San Antonio Digestive Disease Consultants, PA

Ricardo Hernandez, MD ***Steven E. Hearne, MD*** ***Clinton D. Polhamus, MD***

Diplomats of the American Board of Internal Medicine and in the Subspecialty of Gastroenterology

1804 NE Loop 410, Suite 101 San Antonio, TX 78217

Phone: (210) 828-8400 Fax: (210) 804-4454

www.sanantoniodigestivedisease.com

Welcome New Patient:

Thank you for choosing San Antonio Digestive Disease Consultants for your digestive needs. All our doctors are Board Certified Gastroenterologists. We have two locations to serve you; our primary office is located at 1804 NE Loop 410, Suite 101, San Antonio, TX 78217 or our secondary office is located at 12709 Toepperwein Rd, Suite 301, San Antonio, TX 78233. Our office phone number is (210) 828-8400.

The mission of our physicians and staff is to provide outstanding patient care and customer service. In order to meet those standards, please take time to review the enclosed New Patient paperwork which include;

Patient Registration and Consent Forms
Medical Release Form
Patient Medical Questionnaire
Notification for Patient's Rights and Responsibilities/Notice of Privacy Practices
Patient Financial Responsibility Acknowledgement Form

If you have had a previous colonoscopy, we would like to have your report at the time of your visit. Please complete the Medical Release form with provider's name that performed your procedure, sign and return form to our office as soon as possible.

You can return the medical release form by either:

- Enclosed return envelope Fax: 210-804-4454 E-mail: ptinfo@saddc.net

On the day of your appointment please bring the following:

- Completed forms in New Patient Packet
- Insurance card(s)
- Picture ID or Driver's License
- Your medication bottles (prescribed or over the counter)

At San Antonio Digestive Disease Consultants, our goal is to provide quality patient care in a timely manner. Please be courteous and call our office if you are unable to keep your appointment or if you are running late. This time will be reallocated to someone who is in urgent need of treatment. Please note failure to give a 48 hour cancellation notice may result a fee being assessed to your account, fee will be determined based on appointment type. This fee is not billed to your insurance and you will be responsible to pay it out of pocket.

As a courtesy you will receive a phone call reminding you of your appointment time and to inform you of any copays due at the time of your visit. Unless prior arrangements have been made with our business office, all payments are due at the time of your visit.

If you have any questions or concerns about your upcoming visit, please don't hesitate in calling our office at (210) 828-8400. We look forward to seeing you soon.

San Antonio Digestive Disease Consultants

San Antonio Digestive Disease Consultants and Endoscopy Center

Diplomats of the American Board of Internal Medicine and in the Subspecialty of Gastroenterology

☐Ricardo Hernandez, MD ☐Steven E. Hearne, MD ☐Clinton D. Polhamus, MD

Date:_____ ☐ New Patient ☐ Annual Update ☐New Information

TODAY'S VISIT

What is the reason for your visit today? _____

Referring Provider: _____ PCP Provider :_____

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI: _____

Mailing Address:_____City, State, Zip:_____

Home Address:_____City, State, Zip:_____

Patient Phone Numbers (Please check the box after the phone numbers where we may leave detailed messages):

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Personal Information

Age:_____ Date of Birth: _____ Social Security #: _____

Email: _____ Employer:_____

Occupation: _____

Marital Status: ☐ M ☐ W ☐ D ☐ S Full-time Student? ☐ No ☐ Yes

GOVERNMENT REQUIRED FOR ELECTRONIC HEALTHCARE REPORTING ALL PATIENTS MUST COMPLETE THIS SECTION

☐ African American ☐ American Indian / Alaskan Native ☐ Asian ☐ Hispanic

☐Native Hawaiian / Pacific Islander ☐ White ☐ Other Race ☐ Would rather not respond/report

☐ English Speaking ☐ Non-English Speaking

Spouse or Parent/Guardian Information

Last Name:_____ First Name:_____ MI:_____

Address, if different: _____ City, State, Zip: _____

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Age:_____ Date of Birth: _____ Social Security #: _____

Employer:_____ Occupation: _____

Emergency Contact Last Name:_____ First Name: _____

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Co-worker ☐ Other:_____

San Antonio Digestive Disease Consultants and Endoscopy Center

Diplomats of the American Board of Internal Medicine and in the Subspecialty of Gastroenterology

Patient Name: _____ **DOB:** _____

Clinical Information:

Preferred Pharmacy: _____ Telephone: _____

Preferred Laboratory: _____

How did you hear about us? ☐ Physician ☐ Internet ☐ Insurance Carrier ☐ Friend/Family ☐ Website ☐ Hospital ☐ Other _____

INSURANCE INFORMATION

*****Are you under the age of 65 and eligible for Medicare due to disability? ☐ YES ☐ NO**

MEDICARE/MEDICAID PATIENTS

Have you recently enrolled with a replacement policy? If yes, please identify _____

Are you covered under a HMO/PPO policy which makes Medicare your secondary insurance? ☐ NO ☐ YES, PLEASE COMPLETE MSP YEARLY QUESTIONNAIRE FORM IF NOT DONE SO FOR THIS OFFICE.

PRIMARY INSURANCE

Name of Insurance: _____

Name of Subscriber: _____ Subscriber's DOB: _____

Subscriber's SSN # _____ Sex: _____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date: _____ Policy # _____ Group # _____

SECONDARY INSURANCE

Name of Insurance: _____

Name of Subscriber: _____ Subscriber's DOB: _____

Subscriber's SSN # _____ Sex: _____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date: _____ Policy # _____ Group # _____

TERTIARY INSURANCE

Name of Insurance: _____

Name of Subscriber: _____ Subscriber's DOB: _____

Subscriber's SSN # _____ Sex: _____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date: _____ Policy # _____ Group # _____

San Antonio Digestive Disease Consultants and Endoscopy Center

Diplomats of the American Board of Internal Medicine and in the Subspecialty of Gastroenterology

Patient Name:_____ **DOB:**_____

GENERAL CONSENT FORMS

CONSENT TO TREATMENT

I consent to any medical treatment, laboratory procedures, diagnostic or therapeutic treatment, or any other services rendered by the staff of San Antonio Digestive Disease Consultants & Endoscopy Center, **(collectively referred to herein as SADDCEC)** under the general or special instructions of the physician. I also consent to the admission of observers and/or assistants to the room where procedures, tests, or examinations are performed and to the disposal of any specimens removed in accordance with SADDCEC policy.

PATIENT INITIALS: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to SADDCEC reimbursement benefits on all insurance policies otherwise payable to me for services rendered. I authorize SADDCEC to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to the SADDCEC bill and to make refunds to insurance companies, if refunds are due, under provisions of such insurance policies. I hereby assign all rights, as the insured, to bring any action against my insurance company for benefits due under the insurance policies.

PATIENT INITALS: _____

ELECTRONIC PRESCRIPTION

I give my permission to obtain all my medications /prescription history when using and electronic system to process prescriptions on my behalf.

PATIENT INITALS: _____

AUTHORIZTION DISCLOSURE AUTHORIZATION FORM (OPTIONAL)

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members. Individual's you authorize SADDCEC to disclose specific PHI:

BY LAW WE DO NOT DISCLOSE ANY INFORMATION CONTAINING DRUG, ALCOHOL, MENTAL HEALTH STATUS, OR SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS RELATED INFORMATION BY PHONE TO ANYONE

NAME	RELATIONSHIP	TELEPHONE

I HAVE READ A COPY OF THE NOTICE OF PRIVACY PRACTICES? AND UNDERSTAND THAT I AM ENTITLED TO A COPY UPON REQUEST ☐ **YES** ☐ **NO** **INITIAL:** _____

I HAVE RECEVIED SADDCEC'S FINANCIAL POLICY AND DISCLOSURE ☐ **YES** ☐ **NO** **INITIAL:** _____

I HAVE RECEVIED A COPY OF SADDCEC'S PATIENT RIGHTS & RESPONSIBILITES & DISCLOSURE OF OWNERSHIP ☐ **YES** ☐ **NO** **INITIAL:** _____

_____ _____

Patient Signature **Date**

San Antonio Digestive Disease Consultants, P.A.
San Antonio Digestive Disease Consultants Endoscopy Center

1804 NE Loop 410, Suite 101 * San Antonio, Texas 78217
Phone: 210-828-8400 * Fax: 210-828-8648

AUTHORIZATION TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Release from:

Name: _____

Address: _____

City, Tx, Zip: _____

Phone: _____

Fax: _____

Release to:

San Antonio Digestive Disease Consultants, P.A.,

San Antonio Digestive Disease Consultants Endoscopy Center

1804 NE Loop 410 #101, San Antonio, Texas 78217

Phone: 210-828-8400 Fax: 210-828-8648

By signing this form, I authorize the above to provide the following individually identifiable health information about me: (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, and level of detail to be releases, origin of information, etc.):

> All medical information > Radiology Reports > Laboratory/Pathology Reports

> Progress Notes > Operative Reports > Insurance Information

> Other_____

Covering the period(s) of care from _____ to _____.

