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**confidential**  
**fax**

**To:** Digestive Associates of Houston, PA  
Appointment Desk

**Fax Number:** (713) 795-5254

**Phone Number:** (713) 795-4444

**From:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Pages:** \_\_\_\_\_ (including this cover page)

**Date:** \_\_\_\_\_

**Subject:**  **1. New Patient Packet:**  
 Financial Policy (please sign and date on the bottom)  
 Patient Information form  
 New Patient Form  
 Authorization for Release of Medical Information (if needed)  
 Authorization for Release of Health Information to  
Individuals

**2. Copy of picture ID and insurance card (front and back).**

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**My appointment is scheduled on:** \_\_\_\_\_,

**check in at:** \_\_\_\_\_ **a.m. / p.m.**

# DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

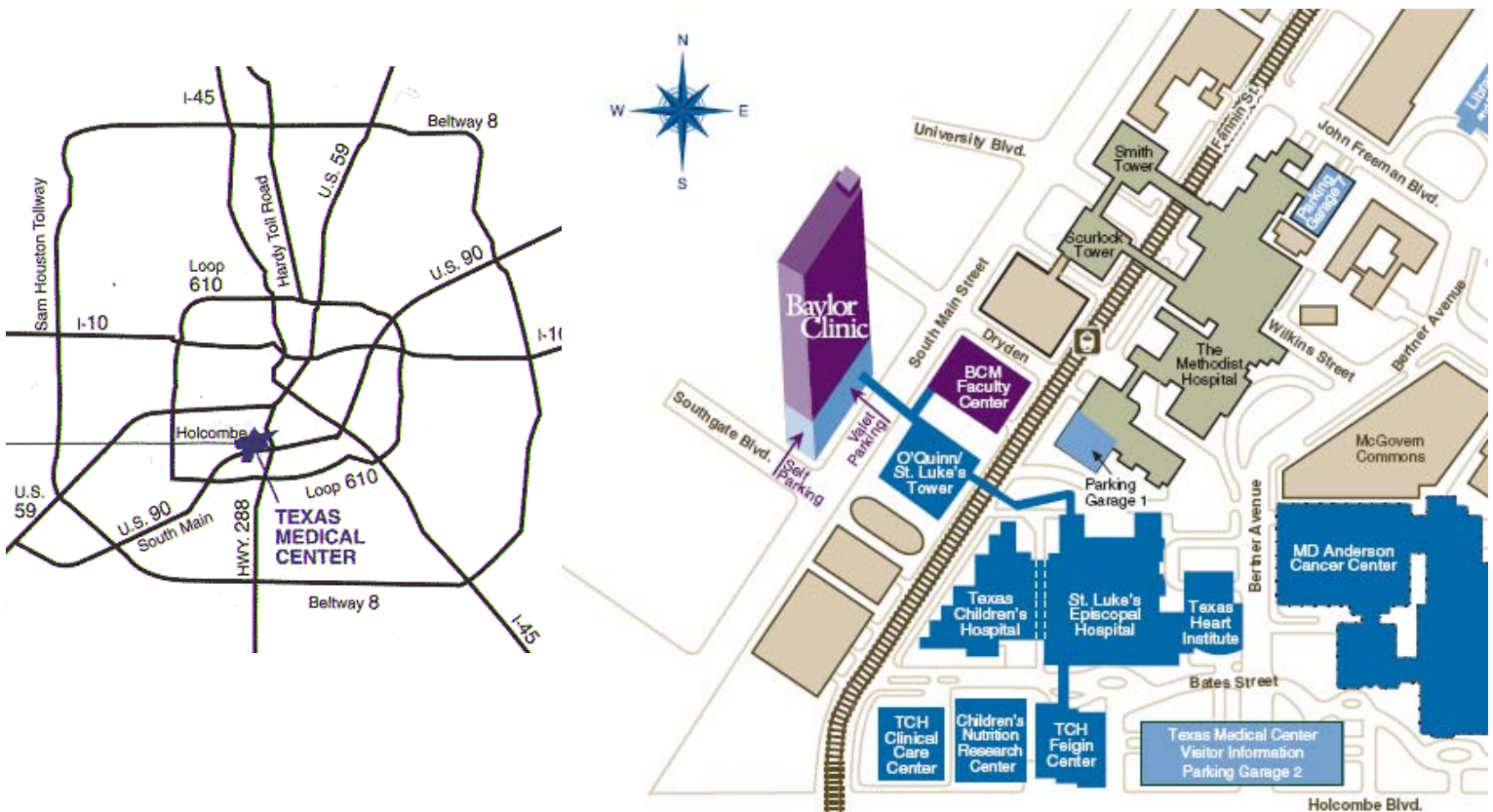
6620 Main Street, Ste 1510, Houston, TX 77030

