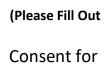


(Please Fill out Completely)

			Cell #:	
			Home #:	
Patient Name:			Email:	
Date of Birth:	Age:	_ Marital Status:	·	Sex:
Social Security #:				
Address:				
Is it ok to release medical	information? Ye	es or NO (To the f	ollowing persons)	
1	2	•	3.	
Referring Physician:			Phone:	
Primary Care Physician:			Phone:	
Emergency Contact:			_ Phone:	
Signature of Patient:			Date:	





Completely)

Purposes of

Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Dr. Peter Kvapil, Dr. Shail Maheshwari, Dr. Varia, and Dr. Clark for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis and treatment of me by Dr. Kvapil, Dr. Maheshwari, Dr. Varia, and Dr. Clark may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected for me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This is protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practices healthcare operations. The physicians are not required to agree to the restrictions that I may request, however if the physicians agree to a requested restriction, that restriction is binding on both the physicians and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that, Dr. Kvapil, Dr. Maheshwari, Dr. Varia, and Dr. Clark have taken action in relevance on this consent. I understand I have a right to review the practices **Notice of Privacy Practices** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performance of healthcare operations of Gastroenterology Specialists. It also describes my rights and the physician's duties with respect to my protected health information.

Dr. Kvapil, Dr. Maheshwari Dr. Varia, and Dr. Clark reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize the practice to call my home or work to remind me of an appointment or to reschedule and appointment. I also authorize the practice to leave scheduling information on my answering machine, or voicemail system.

Signature of Patient or Responsible Party	Date

Shenandoah, TX 77384

Authorization Request	Center for	for Medical Records
I hereby authorize protected health as described below.	Digestive Disease	use or disclosure of information about me
	OB:, authorize, Dr. Kvapil,	
Varia, Dr. Clark to request any and	all medical information from the following persons an	d or facilities.
Physician/Facility		
Address		
Telephone		
Fax		
For the purpose of continued ca	re, attorney/legal, personal use, insurance, other	
Please release the following copies	s of all patient records, to CENTER FOR DIGESTIVE DIS	EASE
persons or facility receiving it, and or withdraw this authorization by noney action already taken in advance	used or disclosed may be subject to re-disclosure by the would then no longer be protected by federal privacy rotifying Center for Digestive Disease to revoke it. How e of this authorization can be reversed and your revocated provider to whom this authorization is furnished mathematical sign authorization.	regulations. I may revoke ever, I understand that ation will not affect those
THIS FORM MUST BE FULLY CO	MPLETED BEFORE SIGNING.	
Signature		

Cancellation & No-Show Policy

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. In order to provide all our highest level of care request that all to cancel their provide 24 hours



patients with the and access we patients that need appointment advance notice.

This will enable us to better utilize available appointments to our patients.

Appointments cancelled with less than 24 hours or if the patient No-shows without notification may be subject to a cancellation fee. The cancellation fees are provided below based on type of appointment:

Office Visit \$50.00

Outpatient Procedure \$100.00

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patients next scheduled appointment.

Please contact our office should you have any questions regarding the Cancellation and NoShow fees and will be glad to assist.

Print Patient Name	Date of Birth
Patient Signature	Date