(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? Yes or NO **(To the following persons)**

1. _____________________________ 2. _____________________________3.______________________

Referring Physician: __________________________________ Phone: _____________________________

Primary Care Physician: ________________________________ Phone: _______________________________

Emergency Contact: ___________________________________ Phone: ______________________________

Signature of Patient: ____ Date: __________________

(Please Fill Out **Completely)**

Consent for 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

129 Vision Park Blvd, Suite 307

Shenandoah, TX 77384

Authorization Request for Medical Records

I hereby authorize use or disclosure of protected health information about me as described below.

I, _________________________, DOB:______________________ , authorize, Dr. Kvapil, Dr. Maheshwari, Dr. Varia, Dr. Clark to request any and all medical information from the following persons and or facilities.

Physician/Facility _______________________________________

Address _______________________________________

____

Telephone _______________________________________

Fax _______________________________________

For the purpose of continued care, attorney/legal, personal use, insurance, other

Please release the following copies of all patient records, to CENTER FOR DIGESTIVE DISEASE

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke or withdraw this authorization by notifying Center for Digestive Disease to revoke it. However, I understand that nay action already taken in advance of this authorization can be reversed and your revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

____ ________________________

Signature Date

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 patients with the highest level of care and access we request that all patients that need to cancel their appointment provide 24 hours 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