me to pay the co-pay, co-insurance and deductible at the time the service is rendered at EACH VISIT.

I agree to pay for any balance deemed applicable according to my health insurance rules and regulations upon billing. I understand and agree that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage.

I acknowledge that I will be responsible for payment of the missed appointment fee that will be charged in the event I do not keep or cancel my appointment at least 24 hours in advance for office visits and at least 48 hours in advance for procedures. A $25 fee for office visits and / or a $50 fee for procedures will be assessed. The fee will be my responsibility and will not be billed to my insurance.

I agree to an additional 25.00 charge for each attempt returned Non-Sufficient (NSF) in the case of an ACH Transaction being rejected.

I agree that if referred to a collection agency or legal action is necessary to collect my balance, I will pay the doctors' reasonable attorney fees and costs of collection. No extension or forbearance, and no attempt to obtain payment from insurance or other sources, shall waive or release my financial obligations under this agreement.

______ **Notice of Patient Rights and Responsibilities:** I acknowledge I have read and understand my rights and responsibilities as a patient.

______ **Notice of Privacy Practice:** I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA}, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to ensure adequate treatment. By Signing below, I acknowledge I have reviewed Diagnostic Clinic of Houston's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I have been informed by Diagnostic Clinic of Houston of their NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing the consent. I understand that Diagnostic Clinic of Houston has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact Diagnostic Clinic of Houston at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES. I understand that I may request in writing that Diagnostic Clinic of Houston restrict how my private information is used or disclosed to carry out treatment payment or healthcare operations. I also understand that Diagnostic Clinic of Houston is not required to agree to my request restrictions, but if Diagnostic Clinic of Houston does agree then they are bound to abide by such restrictions. I understand that I may revoke this acknowledgment in writing at any time, except to the extent that Diagnostic Clinic of Houston has taken action relying on this acknowledgment.

Signature of Patient/Guardian ________________________________

Printed Name ________________________________

Date ________________________________