TRI STAR MEDICAL GROUP
Gastroenterology Specialists of Middle Tennessee

Patient Name _____ **DOB** _____

Patient HIPAA Acknowledgment, Consent Form, and Payment Agreement

_____ (Patient initials) **Consent for Treatment:** I the undersigned, hereby consent to the following: administration and performance of general treatments, use of prescribed medications, performance of diagnostic procedures/tests and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. A photocopy of this consent shall be considered as valid as the original.

_____ (Patient initials) **Patient Financial Responsibility:** I understand my financial responsibility, and I guarantee payment for all charges not covered by my insurance. All applied deductibles, co-pays, and any other fees not covered by insurance will be paid by the patient within 30 days of receiving a statement. It is the patient's responsibility to ensure a referral is obtained if required by their insurance company. The patient assumes full liability if a referral is required and not obtained prior to the services being rendered.

_____ (Patient initials) **Notice of Privacy Practices:** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information:** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*
____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*
NOTE: This revocation only applies to communications from this Practice.

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Declination for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I **DECLINE** to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

NO SHOW AND LATE POLICIES
These policies assure that patients have access to care when needed by maximizing the utilization of available appointments. They are also used to provide a mechanism for appropriately managing the patient that fails to utilize assigned appointment times without sufficient notice.

____ (Patient Initials) **NO SHOW POLICY** – If a patient is unable to keep their appointment, they are required to cancel their appointment within 24 hours of their scheduled appointment. Barring any unusual circumstance, if you have more than **two (2)** No Shows within a **twelve (12)** month period, you may be dismissed from the practice for failure to follow a physician's recommendation. Thank you for understanding our No Show Policy. Please let us know if you have any questions or concerns.

____ (Patient Initials) **LATE POLICY** – Barring any unusual circumstance, if a patient is greater than 15 minutes late for their appointment, they will be asked to reschedule. Late patients will be handled on a case by case basis. Thank you for understanding our Late Policy. Please let us know if you have any questions or concerns.

Patient Signature _____ **Date** _____