I understand that information relevant to HIV testing and/or AIDS related diagnosis may be contained in this information. I understand this information may also include reference to psychiatric treatment or treatment for substance abuse.

The information will be used or disclosed for the following purpose(s):

> At the request of the individual > Continued treatment > Insurance > Legal >Other_____

This authorization will expire on: _____ not to exceed 24 months.

I understand that I have the right to inspect and copy my own protected health information to be used or disclosed under this authorization. San Antonio Digestive Disease Consultants, P.A. and Endoscopy Center will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do have to sign this authorization in order to receive treatment from San Antonio Digestive Disease Consultants, P.A. and Endoscopy Center. In fact, I have the right to refuse to sign this authorization. When my information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that San Antonio Digestive Disease Consultants, P.A. and Endoscopy Center has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above.

_____

Signature of Patient or Legal Guardian Printed Name of patient or Legal Guardian Relationship to patient Date

San Antonio Digestive Disease Consultants

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

San Antonio Digestive Disease Consultants Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. NOTE: If you pay out-of-pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your health plan.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of San Antonio Digestive Disease Consultants. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Individuals involved in you care or payment for your care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: When a research and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures that require your authorization: Disclosure of your health information or its use for any purpose other than those allowed or required by law requires your specific written authorization. Examples of these would be psychotherapy notes, marketing or fundraising activitiies. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders and testing results: Your health information will be used by our staff to send you appointment reminders. We may also contact you to provide results from exams or tests and to provide information that descibes or recommends treaments for your care.

Business Consultants: There are some services provided in our organization through contacts with business Consultants. Examples are billing or copying services, etc. We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- **The right to receive a printed copy of this notice**

- **The right to inspect and copy your protected health information**
  This means that 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 and electronic copies as established by professional, state or federal guidelines.

- **The right to request restrictions on the use and disclosure of your protected health information**
  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 circumstance when the information is needed for your treatment. In certain cases, we may deny your request for restriction. You have the right to request in writing, that we restict communication to your health plan regarding a specific treatment or service that you or someone on your behaf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

- **The right to receive request and alternative means of confidential communications concerning your medical condition and treatment**
  This means that you have the right to ask us to contact you about medical matters using an alternative method and to a alternative destination (i.e., cell phone number or alternative address, etc.) designated by you. You must inform us in writing, using the form provided by our practice. We will follow all reasonable requests.

- **The right to amend or submit corrections to your protected health information**
  This means that if you believe that the information in your health record is incorrect or that information is missing, you have the right to request that we correct the records. Your request must be in writing and include the reason you are requesting the change. In certain cases we may deny your request.

- **The right to receive an accounting of how and to whom your protected health information has been disclosed to entities or persons for reasons other than treatment, payment or healthcare operations**

- **The right to receive notification following a breach of unsecured protected health information**

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer at the address below. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person
If you would like to submit a comment, concern or complaint about our privacy practices, you can do so by sending a letter or contacting the Privacy Officer with your concerns to:

Privacy Officer
San Antonio Digestive Disease Consultants
1804 NE Loop 410, Suite 101
San Antonio, Texas, 78217
210-828-8400

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Revised Effective Date : June 30, 2013

San Antonio Digestive Disease Consultants

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed San Antonio
Patient Name
Digestive Disease Consultants Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient Date

****

San Antonio Digestive Disease Consultants was unable to obtain acknowledgement because:

- ☐ Emergency
- ☐ Patient Non-Responsive
- ☐ Patient Sedated
- ☐ Patient Confused/Disoriented
- ☐ Patient Refused - Reason_____
- ☐ Other_____

_____ _____
Staff Signature Date

SAN ANTONIO DIGESTIVE DISEASE CONSULTANTS P.A.

