HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO METHODIST ACADEMIC MEDICINE ASSOCIATES

I. PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Mailing Address: _____

_____

Telephone number: Work_____ Home_____ Cell_____

II. INFORMATION TO BE DISCLOSED

I authorize _____ to disclose my health information as follows, for service dates:

_____:

- ☐ Entire Medical Record/Outpatient Clinical Record
- ☐☐ History and Physical(s)
- ☐ Operative Report(s)
- ☐ Discharge Summary(ies)
- ☐ Films ☐ Pictures
- ☐ Other_____
- ☐ Laboratory Results
- ☑ Radiology and Imaging Reports
- ☐ Other Test Results _____
- ☐ Pathology Slides, Blocks or Reports

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO:

HOUSTON METHODIST GI ASSOCIATES
DR. KAREN WOODS
6550 Fannin St, Suite 1201
Houston, TX 77030
Tel. 713-441-3372
Fax. 713-797-0622

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Methodist Academic Medicine Associates.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.

_____ _____
Signature of Patient or Qualified Personal Representative * **Date**

* If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Documentation showing Authority to Act on Behalf of the Patient: _____
(Example: Guardian of Patient, Executor of Estate)

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MEDICAL QUESTIONNAIRE

In order to gain insight into your medical needs and problems, we are requesting that you answer these questions as completely as possible. All information will become part of your permanent record and will be held in confidence.

PLEASE PRINT TODAY'S DATE: _____

Name: _____ _____
Last First Middle Spouse's name or Next of Kin

Date of Birth: _____ Place of Birth: _____ Sex: ____ Age: _____

Phone (home): _____ Phone (work): _____

Referring Doctor: _____ Referring Doctor Phone #: _____

PRIMARY GASTROINTESTINAL PROBLEM

Please explain briefly what physical condition caused you to consult a gastroenterologist

_____

_____

_____

PAST MEDICAL HISTORY

Please list any medical problems (such as high blood pressure, diabetes, etc), surgical operations, or serious injuries that you have or have had in the past. If you have had a surgical operation, please name the type of operation, year performed, and, if known, the hospital or surgeon involved.

Illness / Surgeries	Year	Hospital or Physician

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When was your last physical examination? _____

Any abnormalities found? _____

Who performed the exam? _____

Date of last menstrual period: _____ Normal Abnormal (Circle one)
Number of pregnancies: _____ Any miscarriages: Yes No (Circle one)
Do you use birth control pills? Yes No (Circle one)

Do you have any known allergies to medicines, chemicals or foods? Yes No (Circle one)
If yes, please list and describe:

_____

_____

_____

Please list your current medications (both those prescribed by a physician and those you buy over the counter). Please indicate the dosage (if known), how often you take this medicine, and how long you've taken it.

Medication	Dosage (if known)	How often	For how long

FAMILY HISTORY

Please list the age and current state of health, or age and cause of death for the following family members:

Relative	Age	Health Problems	Age (If Deceased)	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

SOCIAL HISTORY

Do you smoke? Yes / No If quit, in what year? _____
Do you drink alcohol? Yes / No Number of drinks per day? _____
Marital Status: S M W D Occupation _____

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Methodist Academic Medicine Associates reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent of a compelling reason, are not cancelled with a 24 - hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank You for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

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Preferred Telephone Contacts and Permission for Discussion with Family Members and Others

Preferred Method of Telephone Contact

If we need to contact you regarding test results, referrals, appointments, or other medical or billing information, please indicate below how you wish to be called. Please check all that apply and indicate below whether we may discuss your medical and billing information with family members or other individual.

Home Telephone: _____

- ☐ Leave only a call-back name and telephone number on my answer machine or with any person who answers the telephone
- ☐ Leave a detailed message on my answering machine
- ☐ Do not leave any type of message or call-back information if I am not there

Cell Phone Number: _____

Work Telephone: _____

- ☐ Leave only a call-back name and telephone number on my answer machine or with any person who answers the telephone
- ☐ Leave a detailed message on my answering machine
- ☐ Do not leave any type of message or call-back information if I am not there

Discussion of Medical and Billing Information with Family Members or Others

- ☐ You may also discuss my medical and billing information with my family members and with other Individuals I have listed below

Name	Relationship	Telephone Number(s)

_____ _____

Signature of Patient or Patient's Qualified Personal Representative* Date

*In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the Individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

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CONSENT TO TREAT

I voluntarily consent and authorize to the physician and other clinical personnel at Methodist Academic Medicine Associates, for the evaluation, testing, and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of Methodist Academic Medicine Associates, and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Methodist Academic Medicine Associates. I understand that this consent may be revoked in writing at any time.