**Baylor Clinic (BCM) Building**

**(Parking and Office Building)**

Tel: 713-795-4444 / Fax: 713-795-5254

[www.dahpa.com](http://www.dahpa.com)



## **DIRECTIONS:**

**\*We are located in the garage building. Do not walk across the sky bridge.**

### **From I-45North/ Hwy 59 North/ I-10**

1. Take I-45 South / 59 South
2. Travel Hwy 59 South to Hwy 288 South
3. EXIT Holcombe Blvd.
4. Turn RIGHT on Holcombe Blvd.
5. Turn RIGHT on Main St.
6. Turn LEFT on Southgate St  
(1<sup>st</sup> traffic light)
7. ENTER garage parking

### **From 59 South**

1. Take 59 North
2. EXIT Greenbriar
3. Turn RIGHT on Greenbriar
4. Turn LEFT on University
5. Turn RIGHT on Main St.
6. PASS Dryden St.
7. Turn RIGHT on Southgate St.
7. ENTER garage parking

### **From I-45 South / Hwy 288**

1. Take I-45 North/288 North
2. Take 610 West
3. EXIT & Turn RIGHT onto Fannin
4. Turn LEFT onto Holcombe Blvd.
5. Turn RIGHT onto Main St.
6. Turn LEFT on Southgate St.  
(1<sup>st</sup> traffic light)
7. ENTER garage parking

### **From 59 South**

1. Take US 90
2. US 90 merged to Main Street
3. Pass Holcombe Blvd
4. Turn LEFT on Southgate St.
5. ENTER garage parking

**\* Transfer from Parking Elevators to Medical Office Elevators next to the security desk.**

**FINANCIAL POLICY**

Welcome to Digestive Associates of Houston, P.A (DAH) and thank you for choosing us! We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community and region, the following policies shall be enforced:

**Self Pay/Non-Contracted Plans:**

- All charges are due and payable at time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

**Patients with insurance:**

- DAH will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay DAH for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90days from the date of service, both the insurance and patient portions of your account then become your responsibility. Our office policy is to automatically charge your credit card/personal check for any outstanding balance after your account becomes more than 90 days past due. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.
- It is the patient's responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If you do not obtain a referral from your primary care physician prior to receiving services or a referral cannot be verified by our office, you have the option of re-scheduling your appointment. If you keep your appointment and/or receive services in our office, it is with the understanding that your health plan may not pay for charges related to the services provided by Digestive Associates of Houston, PA and that without a referral you will be responsible for payment of all charges.
- Pre-existing clause: If the patient has a current pre-existing clause in the policy, the patient is required to pay the full charge for the service being rendered instead of patient's copay.

**No-Show and Cancellation Policy:**

- If the patient fails to cancel his/her procedure /test appointment at least 72 hours in advance, the patient is responsible for \$50 fee which will not be applied to any copay, deductible or coinsurance.

**Delinquent / Unpaid Account:**

- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent.
- Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physician's established guidelines. Changes shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing.

**Refunds:**

- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full.

**Third Party Litigation:**

- Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.)

**Insurance / Disability forms:**

- There will be a \$25 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms and disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

**Returned Checks:**

- Checks returned to Digestive Associates of Houston, P.A. for insufficient funds, closed account, stopped payment, or for any other reason will be subject to \$50.00 fee.

**Medical Record:**

- A reasonable fee of \$25.00 shall be charged for the first twenty pages and \$0.15 per page for every copy thereafter. Requests will be completed within ten (10) business days.

**I, the patient/patient's legal representative, understand and agree to abide by the financial policy set forth.**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature of Patient (or Personal Representative)**

\_\_\_\_\_  
**Date**

# Patient Information

# DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

PATIENT NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	AGE	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK /CELL)
ADDRESS	SOCIAL SECURITY NUMBER		SEX (M or F)	MARITAL STATUS
CITY, STATE, ZIP	EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER NAME & ADDRESS	OCCUPATION		E-MAIL ADDRESS	
REFERRING DOCTOR NAME, ADDRESS & TELEPHONE NO.				
PRIMARY CARE DOCTOR NAME, ADDRESS & TELEPHONE NO.				

