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 healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps that are 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, Master Card. 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 the payment to you, please send it to us, along with all the paperwork that has been 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 you 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 subscriber or group #, ect.) since your last visit. This protects you from paying a bill due to 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.

**Why Insurance Companies Denies Payments:** 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 that must be filed first.
6. You did not have the referral # for your visit/service.
7. You have exceeded your maximum dollar/visit amount.

**Assignment of Benefits**

DHAT/DHM may file a claim for services rendered by the physician, facility, pathologist and/or anesthesiologist. DHAT/DHM is authorized to transfer any patient overpayment to one of these associated entities if applicable. I hereby authorize DHAT/DHM to: (1) release any information necessary to the insurance carries regarding my illness and treatments; (2) process insurance claims generated in the course of my examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for a period of a lifetime. This order will remain in effect until revoked by me in writing.

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

I have read, understand, and agree to the above financial policy. I understand that fees are due and payable on the date the services are rendered. I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that charges not covered by my insurance company, as well as any applicable co-payments and/or deductibles, are my responsibility. Balances that remain unpaid after 90 days may be referred to an outside collection agency for further collection efforts.

_____ _____
Signature Date

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Digestive Health Associates of Texas, P.A.

## Patient Information

Physician you are seeing: Dr Yamini Maddala  Referred By: _____

Patient Name: _____  Date of Birth: _____  Age: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

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

Patient Social Security #: _____  Ethnicity: _____  Declined: ☐

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widowed

☐ Domestic Partner  Sex: ☐ M ☐ F  Race: _____  Declined: ☐

E-mail Address: _____

Employer: _____  Occupation: _____

Primary Language: _____  Secondary Language: _____

## Emergency Contact Information

Emergency Contact Name: _____  Relationship: _____

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

## Pharmacy Information

Pharmacy Name and Address: _____

Pharmacy #: _____  ☐ Consent for External Rx History

## How did you hear about Digestive Health Associates of Texas?

☐ Phone Book  ☐ Health Fair  ☐ Other _____

☐ Referring Physician  ☐ Primary Care Physician

☐ Advertisement  ☐ Insurance Company

☐ Website  ☐ Friend/Family  _____

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Digestive Health Associates of Texas, P.A.

## Insurance/Financial Information

**Primary Insurance:**
Name of Insurance:_____ Phone #:_____

Claims
Address: _____ _____ _____ _____
Street City State Zip

Subscriber #:_____ Group #: _____

Subscriber Name if
Other than Patient:_____ Date of Birth: _____

Relationship to Patient: _____

**Secondary Insurance:**
Name of Insurance:_____ Phone #:_____

Claims
Address: _____ _____ _____ _____
Street City State
Zip

Subscriber #:_____ Group #: _____

Subscriber Name if
Other than Patient:_____ Date of Birth: _____

Relationship to 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.
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 result of treatment or examinations performed.
This form has been fully explained to me and I understand and except the contents with my signature below.
All of the above will be discussed with me by the physician prior to any proposed treatments, testing or surgical procedures being scheduled.

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

**My signature below indicates that I have read and understand the Consent for Medical Treatment, and 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 ***Digestive Health Associates of Texas, P.A.*** may use and disclose medical information about you, and about how you can gain access to this information. Please review this document 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.

**DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.** 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 reference to 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. Upon your request, we will provide you with a revised Notice of Privacy Practices 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 within the practice, and if such is maintained by the practice, on its website. **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 specified 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, telephone), and 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 copy your PHI** - This means you may 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 fee for paper or electronic copies as established by professional, state, or federal guidelines.

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

**You have the right to request disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**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, please feel free to contact our Privacy Manager. Contact information is provided on the following page 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.

**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 and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**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, making a determination of eligibility or coverage for insurance benefits. **Healthcare Operations** - We may use or disclose, as needed, your PHI in order to 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.

**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 the PHI, 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 for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; 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 Manager at: 214-689-5960. We will not retaliate against you for filing a complaint.

Revised Date: 06-01-2016 Publication Date: 04-13-2004

DHAT
Digestive Health Associates of Texas, P.A.

## Patient Authorization for Person Representation

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

_____
Name of Person Representative and Relationship to the Patient

_____
Address, City, State, Zip

_____ _____
Phone # E-mail Address

I authorize disclosure of the following PHI to my Designated Personal Representative:

☐ Procedures & Biopsies ☐ Labs ☐ All Information

## Patient Authorization for Communication through Alternative means

I authorize ***Digestive Health Associates of Texas P.A.*** (DHAT/DHM) to communicate my protected health information (PHI) in the manner indicated below. I understand that it is my responsibility to notify DHAT of any changes in this manner of communications and that any disclosure made to the designated address or number, indicated by me is subject to the re-disclosure statement within this authorization.