□ RICARDO HERNANDEZ, MD □ STEVEN HEARNE, MD □ CLINTON POLHAMUS, MD

LOCATION: □ NE LOOP 410 □ TOEPPERWEIN

Patient Questionnaire

PATIENT LABEL

Date: _____

1. Are you taking any type of these medications? Aspirin, Ibuprofen, Aleve Y or N
2. Can you take a transfusion if absolutely necessary? Y or N
3. Have you or a family member had a reaction to anesthesia? Y or N
4. Have you had a colonoscopy? Y or N If yes, when? _____
5. Have you had a scoping of the stomach (Upper Endoscopy)? Y or N
   If yes, When? _____
6. Is there a family history of stomach, colon, pancreas, liver or gallbladder cancer? Y or N
   If yes, please explain: _____
7. Is there a family history of colon polyps? Y or N If yes, who? _____
8. Do you smoke? Y or N If yes, how much? _____
9. Do you drink? Y or N If yes, how much? _____
10. Do you use illegal drugs now or in the past? Y or N
11. What is your occupation? _____
12. What is your marital status? _____
13. Is your weight stable? Y or N
14. Have you lost weight? Y or N
15. List all allergies to medication: _____

    _____

    _____

    _____

    _____
16. List <u>current</u> medical conditions: _____

    _____

    _____

    _____

    _____
17. List <u>past</u> medical conditions: _____

    _____

    _____

    _____

    _____

18. List surgeries and dates: _____

_____

_____

_____

19. Do you have any of the following? (Please check YES or NO)

	YES	NO		YES	NO
Abdominal Pain			Free or easy bleeding		
Alzheimer's			Heart Attack		
Anemia (low blood count)			Heart Disease		
Aneurysm			Heartburn		
Anxiety			Hepatitis		
Are you on oxygen?			High Cholesterol		
Arthritis			Hoarseness		
Asthma			Hypertension		
Bipolar			Kidney problems		
Black stool			Mental Retardation		
Blood in stool			Nausea or Vomitting		
Blood in urine			Pacemaker		
Change in bowel habits			Parkinson's Disease		
Chest Pain			Psychiatric Illness		
Constipation			Quit breathing		
COPD or Lung Disease			Seizures		
Coughing of blood			Sleep Apnea		
Defibrillator			Snoring		
Depression			Stent		
Diabetes			Stroke or TIA		
Diarrhea			Thryoid Disease		
Emphysema			Trouble swallowing		
Excessive headaches			Ulcers		
Fill up easily			Yellow skin or eyes		
Food gets stuck					

20. **For Females**:

Do you have periods? Y or N

When was your last period? _____

Are you on birth control? Y or N

Could you be pregnant? Y or N

PATIENT LABEL

San Antonio Digestive Disease Consultants and Endoscopy Center
Patient's Rights and Responsibilities

Every patient has the right to be treated as an individual with his rights respected. We want to assure that the rights of all patients coming to San Antonio Digestive Disease Consultants and Endoscopy Center are respected without regard to sex, culture, economic status, education handicap, race, color, age, or religious background.

PATIENT RIGHTS

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive consideration and respectful care from competent personnel in a clean and safe environment. To be free from mental, physical, sexual and verbal abuse, neglect, and exploitation. And free from use of unnecessary restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
- To understand the indications for the procedure. To receive all the information they need to give informed consent for any procedure, including the possible risks and benefits of the procedure.
- To receive complete information regarding diagnosis, planned treatment and prognosis, as well as alternative treatments/procedures and the possible risks/side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.
- To participate in all decisions involving health care, except when such participation is contra- indicated for medical reasons.
- To refuse treatment in accordance with laws and regulations and to be told what affects this may have on their health.
- To assure safe use of equipment by trained personnel.
- To be provided privacy, confidentiality and integrity of all information and records regarding their care.
- To be provided privacy, safety and security of self and belongings during the delivery of patient care service.
- To have the right to access information contained in their medical record. To approve or refuse the release of their medical records except when it is required by law and to ask for an accounting of such.
- To be aware of fees for service and the billing process.
- To complain without fear of reprisals about the care and services that they are receiving.
- Has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.
- The right to continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- To be informed if the facility has authorized other healthcare and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and functions of this institution and to refuse to allow their participation in the patient's treatment.
- To be assured that in the event of needed long-term care; this organization will provide the mechanisms to help advance the development of continuing quality care for those patients who require it.
- The right to appropriate assessment and management of pain.

PATIENT RESPONSIBILITIES

- To provide accurate past and present medical history present complaints, past illnesses, hospitalizations, surgeries, existence of advance directives, medication and other pertinent data.
- For asking questions when they do not understand something regarding their care or treatment.
- For assuring that the financial obligations for health care rendered are paid in a timely manner.
- For their actions if they should refuse a treatment or procedure, or it they do not follow or understand the instructions given them by the physician or Center employee.
- For keeping their procedure appointment. If they anticipate a delay or must cancel, they will notify the Center as soon as possible.
- For the disposition of their valuables, as the Center does not assume this responsibility.
- For showing respect and consideration to other people and property.