## Pharmacy

Pharmacy Name	TELEPHONE NO.	FAX NO.
ADDRESS		
CITY, STATE, ZIP		

## Primary Insurance

*(If you have Medicare and other insurance, please refer to Appendix A for reference.)*

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS		INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP		INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION		
INSURANCE COMPANY NAME	INSURED'S ID #		
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #		
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT		

## Secondary Insurance

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS		INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP		INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION		
INSURANCE COMPANY NAME	INSURED'S ID #		
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #		
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT		

## Authorization and Acknowledgement

**AUTHORIZATION:** I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. \_\_\_\_\_ Initials

**ASSIGNMENT OF BENEFITS STATEMENT:** I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred. \_\_\_\_\_ Initials

**ACKNOWLEDGMENT OR RECEIPT OF PRIVACY NOTICE:** I hereby acknowledge receipt of the Notice of Privacy Practices (attached) given to me by the above company. \_\_\_\_\_ Initials [ ] Consent refused by patient. Witness by: \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature of Patient (or Personal Representative) \_\_\_\_\_

Date \_\_\_\_\_

**NEW PATIENT FORM**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Day time Phone#

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referring physician

\_\_\_\_\_  
Office Phone#

**REASON FOR REFERRAL**

\_\_\_\_\_

**CURRENT MEDICATIONS**

NONE

NAME	DOSE	ONSET

**ALLERGIES (PLEASE LIST)**

NONE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<input type="checkbox"/> ALLERGIC TO IODINE?
<input type="checkbox"/> ANY METAL IN YOUR BODY?
<input type="checkbox"/> IF YES, WHERE? _____
<input type="checkbox"/> CLAUSTROPHOBIC?

**LIST DOCTORS YOU CURRENTLY SEE**

**PHONE**

**REASON**


**HAVE YOU EVER HAD MAJOR TRAUMA TO YOUR ABDOMEN?**

\_\_\_\_\_  
\_\_\_\_\_

**WHAT ARE YOUR MAIN CONCERNS?**

\_\_\_\_\_

**DIGESTIVE ASSOCIATES OF HOUSTON, P.A.**

Isaac Raijman, MD Dang M Nguyen, MD H. Chami Amaratunge, MD  
Tel: (713) 795-4444 / Fax: (713) 795-5254

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**ATTENTION: It is the patient's responsibility to obtain any medical records prior to the appointment. Patients may use this form to obtain patient medical information from any physician offices, hospitals or other healthcare facilities where they require patient written authorization.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS No: \_\_\_\_\_  
Address: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ (Doctor Name/Facility Name),

Tel: # \_\_\_\_\_, Fax #: \_\_\_\_\_ to release the following medical

information to:

**Digestive Associates of Houston, P.A.**  
**Isaac Raijman, MD Dang M Nguyen, MD H. Chami Amaratunge, MD**  
**6620 Main St, Suite 1510, Houston, Texas 77030**  
**Tel: 713-795-4444 Fax: 713-795-5254**

Check all that may be released:

- Complete record
- Records of care from \_\_\_\_\_ to \_\_\_\_\_
- Records of care concerning the following condition(s): \_\_\_\_\_.
- Other. Specify: \_\_\_\_\_.
- Please exclude the following specified information: \_\_\_\_\_.

Purpose of disclosure:

- Medical Care
- Insurance
- Legal
- Other: \_\_\_\_\_

This authorization is valid until the 180<sup>th</sup> day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or status if signed by anyone other than patient



## **\*IMPORTANT REMINDER TO PATIENT\***

- **BRING YOUR PICTURE ID AND INSURANCE CARD**

It is required by the Federal Trade Commission (FTC) that you must present your picture ID (e.g. Driver License) and insurance card when you check-in for your office visit. If we don't have a current picture on file, we will also take a picture when you check in.

- **POS AND HMO PLANS**

Most of these plans require that you obtain a referral from your primary care physician prior to receiving any services in our office. If you do not obtain a referral from your primary care physician prior to receiving services, or a referral cannot be verified by our business office, you have the option of re-scheduling your appointment. If you keep your appointment and/or receive services in our office, it is with the understanding that your health plan may not pay for charges related to the services provided by Digestive Associates of Houston, PA and that without a referral you will be responsible for payment of all charges.

- **SELF PAY/NON-CONTRACTED PLANS**

Payment is due at the time of service unless prior financial arrangements have been made with our business office. All previous balances are expected to be paid in full prior to new services being rendered.

- **COPAY/DEDUCTIBLE/PRE-EXISTING CLAUSE**

Our office will collect your copay/deductible when you check-in for your office visit. All charges are due and payable at time of service.

If you have a pre-existing clause in your policy, you are required to pay the full charge amount when then service is rendered.

- **MEDICAL RECORD**

It is the patient responsibility to obtain previous medical records sent to our office. You may be asked to reschedule your appointment if no medical records are received at the time of your visit.