Texas Liver Consultants at the Texas Liver Institute

Patient Information

Welcome to our office. We appreciate the confidence that you have placed in us regarding your healthcare needs. To assist us in serving you, please complete the following forms as thoroughly as possible. The information provided on these forms is very important, so if you have any questions please do not hesitate to ask. Thank you from the Texas Liver Institute!

Date: _____

Patient name: _____ Date of birth: _____ Age:_____

Address:_____ Zip code:_____

Home phone: _____ Cell phone: _____

Employer name: _____ Work phone:_____

E-mail:_____ Race: _____ Sex: ◯ Male ◯ Female

Social security #: _____ Driver's license #: _____

Marital status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Preferred language: _____

Primary doctor:
Name: _____ Phone #: _____

Insurance information:
Primary insurance company:_____
Policy #:_____ Group #:_____
Policy holder name:_____ Date of birth:_____

Secondary insurance company:_____
Policy #:_____ Group #:_____
Policy holder name:_____ Date of birth:_____

Guarantor information:
Name: _____ Date of birth: _____
Employer: _____ Work phone #: _____
Guarantor social security #: _____

IF YOU HAVE MEDICAL COVERAGE, PLEASE FURNISH US WITH YOUR INSURANCE CARD/CARDS, PHARMACY CARD/CARDS AND DRIVER'S LICENSE TO COPY FOR YOUR FILE.
IF YOUR INSURANCE REQUIRES A CO-PAY, PLEASE PAY AT THE TIME OF SERVICE.
IT IS OUR PLEASURE TO PROVIDE YOU WITH YOUR MEDICAL NEEDS. OUR POLICY IS TO RECEIVE PAYMENT AT THE TIME OF SERVICE.

I HEREBY ASSIGN PAYMENT OF MEDICAL BENEFITS TO TEXAS LIVER CONSULTANTS FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE ABOVE SAID INSURANCE COMPANIES.

Date: _____ Signature: _____

Texas Liver Consultants at the Texas Liver Institute

Consent for Release of Medical Information to Family Member(s) or Personal Representative(s)

May we leave messages on your voicemail regarding your care? ☐ **Yes** ☐ **No**
(Please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow up of lab, appointments, etc).

Emergency Contact: (This person is able to make appointments & receive medical information)

Name: _____ Phone #: _____
Address: _____Relationship:_____

Name: _____ Phone #: _____
Address: _____Relationship:_____

Name: _____ Phone #: _____
Address: _____Relationship:_____

In case of emergency, notify:
Name: _____ Relationship: _____
Address: _____ Phone #: _____

How were you referred to us? _____

☐ **Yes, the practice may discuss the following items with the person(s) listed below:**

- ☐ Medical Condition/Treatment
- ☐ Appointments
- ☐ Prescriptions
- ☐ Financial
- ☐ Pathology and/or lab results
- ☐ Psychiatric
- ☐ Mental health
- ☐ Substance abuse
- ☐ All results, medical care and treatment plan

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

I understand this authorization may include information related to HIV, AIDS, psychiatric care, treatment for alcohol and/or drug abuse or genetic testing. _____**(Initials)**

Texas Liver Consultants at the Texas Liver Institute

Patient Authorization for Release of Protected Health Information

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (45CFR-164.5008) It authorizes Texas Liver Consultants at The Texas Liver Institute and/or any of its physicians to use/disclose or obtain my medical records:

- ☐ Nazeer Ahmed, MD
- ☐ Eric Lawitz, MD
- ☐ Fred Poordad, MD
- ☐ Krishna Venkata, MD
- ☐ Hope Baker, MD
- ☐ Sadu Meer, MD
- ☐ Fabián Rodas, MD
- ☐ Carmen Landaverde, MD
- ☐ Jan Petrasek, MD, PhD
- ☐ Eugenia Tsai, MD

Under the Privacy Rules, I have the right to revoke the authorization at any time, and Texas Liver Consultants at The Texas Liver Institute and/or any of its physicians must cease using this authorization. However, Texas Liver Consultants may complete any action it initiated prior to revocation and which rely on my medical records for completion. Any disclosed information may be subject to redisclosure by the recipient.

You may send your revocation in writing to: 607 Camden Street, San Antonio, TX 78215

Name: _____
Date of birth: _____
Social security #:_____

I understand that the information in my health records may include information relating to sexually transmitted disease (AIDS, HIV). It may also include information relating to behavioral or mental health service and treatment for alcohol and drug abuse.

This authorization expires 10 years after the date signed or _____

_____
Please print name

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of witness

_____Laboratory _____X-Rays _____Progress Note(s) _____Other

Texas Liver Consultants at the Texas Liver Institute

Acknowledgement of Receipt of Privacy Practices

PATIENT'S RECORD

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices from the medical practice of Texas Liver Consultants at The Texas Liver Institute.

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Note: Texas Liver Consultants at The Texas Liver Institute reserves the right to modify the privacy practices outlined in the notice.

Texas Liver Consultants at the Texas Liver Institute

Payment Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable health care. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If no payments are made after 3 consecutive appointments, or if your balance is over $200 with no indication of payment effort on the responsible party's behalf, your appointment will be canceled or rescheduled until your balance is paid or back in good standing. If your account is over 90 days past due, your account will be transferred to collections. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to charge $25 for a missed appointment or one canceled within 24 hours of your scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Texas Liver Consultants at the Texas Liver Institute

CONSENT FOR TREATMENT

I understand that my health condition requires medical care, and I authorize and consent to any and all diagnostic procedures, tests, medical treatment, and care required in the diagnosis of my illness and course of treatment by the physician and/ or his designee, including advanced nurse practitioners and physician assistants, medical staff and other agents, and/ or employees of Texas Liver Consultants and/or Texas Liver Institute. I authorize the discussion of psychiatric, mental health and substance abuse information with medical personnel. I further authorize and consent to such diagnostic and special needs testing, communicable disease testing, including HIV testing, as allowed by law, medical treatment and hospital care as my physician(s), or other of Texas Liver Consultants (Texas Liver Institute) (collectively my "doctors") consider to be necessary. I authorize Texas Liver Consultants/Texas Liver Institute nurses, employees, and others as necessary, to carry out the instructions of my doctors regarding the procedures and treatment they order. I recognize that Texas Liver Consultants includes a teaching and research facility and that my treatment and care will be observed and, in some instances, aided by residents, medical students, nursing students, and other health care personnel in the course of education and training. I consent to their presence and participation in my care. I understand that: (1) absent an emergency, no substantial procedures are performed upon a patient unless and until the patient (or patient's representative) has had an opportunity to discuss the risks and benefits with the doctor to the patient's satisfaction; (2) I have the right to consent, or to refuse to consent, to any proposed procedure or therapeutic treatment regimen; and (3) no patient will be involved in any research or experimental procedure without his or her full knowledge and consent. I understand that there are certain medical treatments and surgical procedures that require detailed explanation of risks and hazards involved. If it is determined that I require such specific treatments and/or procedures, I understand that I will be asked to give a separate consent. _____ **(Initials)**

ASSIGNMENT OF BENEFITS

I assign and transfer to Texas Liver Consultants, Texas Liver Institute and/or their agents, to the extent permitted by law and for myself and my dependents, all right, title and interest in all amounts that may be paid by any payer, or under any state, federal, county or agency assistance program, for all medical care rendered. I authorize payment by any such entity or under any such plans, policies, and programs to be made directly to Texas Liver Consultants, Texas Liver Institute and/or their agents respectively and in accordance with services and items provided to me and intend that each entity, and/or its agents has an independent right of recovery to such payments as a beneficiary under all such plans, policies and programs to the extent permitted by law. I further assign all rights, claims and causes of action against any person or entity who may be financially responsible for payment of my medical charges and against any person or entity who may have caused or contributed to the injury or illness for which I receive treatment, and I consent to Texas Liver Consultants, Texas Liver Institute, and/ or their agents, independently or jointly with me or others pursuing recovery against such persons or entities in its own behalf or in my place for the charges incurred in my care. _____ **(Initials)**

PATIENT CREDIT

I understand that Texas Liver Consultants will not refund any credit $3.00 and under. I can, however, use credit for future visits. _____**(Initials)** I understand that Texas Liver Consultants will refund any amount over $3.00. In the event I am unable to receive the refund, please make payable to:

____TLI Non-profit donation or ____ Beneficiary: Name: _____ Phone: _____

Address: _____

I have been given an opportunity to ask questions about my rights and responsibilities as a patient and about the representations in this form. By my signature, I certify that this consent to treatment has been fully explained to me, that I have read it or have had it read to me, and that I understand, accept and agree to all the terms and conditions. I understand that if I do not timely provide all insurance information, I will remain responsible for payment of all charges for the medical care provided to me.

If executing this document on behalf of a patient, I certify that I have the authority to execute this form on behalf of the patient.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date