
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
 Authorization for Release of Medical Information (if needed)
 New Patient Form

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

My appointment is scheduled on: _____,

check in at: _____ a.m. / p.m.

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

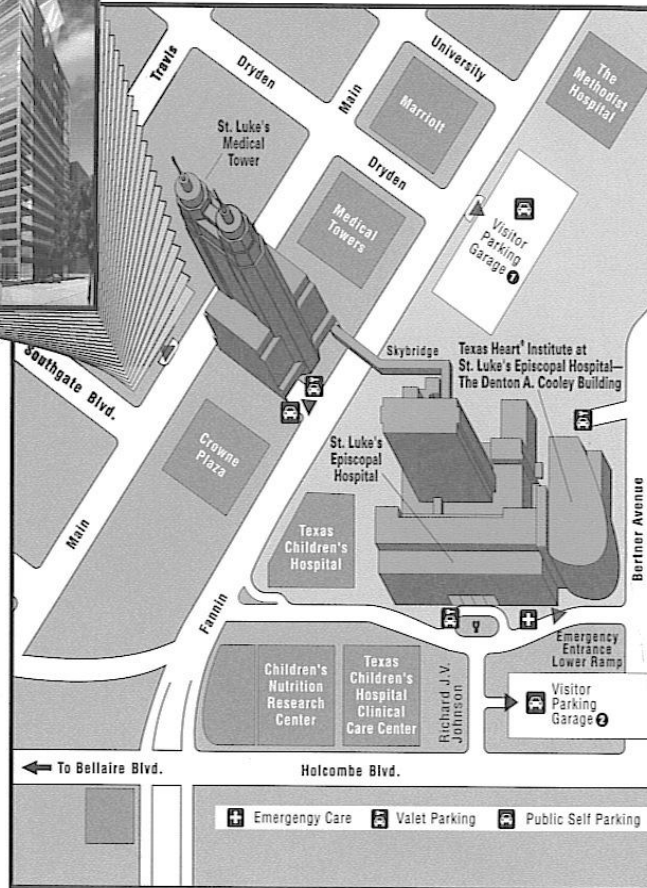
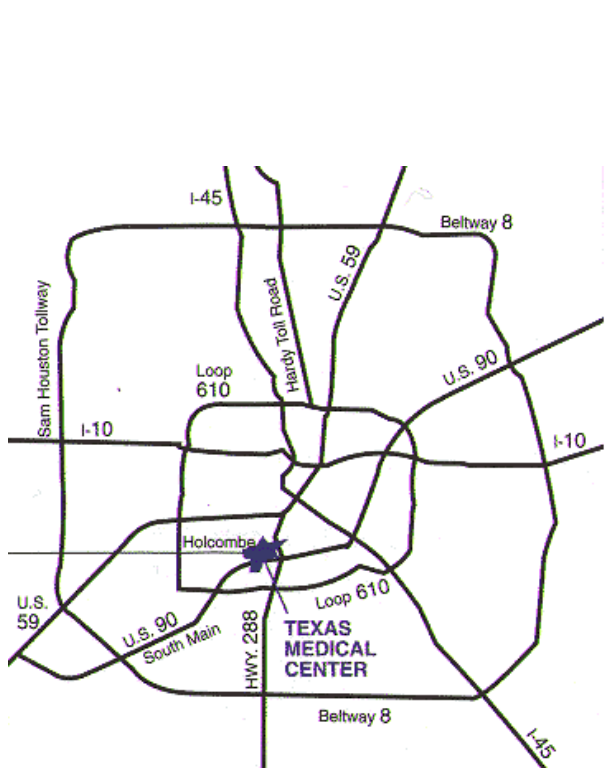
6620 Main Street, Ste 1510, Houston, TX 77030

Baylor Clinic (BCM) Building

(New Parking and Office Building)

Tel: 713-795-4444

www.dahpa.com



DIRECTIONS:

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

From I-45 North/ 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 (1st 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. (1st 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.**

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

Isaac Rajjman, MD Susana Escalante-Glorsky, MD

FINANCIAL POLICY

Welcome to Digestive Associates of Houston, P.A. 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:

Uninsured Patients:

- 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:

- The physicians will bill insurance plans as a courtesy to their patients if the patient provides the required insurance information before the filing deadline and signs an assignment of benefits statement. All information given regarding the ability to pay, third party insurance, employment, etc., will be subject to verification.
- 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 we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.
- If the patient's insurance rejects, denies or only covers a portion of treatment, the patient shall be responsible for immediate payment for the medical service provided. This payment may be requested and is due at the time of service. A pre-treatment deposit may be required.

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.

Patient Name

Signature of Parent or Personal Representative

Date

Patient Information

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

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

Responsible Party *(if other than patient)*

| | | |
|--|----------------------|---------------------------------|
| RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name) | PRIMARY PHONE (HOME) | SECONDARY PHONE (WORK /CELL) |
| ADDRESS | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| CITY, STATE, ZIP | SEX (M or F) | PATIENT'S RELATION TO RESP |
| EMPLOYER NAME & ADDRESS | OCCUPATION | RESP PARTY ID (Office Use Only) |

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: _____

Signature of Patient / Parent / Guardian / Insured

Printed Name

Date

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

Isaac Raijman, MD Susana Escalante-Glorsky, MD

Main: (713) 795-4444 / Fax: (713) 795-5254

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*****This form may be used for our office to obtain patient medical information from any physician offices, hospitals or other healthcare facilities where they require patient written authorization.**

Patient Name: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

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 Susana Escalante-Glorsky, 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 180th 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

DIGESTIVE ASSOCIATES OF HOUSTON, PA

Isaac Raijman, MD Susana Escalante-Glorsky, MD

NEW PATIENT FORM

Primary Office: 6620 Main St., Ste 1510, Houston, TX 77030

Pearland Clinic: 8619 W. Broadway St. Ste 101, Pearland, TX 77584

Name

Day time Phone#

Date

Referring physician

Office Phone#

Update

REASON FOR REFERRAL

| |
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| |
| |
| |
| |

CURRENT MEDICATIONS

NONE

ALLERGIES

NONE

| NAME | DOSE | ONSET | |
|------|------|-------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | <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?

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|--|
| |
| |
| |
| |

PLEASE COMPLETE THIS FORM AS MUCH AS POSSIBLE OR SPEAK WITH OUR STAFF IF YOU HAVE ANY QUESTIONS.

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

Isaac Raijman, MD Susana Escalante-Glorsky, MD

PATIENT INFORMATION SHEET

(Please sign this form only if you need to schedule a screening colonoscopy)

SCREENING COLONOSCOPY

Patients who have screening examinations have no signs or symptoms, and have a set benefit from their insurance company.

You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance policy will pay differently. The colonoscopy is no longer considered a screening procedure, it is considered a surgical procedure.

I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay and out-of-pocket expenses in the event that my scheduled screening examination does result in a procedure with a polyp or abnormality.

Signature of Patient/Parent/Guardian/Insured

Printed Name

Date