PATIENT NAME (PRINT NAME) _____ **PATIENT DATE OF BIRTH** _____

SIGNATURE OF PATIENT or GUARANTOR, if minor _____ **DATE SIGNED** _____

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT FOR SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to Methodist Academic Medicine Associates, realizing I am responsible to pay non-covered services. I certify that the information given by me to Methodist Academic Medicine Associates, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.
I HAVE READ AND UNDERSTAND THIS INFORMATION.

PATIENT NAME (PRINT NAME) _____

SIGNATURE OF PATIENT or GUARANTOR, if minor _____ **DATE SIGNED** _____

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HOUSTON METHODIST HOSPITAL SPECIALTY PHYSICIAN GROUP AND ITS PHYSICIAN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for Houston Methodist Hospital Specialty Physician Group and its Physicians. The Notice describes your legal rights regarding your health information and we'll inform you of the legal duties and privacy practices of Houston Methodist Hospital Specialty Physician Group and its physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of the Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call the Privacy Official at 713.383.5129.

Patient Name: _____

Signature of Patient or
Patient's Qualified Representative: _____

Date: _____

Print Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as the Notice of Privacy Practices on behalf of the newborn (s).

For Staff Use Only

Date Acknowledgement noted in practice management system: _____

Comments if Notice not provided or Acknowledgment not obtained: _____

_____

Processed By: _____

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TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS
NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information.
Please review carefully.

This Notice of Privacy Practices identifies the general ways your protected health information can be used or disclosed. Protected health information is the individually identifiable personal health information found in your medical and billing records. This information is created or received by a health care provider, insurance company, or employer, and relates to your past, present, or future physical or mental health conditions or the payment for health care services. This information can be transmitted or maintained in any form by TMH Physician Organization and its Physicians.

This Notice describes your legal rights regarding your health information. It also informs you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated in the individual offices of each physician of TMH Physician Organization. If you receive services by your physician or a health care provider at a different location, there may be different health information privacy policies or notices, and there will be different contact information.

For the purpose of this Notice, the terms "TMH Physician Organization and its Physicians," "TMH Physician Organization," "we" and "our" refer to TMH Physician Organization as an organization as well as each individual physician affiliated with the TMH Physician Organization, with respect to health information generated or maintained by TMH Physician Organization's physicians.

OUR LEGAL DUTIES

We are required, by law, to keep your identifiable health information private; provide you with this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your health information. Not every use or disclosure in a category will be listed.

Treatment: We may use or disclose your health information to a physician or other health care provider in order to provide care and treatment to you. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose health information about you to those who may be involved in your health care outside of TMH Physician Organization, such as hospitals, physicians, and others who provide you with follow-up care and medical equipment or product suppliers. We may contact you to provide appointment reminders and to provide you with information about health-related benefits and series provided by TMH Physician Organization or by Houston Methodist, or treatment alternatives that may be of interest to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan will pay TMH Physician Organization or reimburse you for the surgery. TMH Physician Organization also will tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

Health Care Operations: We may use or disclose health information about you to support the programs and activities of TMH Physician Organization and Houston Methodist such as quality and service improvement; health care delivery review; staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements.

Additionally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Health Information Exchange (HIE): We may make your health information available electronically through an information exchange network to other providers involved in your care who request your electronic health information. The purpose of this information exchange is to support the delivery of safer, better coordinated patient care. Participation in the information exchange is voluntary. If you do not want your Houston Methodist health information to be accessible to authorized health care providers through the HIE, you may submit a signed non-participation (opt-out) form, available from your registration representative or www.houstonmethodist.org. If you decide not to participate, health care providers will not be able to access your health information through the HIE.

Authorization for Other Disclosures: We will not use or disclose your health information, except as described in this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your health information for the purpose covered by the authorization. However, we are unable to take back any uses or disclosure already made with your authorization. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, the sale of your health information and most uses and disclosures for which we are compensated.

Family and Friends: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We will also disclose health information to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

Fundraising: We may use or disclose health information about you to contact you in an effort to raise money for our organization and its operations. We may disclose this information to Houston Methodist Hospital Foundation to

assist us in our fundraising activities. Only contact information such as your name, address and telephone number, and information related to the department of your service, your treating physician, outcome information, health insurance status, and the dates you received treatment or services at Houston Methodist would be released. You have the right to opt out of fundraising communications at any time and your request must be honored. Any such communication will have clear and conspicuous instructions on how to opt out of future fundraising communications.

Future Communications: We may use or disclose your information to communicate with you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which Houston Methodist participates. If we receive any financial compensation for such communications (with limited exceptions), we will obtain your authorization prior to sending the communication and your authorization can be revoked at any time.

