



Patient Update Information

Please only update if anything below has changed since your last visit.

Physician you are being referred to: _____ Primary Care Physician: _____

Referring Physician: _____

Patient Name: _____

Address: _____
Street City State Zip Code

Primary #: _____ Cell #: _____ Work #: _____

Patient Social Security #: _____ Ethnicity: _____ Decline: _____

Marital Status: Single Married Divorced Separated Widowed Domestic Partner

Sex: M F Transgender Consent for Patient Portal: Yes No

E-mail Address: _____

Employer: _____ Occupation: _____

Primary Language: _____ Secondary Language: _____

Would a translator be required? Yes No

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Primary #: _____ Cell #: _____ Work #: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____ Consent for External Rx History: Yes No

Insurance/Financial Information

Primary Insurance:

Name of Insurance: _____ Phone #: _____

Claims

Address: _____
Street City State Zip Code

Subscriber #: _____ Group #: _____

Subscriber Name If

Other Than Patient: _____ Date of Birth: _____

Relationship to the Patient: _____

Secondary Insurance:

Name of Insurance: _____ Phone #: _____

Claims

Address: _____
Street City State Zip Code

Subscriber #: _____ Group #: _____

Subscriber Name If

Other Than Patient: _____ Date of Birth: _____

Relationship to the Patient: _____

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 judgment of the 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. This has been fully explained to me. I understand and accept these terms, as indicated by my signature below.

It is very important that our office be notified of any cancellations as early as possible, so that your appointment can be offered to another patient in need. Your cooperation is appreciated in this matter.

My signature below indicates that I have read and understand the Consent for Medical Treatment and that I have received a copy of the Notice of Privacy Practices for Digestive Health Associates of Texas, P.A.

Signature

Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information.

Please review it carefully

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in regarding your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long, as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the below under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as the determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose your PHI, for the support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department 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 the Privacy Officer

We will not retaliate against you for filing a complaint.

Current Symptoms

General

Chills/Fever
Decreased Energy
Difficulty Sleeping
Fainting/Dizziness

Eyes/Ears/Nose/Throat

Blurred or Doubled 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
Palpitations
Swollen Ankles
Leg Cramps
Heart Murmur
Heart Problems

Respiratory

Coughing
Coughing Up Blood
Tuberculosis
Positive TB Skin Test
Bronchitis
Emphysema
Pneumonia
Lung Disease
Asthma

Gastrointestinal

Poor Appetite
Trouble Swallowing
Pain Swallowing
Indigestion
Heartburn
Nausea
Vomiting
Vomiting Blood
Bloating
Abdominal Pain
Diarrhea
Ulcer Disease
Liver Disease
Hepatitis
Gall Bladder Disease
Lactose Intolerance
Hemorrhoid
Bloody Bowel Movements
Jaundice (yellow eyes/skin)
Constipation
Loss of Bowel Control
Celiac Disease

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

Migraines
Severe Headaches
ADD/ADHD
Nervous Disorders
Epilepsy
Seizures
Convulsions
Numbness or Tingling
Paralyzed Body Part

Psychiatric

Crying Often
Anxiety
Feeling Depressed
Tension/Stress
Easily Upset/Irritated
Frequently Nervous
Thinking of Suicide

Endocrine

Diabetes
Thyroid Problems

Hematologic/Lymphatic

Anemia
Tumor/Cancer
Bruise Easily
Bleeds Excessively
Blood Disorders

Allergic

Hay-Fever
Hives
Allergies to Foods