San Antonio Digestive Disease Consultants and Endoscopy Center
Patient's Rights and Responsibilities

COMPLAINTS/GRIEVENCES

San Antonio Digestive Disease Endoscopy Center regards the doctor-patient relationship to be sacred requiring trust, mutual respect, and confidentiality. To that end, if you have any comment, grievance or complaint regarding the care you received by this facility or a physician or employee of this facility, please voice your concern by letter, email or telephone call our Practice Administrator.

SAN ANTONIO DIGESTIVE DISEASE CONSULTANTS AND ENDOSCOPY CENTER

Attention: Practice Administrator
1804 NE Loop 410, Suite 101
San Antonio, TX 78217
Telephone: 210-828-8400 Email: admin@saddc.net

Complaints and grievances may also be filed through:

Texas Department of State Health Services Director
Health Facility Complaint Division
1100 W. 49th Street
Austin, TX 78756 888-973-0022

OR

Office of Quality Reporting
The Joint Commission 800-994-6610
complaint@jointcommission.org

ADVANCE DIRECTIVE NOTIFICATION

In the State of Texas, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions San Antonio Digestive Disease Consultants and Endoscopy Center respects and upholds those rights.

However, unlike in an acute care hospital setting, San Antonio Digestive Disease Consultants and Endoscopy Center does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

DISCLOSURE OF OWNERSHIP

San Antonio Digestive Disease Consultants and Endoscopy Center is proudly owned by the physicians. They physician who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Their investments enables them to have a voice in the administration of policies of our facility to ensure the highest quality of surgical care for our patients.

By signing this document, I acknowledge that I have read and understand its contents:

_____ _____

PATIENT/PATIENT RESPRESENTATIVE SIGNATURE **DATE**

San Antonio Digestive Disease Consultants and Endoscopy Center

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you the best possible medical care. Part of this commitment is providing you with a clear outline of our operational and financial policies. In response to the complex healthcare industry, we have taken the steps to optimize our operations in order to spend more time on patient care and less time on administration. Please carefully read items below as they are strictly enforced.

Financial Responsibility
Please understand that you are ultimately responsible for payment of medical services you receive. *Insured patients, know your insurance plan and what your benefits are.*

Proof of Identity/Insurance
All patients must complete our patient information form(s), provide photo ID and a current valid insurance cards. We will submit claims to your insurance carrier and assist you in any way we possibly can. It is important that you keep us informed regarding any changes in your insurance information.

Referrals and Pre-Authorization
We make every effort to obtain appropriate insurance referral and authorizations prior to an office visit or procedure. However it is ultimately your responsibility to verify that this referral/authorizations are in place prior to services/test/procedures are performed. If services are performed without valid referral/authorization, you may be financially responsible for entire bill.

Co-pays/Deductibles
All co-payments, deductibles, co-insurance and past due balances are due at time of service. This amounts are part of your contract with your insurance company. Failure to pay can be considered a breach of contract.

Returned Checks
There will be a $35.00 charge on all returned checks.

Credit Card on File
We continue to look for ways to make your healthcare experience as hassle-free as possible. One of these things we can do minimized paperwork, mail and additional fees associated with issuing patient's statements for balances un-collected at time of service. We have implanted a new process that allows us to charge or debit your banking account once payment is received from your insurance company. Your authorization is **ONLY** to charge for any outstanding balance identified as patient responsibility.

Missed Appointments/Late Cancellation Fee
San Antonio Digestive Disease Consultants and Endoscopy Center is dedicated to providing the highest quality care to patients and want to thank you for the privilege of providing your care. Every scheduled appointment that is missed jeopardizes the patient/physician relationship and prevents us from providing care to other patients in need. Additionally, procedure appointments require medications and supplies being ordered and prepared in advanced specifically for those patients.

We require notification of cancellation at least 48 hours prior to the appointment or earlier if possible. This can be done by calling our office @ (210) 828-8400, if calling after hours you may leave a message with the answering service attendant to forward to us.

A "**no show**" is missing a scheduled appointment. A **"late cancellation"** is canceling an appointment without calling us to cancel 48 hours in advance of an office visit or a procedure. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

FEES **PHYSICIAN APPOINTMENTS $50.00** **PROCEDURE APPOINTMENTS $100.00**

Additional Fees
Please be aware that there may be charge involved for administrative request that our office performs such as completion of disability forms, medical records, and yearly financial statements.

PATIENT ACKNOWLEDGMENT
I have read and understand San Antonio Digestive Disease Consultants and Endoscopy Center Financial Policy.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date