**(Check All That Apply)**

☐ Primary# ☐ Cell# ☐ Work # ☐ Fax # ☐ U.S. Mail ☐ E-mai Addressl

☐ Leave a detailed message on my answering machine/voice-mail.
☐ Leave a brief message with only a call back number, the staff member's name and the name of the office on my answering machine/voice-mail.

**Expiration or termination of authorization –** This authorization will remain in effect until terminated by the patient, the patient's personal representative, or another individual of 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.***
***7610 Stemmons Frwy. Suite 500***
***Dallas, Texas 75247***
***Attention: Privacy Manager***

**Re-disclosure Statement –** I understand that the practice has no control regarding persons who may have access to the mailing address, telephone, cell phone, or fax that I have designated to receive my PHI. Therefore, I understand that re-disclosure of my PHI under this authorization is not the responsibility of ***Digestive Health Associates of Texas, P.A.***

_____ _____
Signature Date

DHAT
Digestive Health Associates of Texas, P.A.

Patient's Name:_____ Date of Birth: _____

Weight _____ Height _____

## Patient History

**Current Medications –** Please list any medications you are CURRENTLY taking, including Vitamins and Alternative Medicines or Herbs.

Name Dose and Frequency of Medication:

_____ _____

_____ _____

_____ _____

_____ _____

## Medical History

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

**Drug or Food Allergies/Intolerance and Reactions:** ☐ **None**

_____ _____

_____ _____

## Surgical/Hospitalizations

| Date | Hospital Name/Location | Doctor's Name | Reason |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

_____ _____

Signature Date

DHAT
Digestive Health Associates of Texas, P.A.

Patient's Name:_____ Date of Birth: _____

## Family History

| List any significant medical conditions. | Date of Birth | Medical Conditions/Cause of Death |
|---|---|---|
| Father: ☐ Alive ☐ Deceased | _____ | _____ |
| Mother: ☐ Alive ☐ Deceased | _____ | _____ |
| Number of Siblings: _____ | _____ Sisters | _____ Brothers |
| Number of Children: _____ | _____ Sons | _____ Daughters |

**Is there any family history of the following? Please list the family member.**

Celiac Disease _____ Ulcerative Colitis/Crohn's _____

Colon Cancer _____ Liver/Gall Bladder Disease _____

Diabetes _____ Heart Disease _____

Pancreatic 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 do you smoke in a day?

☐ 5 or Less ☐ 6–10 ☐ 11–20 ☐ 21–30 ☐ 31 or more

If you are a current smoker, how soon after you wake, 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

_____ _____

Signature Date

DHAT
Digestive Health Associates of Texas, P.A.

Patient's Name:_____ Date of Birth: _____

**Have you ever had a colonoscopy?** ☐ **No** ☐ **Yes (Date:_____)** **Polyps** ☐ **Yes** ☐ **No**

**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 ☐ 2–4 Times a Month ☐ 2–3 Times a Week ☐ 4 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?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or More

If yes, how often, did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily/Almost Daily

**Do you have any tattoos?** ☐ **Yes** ☐ **No**

**Do you have any piercings?** ☐ **Yes** ☐ **No** **Where** _____

| | None? | How Much? | How Often? | How Long? | When did you quit? |
|---|---|---|---|---|---|
| Illicit Drugs | _____ | _____ | _____ | _____ | _____ |
| Caffeine | _____ | _____ | _____ | _____ | _____ |

**Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No** **Date:** _____

**Travel**

Have you recently traveled outside the United States? ☐ Yes ☐ No Where? _____

**Hobbies** _____

_____ _____

Signature Date

DHAT
Digestive Health Associates of Texas, P.A.

Patient's Name:_____ Date of Birth: _____

**Current Symptoms** – Please check all that apply.

**General**
- ☐ Chills/Fever
- ☐ Decreased Energy
- ☐ Difficulty Sleeping
- ☐ Fainting/Dizziness

**Eyes/Ears/Nose/Throat**
- ☐ Blurred or 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
- ☐ 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 History
- ☐ Gall Bladder Disease
- ☐ Lactose Intolerance
- ☐ Hemorrhoid History
- ☐ Bloody Bowel Movements
- ☐ Abdominal Swelling
- ☐ Jaundice (yellow eye/skin)
- ☐ Constipated/Using Laxatives
- ☐ 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
- ☐ Fainting
- ☐ ADD
- ☐ Nervous Disorders
- ☐ History of Epilepsy
- ☐ History of 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**
- ☐ History of Anemia History of
- ☐ Tumor/Cancer
- ☐ Bruise Easily
- ☐ Bleeds Excessively

**Allergic**
- ☐ Hay-fever
- ☐ Hives
- ☐ Allergies to Foods

_____ _____
Signature Date