GI Alliance

Patient No-show, Cancellation and Re-scheduling Policy

No-shows:

Defined as a patient who does not arrive for their scheduled office visit, telemedicine visit, or procedure.

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient does not show up for a scheduled appointment it:

-Potentially jeopardizes the health of the "no-showing" patient.

-Displaces the care of another patient that would have taken the appointment slot.

- A patient who does not show for their office/telemedicine visit appointment **will be charged $50.00 per occurrence.**
- A patient who does not arrive for their scheduled procedure **will be charged $100.00 per occurrence.**
- These fees will be charged to the patient and not the insurance company, and are **due at the time of the patient's next office visit.**
- A patient who repeatedly does not show for their office/telemedicine visit appointment or scheduled procedure could lead to the patient's dismissal from the practice.

Cancellations and Rescheduling:

Defined as a patient who does not cancel their scheduled office visit, tele visit, or procedure in a timely manner.

- A patient who cancels an appointment without providing two (2) business days' notice **will be charged $50.00 per occurrence.**
- A patient who cancels a scheduled procedure without providing four (4) business days' notice **will be charged $100.00 per occurrence.**
- A patient who re-schedules an appointment more than two (2) times after the initial scheduled appointment **will be assessed a fee of $50**. Repeated requests to re-schedule appointments and procedures could lead to the patient's dismissal from the practice.

Cancellation and rescheduling fees will be charged to the patient and not the insurance company and are due at the time of the patient's next office visit.

I have read and understand the No-show, Cancellation and Rescheduling Policy and agree to its terms.

Signature (Patient/legal Guardian)	Relationship to Patient
Printed Name	Date

TDDC

Texas Digestive Disease Consultants

Today's date _____ Name of physician you are seeing today _____

Last name of patient _____ First name _____ Middle Initial _____

Street address _____

City _____ State _____ ZIP _____

Home Phone _____ Work phone _____

Mobile phone _____ E-mail address _____

Date of birth _____ Age_____ Sex _____ Marital status _____

Social security number _____ Occupation _____

Employed by _____

Preferred method of contact (please circle one) Home phone Cell Work Portal Letter Declines to specify

Emergency contact _____ Relationship to patient _____

Home phone _____ Work phone _____

Referred by _____ Referring physician phone _____

Primary insurance _____ Insured name _____

Relationship to patient _____ Insured DOB _____ Insured SSN _____

ID# _____ Group # _____ Insurance phone _____

Employer name _____

Secondary insurance _____ Insured name _____

Relationship to patient _____ Insured DOB _____ Insured SSN _____

ID# _____ Group # _____ Insurance phone _____

Employer name _____

☐ I authorize the insurance listed above to pay directly to Texas Digestive Disease Consultants all benefits due me, as provided for in the above policy contract with the aforementioned company(ies). I will pay for all such charges that may be denied by the insurance company(ies) above mentioned. I hereby consent to receiving calls or texts on my mobile device.

☐ I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

☐ I hereby consent to treatment rendered by Texas Digestive Disease Consultants, which could include in office procedures and injections.

_____ _____

Signature of Patient/Guardian/Personal Representative Date

_____ _____

Name of Guardian/Personal Representative (please print) Relationship to patient

Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Please print all information, then sign and date authorization form at bottom.

Patient Name: _____ **Date of Birth:** _____ _____

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone, electronically or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of your protected health information, including medical and personal information pertaining to your condition and treatment (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI and payment information to me via the means described below. I also approve of making a payment via the below means. I understand that is it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐text message ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date): _____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Practice Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

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

Secure Communication – Note that regular email and electronic communications are not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____

Authorized Signature (patient, parent, or legal guardian) Date Signed

_____ _____

Description of Authorized Representative's Authority (as applicable) Authorized Representative's Printed Name

_____ _____

Minor's Signature (as applicable) Date Signed

TDDC

Texas Digestive Disease Consultants

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Form must be completed for all persons under the age of 18 years

The Texas Family Code allows only certain people to consent to medical treatment for minors if parental consent cannot be obtained. These are:

1. A grandparent
2. An adult sister or brother
3. An adult aunt or uncle
4. An educational institution in which your child is enrolled, which has written authorization to consent to treatment
5. Any adult who has care and control of the child and who has written authorization from the parent to consent to treatment.

I, _____, am

☐ the parent

☐ the guardian (specify relationship)

of the minor child, _____, and hereby authorize Texas Digestive Disease Consultants and/or its authorized agents, to consent to what ever medical treatment they may deem necessary while said minor is under their care in accordance with Texas Family Code Section 32.001.

Nature of expected medical treatment: Gastroenterology Specialist Care

Date treatment is expected to begin: _____

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

Communication of Protected Health Information
Release Form

Patient Name:_____ Patient ID:_____ D.O.B.:_____

Date:_____GI Physician:_____

By signing this release, I authorize GI Alliance on behalf of itself and the other companies/components, which have been designated as a HIPAA Affiliated Covered Entity to discuss my health information and payment information to me via text message or telephone, or in person or by telephone, with the individual(s) and/or organization(s) listed below.

I acknowledge that this release is for verbal or written communication only and does not allow for copies of my medical records to be released. This release will expire when I am no longer receiving care from GI Alliance.

(PLEASE PRINT NAMES)

Physician: _____ Physician: _____

Spouse: _____ Mother: _____

Father: _____ Guardian: _____

Brother: _____ Sister: _____

Son: _____ Daughter: _____

Other Individual: _____ Individual's Relationship to Patient: _____

Other Individual: _____ Individual's Relationship to Patient: _____

I authorize that my health information may be disclosed as well as information relating to the following items that I have initialed below:

_____ Mental Health _____ Genetics

_____ Drug, Alcohol, or Substance Abuse _____ HIV/AIDS

I understand that this authorization may authorize the communication of all medical records including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any disclosure by the recipients is prohibited.

I understand that once the above information is disclosed, It may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I acknowledge that I have the right to revoke this release, in writing, prior to its expiration. I further acknowledge that the written revocation will not affect *any* communication of my medical information to the individual(s) and/or organization(s) listed on this form prior to the time that it is revoked.

_____ _____

Authorized Signature (patient, parent, or legal guardian) Date Signed

_____ _____

Description of Authorized Representative's Authority (as applicable) Authorized Representative's Printed Name

_____ _____

Minor's Signature (as applicable) Date Signed

Revised 11/2022