

Comprehensive Gastroenterology

3323 Colorado Blvd., Suite 105, Denton, TX 76210 | (940)243-0912 | (940)243-0921 Fax

➤ Financial Policy

- It is your responsibility to obtain appropriate referrals and authorizations (as required by your insurance company) PRIOR to each visit.
- It is your responsibility to update your insurance information with us when there have been changes such as new cards with new I.D. and Group numbers or if you change to a different insurance company. If this is not updated and results in a no pay or denial from your insurance company, then you will be responsible for the amount due.
- Co-payments, co-insurance, and deductibles are due at the time of your visit. Any amount not paid at that time will be billed to you; payment is due within thirty days.
- Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims by your insurer. Rejection of all or a portion of your bill by your insurance company does not relieve you of the financial obligation that you have incurred.
- You are responsible for confirming that your insurance policy is current and up to date. You are responsible for all billed charges if your insurance coverage is not current.
- The hospital, pathologists, and labs are also their own entity and are not affiliated with Dr. Awan. They bill separately for their services.
- We will be happy to file your primary insurance for you. We will also file your secondary insurance as a courtesy. Your insurance company may need additional information, it is your responsibility to comply with their request.
- There is a \$40.00 fee for all checks returned due to insufficient funds.
- Payment is due at the time services are rendered. If you fail to pay the balance due and your account is turned over to a collection agency, you will be responsible not only for the account balance but also for the collection agency's fee.
- ✓ ***I have read and understand the above financial policy for Comprehensive Gastroenterology.***

Signature of Patient

Printed Patient Name

Date

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HIPAA Information and Consent Form

The Health Insurance and Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "short" version. A full version is posted in the office, and available upon request. There are rules and restrictions on who may have access to your Protected Health Information (PHI). HIPAA provides certain rights and protections to you as the patient.

As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided in our office, but also disclosures for your health information may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third party payers or insurers for claims review, determination of benefits and payments; our submission of your health information to auditors hired by third party payers and insurer, among other aspects or payment described in our Notice of Privacy Practices.

We may call patients in the waiting room when it is time for them to go to an examining room. To do this, we may use your first and/or last name.

It is the policy of this office to remind patients for their appointments. We may contact you to provide appointment reminders or to have you contact the office. To do this, we may mail you letters in envelopes with our practice name and return address, call you at the preferred number you provide on your PHI form and leave message on your voicemail or leave messages with family members that you have authorized on your PHI form or their voice mail.

You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. You must request restrictions in writing. However, we are not obligated to alter internal policies to conform to your request.

By signing this consent, you signify that you agree that all payments are deemed your responsibility and are due at the time of service, unless prior arrangements have been made, or you have insurance coverage in which you have provided copies of for filing purposes.

My signature on this form will serve as "SIGNATURE ON FILE" for processing any applicable insurance claims. I understand that my insurance may deny benefits if determined I received an examination too frequently or received examinations by separate doctors for the same illness. I agree to pay for services that my insurance deems my responsibility.

I agree to pay my Copay, co-insurance, and or deductible at the time of services rendered. I also understand that all costs are estimates and that the insurance will make the final determination in the amount that I am responsible for.

By signing this consent, you signify that you agree that we can, will use, and disclose your health information to treat and to obtain payment for our services rendered to you.

We may decline treatment should you refuse to sign this consent.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature _____

Date: _____

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➤ Notice of Privacy Practices

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

Understanding Your Health Information

Comprehensive Gastroenterology doctors, nurses, pharmacists, laboratory techs, and other health care professionals may use health information about you to provide you with treatment or services. We may also disclose health information about you to others who are involved in taking care of you. Every time you visit a hospital, physician or healthcare provider, a record of your visit is made in order to manage the care that you receive. The confidentiality of your health information is also protected under both the state and federal law.

Your Health Information Rights

Your health information is the physical property of the physician/facility who compiled it. The information does belong to you and you have certain rights over that information. You have the right to:

- Request, in writing, if you have a restriction on certain uses and disclosures of your record. Note, this request is not required by law, such as when it is determined that compliance with the restriction cannot be reasonably guaranteed. This also applies to amendments to your health information. You will be notified of the outcome of your request.
- Obtain or inspect a copy of your medical record as required by law.
- Communication preferences. Reasonable requests will be granted.
- Receive a printed copy of this Notice of Privacy Practices, upon request.
- Obtain an accounting of disclosures of your information as provided by law.

Practice Responsibilities

We have certain responsibilities regarding your health information, including:

- Maintain the privacy of your health information.
- Provide you with this notice and abide by the terms currently in effect.
- We reserve the right to change the privacy policies and practices and to make changes when applicable to any health information that our office maintains. When/if changes are made, the revised Notice of Privacy Practices will be available and provided when requested.

Uses and Disclosures of Health Information without Authorization

When you obtain our services, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support our operations. The following categories describe ways that we use or disclose your information, and examples are provided in each category. These examples are not exhaustive, but all of the ways your health information is used or disclosed should fall within one of the categories.

➤ Notice of Privacy Practices, Continued...

Your health information will be used for payment.

- For example, health information about you may be disclosed so that services provided to you may be billed to an insurance company or a third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine whether your health plan will cover the treatment.

Your health information will be used for health care operations.

- For example, the information in your health record may be used to evaluate and continually improve the quality of care and services we provide.

Business associates.

- There are some services that we provide through contracts with third party business associates. Examples include laboratories and transcription agencies. To protect your health information, we require these business associates to appropriately safeguard your information.

Disclosures Requiring Verbal Agreement

- Unless you give notice of an objection, medical information may be released to a family member or friend who is involved in your medical care or who helps pay for your care. Information about you may be disclosed to notify or assist in notification of a family member or friend about your location and general condition.

Disclosures Required by Law or Otherwise Allowed without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement. Examples would be: reporting gunshot wounds or child abuse; or responding to court orders;
- For public health purposes, such as reporting various diseases or disclosures to the FDA regarding adverse events with respect to medications or devices;
- For health oversight activities, such as audits, inspections, or licensure investigations;
- To avoid a serious threat to the health or safety of a person or the public;
- For workers' compensation purposes;
- To military command authorities as required for members of the armed forces;
- To correctional institutions or law enforcement officials.

Other allowable uses and disclosures without authorization

- Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives

