ALLIED
DIGESTIVE DISEASE CENTER
OF HOUSTON PA

Patient Name: ____________________ DOB: ____________

Phone#: ____________________ Mobile#: ____________

Email: ____________________

Address: ____________________

Pharmacy Name ____________________ Pharmacy#: ____________

Chief Complaint: ____________________

How did you hear about us? ____________________

Primary Care Physician Name and Number? ____________________

Insurance: ____________________ Member ID: ____________

Group#: ____________________ Phone#: ____________

Relationship to Insurer: ____________________ Other: ____________

Insurance: ____________________ Member ID: ____________

Group#: ____________________ Phone#: ____________

Relationship to Insurer: ____________________ **Other:** ____________

Insurance: ____________________ Member ID: ____________

Group#: ____________________ Phone#: ____________

Relationship to Insurer: ____________________ Other: ____________

WELCOME

Policies and Procedures

Dear Patient:

Welcome to Allied Digestive Disease Center of Houston. Our goal is to provide you with excellent quality medical care. The following policies and procedures are in place to help make your visit more pleasant.
Please take time to review and initial these policies so you will have a clearer understanding of our mutual expectations.

___ **Office Hours: Monday through Friday from 8:30am to 5:00pm.** We will be available during these hours for information, appointments and prescriptions. If you need assistance on nights or weekends, please call the office and the answering service will reach the physician on call. If you feel that you have an emergent situation, please call 911for immediate assistance.

___ **Prescription Refills:** Please call your pharmacy request refills and they will contact the office for approvals. Please allow us 24 hours to approve refills. Medications cannot be refilled over the weekend. Contact us on the weekday before you need your refill.

_._**Appointments:** Please make every effort to make your appointment. If you cannot make your appointment, please call the office as soon as possible. We will make every effort to schedule your appointment at a convenient time for you. **Arrive 15 minutes early for check-in.** You will receive a reminder call and/or an email reminder on your appointment with arrival time.

___ **Payments are due at the time services are rendered.** This includes applicable co-pays, co-Insurance and deductibles as well as any outstanding balances, unless previous arrangements have been made. We accept cash, checks, and credit cards. Co-pays and co-insurance amounts are required at time of service per managed care contracts. If you have a deductible, we will ask for the "allowed" amount as per the insurance company agreement. We accept Medicare assignment.

If you have any questions, concerns or comments, please give us your feedback. We are hopeful we will exceed your expectations for excellent care and communication from the physician and staff.

I hereby acknowledge that I have been given a copy, reviewed, and agree to the Policy Practices of Dr. Babatunde Adeyefa at Allied Digestive Disease Center of Houston, P.A

Printed Patient Name

Responsible Party (if not patient)

Signature of Patient or Responsible Party

Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Dr. Adeyefa 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. Adeyefa 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 physician and the attending physicians. ·

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Adeyefa has tal!:en 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.Adeyefa reserves 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 an appointment. I also authorize the practice to leave scheduling information on my answering machine, or voicemail system.

____

Signature of Patient or Responsible Party

____

Date

ALLIED DIGESTIVE DISEASE CENTER OF HOUSTON, PA
21212 Northwest FWY STE 425-A CYPRESS TX 77429
Ph.: 832-912-4481
Website: www.alliedgidoc.com
BABATUNDE ADEYEFA, M.D.

RELEASE OF MEDICAL INFORMATION

We will need to access your private healthcare information for the purpose of treatment, payment, and operations. In using this information our office will comply with state and federal laws pertaining to your privacy rights, including HIPPA act. We will disclose your information only when sharing the information for the purpose of treatment, payment, and operation. This information may be shared with but is not limited to your primary care physician(s), referring physician(s), and specialist(s) who will be involved in your medical care treatment.

In order to obtain medical records from another physician or medical institution, or to provide medical records as stated above please sign below in acknowledgement of your consent.

Please specify a spouse, family member, friend, or physician(s) that we may release and request medical information or records to:

____

Please sign below in acknowledgement that you have read, understood, and agree to the above stated policy

Patient Signature:____

Patient Name (Print):____**Date:**______________