Public Health and Safety: We may use or disclose health information, as authorized or required by local, state or federal law, for the following purposes deemed to be in the public interest or benefit:

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect, or domestic violence;
- To help identify, locate, or report criminal suspects, crime victims, suspicious deaths, or criminal conduct on the premises of TMH Physician Organization's physicians;
- To respond to a court order, subpoena, or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs, or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence, and national security issues;
- To facilitate organ and tissue donation;
- To assist coroners, medical examiners, and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request form your military command authority (if you are a member or veteran of the armed forces);
- To provide information to a workers' compensation program.

Business Associates: There are some services provided at TMH Physician Organization and its Physicians through contracts with business associates. When there services are contracted, we will disclose your health information to the business associate so they can perform the job we have asked them to do. However, business associates are required by federal law to appropriately safeguard your information.

Research: We will disclose information to researchers after approval by an Institutional Review Board (IRB) in preparation for a research study, to recruit research subjects, or for a research study. The IRB reviews research proposals and establishes protocols to protect your safety and the privacy of your health information.

Special Privacy Protections for Alcohol and Drug Abuse Information: Alcohol and drug abuse information has special privacy protections. We will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; a court order requires disclosure of the information; medical personnel need the information to meet a medical emergency; qualified personnel use the information for the purpose of conducting scientific research,

management audits, financial audits, or program evaluation; or it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

YOUR HEALTH INFORMATION RIGHTS

Your medical record that is created after your physician has affiliated with TMH Physician Organization is the property of TMH Physician Organization. You have the following rights, with certain exceptions, regarding the health information that is created about you by TMH Physician Organization and its Physicians.

You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our web site, www.houstonmethodist.org.

Confidential Communications: You have the right to request that we communicate health information to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to TMH Physician Organization's contact person, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request should also be communicated by you to each of your physicians.

Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. To request a restriction, you must make your request in writing to the listed contact person. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Additionally, you have the right to request that we not use or disclose information to a health plan for purposes of payment or health care operations (not for treatment) if the health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. Your request for restriction must be submitted in writing to our listed contact person. In this case, TMH Physician Organization must honor your request. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Access: You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our listed contact person. You will be charged fees as authorized by law. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Amendment: If you feel that the heath information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for amendment must be made in writing to our listed contact person, and include a reason that supports your request.

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Accounting of Disclosures: You have the right to receive a list of certain disclosures that we have made within the last six years of your health information. Your request for an accounting must be in writhing to our listed contact person, and must state a time period for which you want an accounting. You may request one accounting free of charge within a 12-month period. A fee will be charged for additional lists within this same time period.

Breach Notification: In certain instances, you have the right to be notified in the event that we, or one of our Business Associates, discover an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made in accordance with state and federal requirements.

Revisions of this Notice: We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in the individual offices of Physicians of TMH Physician Organization and on TMH Physician Organization's web site. In addition, a paper copy of the revised Notice will be available upon request.

To Report a Complaint: If you believe your health information privacy rights have been violated, you can file a complaint with us or with the Secretary of the United States Department of Health and Human Services. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

Contact Person: If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your health information rights listed in this Notice, please contact:

Privacy Official
Houston Methodist
1130 Earle Street AX200
Houston, Texas 77030
713-383-5129

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MEDICARE STATUS PAYER QUESTIONNAIRE

Is Medicare primary or secondary insurance for your visit today?

There may be situations where **MEDICARE IS NOT YOUR PRIMARY PAYER** or Medicare coverage policies vary. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

What is the responder's relationship to the patient? ☐ SELF ☐ SPOUSE ☐ OTHER: _____

1. Are you receiving Black Lung Benefits? ☐ Yes ☐ No
   If yes, date benefits began: _____

2. Are the services for which you are seeing the doctor today is to be paid for by a government research program? ☐ Yes ☐ No

3. Has the Department of Veterans Affairs authorized and agreed to pay for care given to you at this facility? ☐ Yes ☐ No

4. Is your appointment today due to an illness/injury related to an accident? ☐ Yes ☐ No
   If yes, was the accident: ☐ Work related
   ☐ Non-work related

5. Are you entitled to Medicare based on: **(Check all that apply)**
   ☐ Age
   ☐ Disability
   ☐ End Stage Renal Disease (ESRD)

6. Are you currently employed?
   ☐ Yes
   ☐ No, retired. Date of retirement: _____
   ☐ No never employed

7. Do you have a spouse who is currently employed?
   ☐ Yes
   ☐ No, retired. Date of retirement: _____
   ☐ No, never employed
   ☐ Not applicable

8. Are you covered by any Employer Group Health Plan, including Federal Employee Health Benefits or any retirement policy? ☐ Yes ☐ No

For Office Use Only: ___ Form A Only ___ Form A and Form B

Recorded by: _____ Date: _____