



L I V E R
SPECIALISTS
of TEXAS

Joseph S. Galati, M.D.

Medical Director

The Methodist Hospital

Center for Liver Diseases and Transplant

Welcome to **Liver Specialists of Texas (www.texasliver.com)**. On behalf of the office staff and physicians we are pleased that you have chose us to provide you with quality healthcare. Because this is a specialty clinic, we have specific methods that differ your primary care physicians office.

There may be the need to order specialized laboratory tests, and perform procedures to aid in the diagnosis and treatment of your condition. The results of these tests can take time. If you have a procedure that requires a biopsy (liver, stomach, or colon), the pathology report will usually be available within 2 weeks. Kindly do not call the office asking about these results. Results will be discussed in the office during the follow-up appointment or by phone once we have had a chance to review all of the reports. During this time period you may be prescribed medications to aid in your treatment. This time will give us a chance to see how the medications are helping you.

If a procedure is necessary to make a diagnosis and formulate a treatment plan, and we are in agreement that the procedure should be performed, you will be educated as to the type of procedure and the preparation required for the procedure.

After your initial consultation, you will be given a follow-up appointment. At this appointment all of your laboratory studies and reports will be reviewed and discussed with you. This appointment will typically be 4-6 weeks after your initial consultation, procedure or radiology study. **Please be assured that if a test result is of an immediate concern to the physicians, we will phone you to discuss the result or ask that you come in sooner to see us.**

Depending on your medical condition, you may be seen by our **Advanced Nurse Practitioner, Lauren Thomas, R.N.** Lauren will be working directly with all of the physicians in the office. All treatment plans will already have been approved by the physicians in charge of your case.

Our office will verify your insurance benefits prior to your appointment. Based on the information that we receive from your insurance company, you may be required to pay a co-pay, a part or all of your deductible if it hasn't been met, or a percentage of your total bill depending on your specific benefits. We are happy to answer any questions that you might have.

We require you to contact our office 48 hours in advance if you are not able to keep your appointment. It is important that we are notified so that we may provide treatment to another patient.

Our goal is to have the physicians on time for your appointment. We care for very complex patients, and emergencies arise that we need to tend to, causing a delay in your appointment. Patients may require more time than they are allotted, adding to delays. Please be assured that when it is your turn, our physicians will show you the same attention and respect.

Thank you for following these policies. This allows our staff to focus on the most urgent situations we are faced with on a daily basis. We look forward to helping you and addressing the problems you may be experiencing.

6624 Fannin, Suite 1990 • Houston, Texas 77030 • Tel (713) 794-0700 • Fax (713) 794-0610

Located in the St. Luke's Medical Tower

www.texasliver.com



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OFFICE FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to a minimum, we require you pay at the time of service so we do not have to send bills. In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

The following is included in your initial bill:

- Initial office visit and examination
- Communication by phone and/or letter to your primary medical doctor concerning the initial visit
- Information booklets
- Review of previous medical records
- Analyze current and previous laboratory and radiological information

Not included in the initial bill:

- Review of outside biopsy slides. You will receive a separate bill for reading of liver biopsies. This interpretation will not be filed with your insurance company and you will be directly responsible for this service.

Self-Pay:

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and credit cards.

Insurance:

PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be denied if payment is not made at check-in time. As a courtesy to our patients, our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law, your insurance company must remit payment or deny your insurance claim within 45 days of initial notice. If your insurance company has not paid your account in full within 60 days, we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We will file the claim to your insurance company, but your insurance policy is a contract between you and your insurance company. We are not a party to that contract and so your balance will be due immediately.

Insurance Coverage Changes:

In the event that your insurance coverage changes to a plan where we are NOT PARTICIPATING PROVIDERS, you will be responsible for payment of all fees at the time service is rendered. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines and insurance payments.

Financial Responsibility for Minors:

Unless prior arrangements have been made, charges for a minor child seen in the office are the responsibility of the adult accompanying the minor child.

Cancellation and No-Show Policy:

- There is a **PROCEDURE** cancellation fee of \$75.00 for cancellations and no-shows of less than 48 hours*. Fee is not applied toward surgical fee, or insurance, and is non-refundable.
 - There is a **NEW PATIENT** office visit cancellation fee of \$75 for cancellations and no-shows of less than 48 hours*.
 - There is a **FOLLOW UP** office visit cancellation fee of \$75 for cancellations and no-shows of less than 48 hours*.
- *48 hours does not include weekend days or holidays; a no-show is defined as a patient who misses their scheduled appointment.

Returned Checks:

Returned checks are subject to a \$25.00 charge, returned checks older than 30 days may be subject to an additional \$50.00 charge.

The Liver Specialists of Texas (LST) strongly supports the Patient Friendly Billing initiative and strives to make patient financial information clear, concise, correct and patient friendly. LST encourages its patients to understand and be responsible for their financial obligations. In an effort to process claims promptly and as seamlessly as possible, LST is working with a collection agency to collect outstanding balances. As of October 1, 2008, all accounts not paid in full within 60 days of the original date of service will be charged an additional \$25.00 rebilling fee. Additionally, LST may send outstanding accounts greater than 120 days of the original date of service to the credit bureau. Should you need to make payment arrangements, please call (713) 794-0700.

As stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations that must be met, we ask all patients pay for their co-pays and deductibles at the time of service.

I have read, understand, and agree to abide by the financial policy set forth.

Signature of Patient / Responsible Party

Date



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_____ I agree to have my photograph taken for my medical record

_____ I do not agree to have my photograph taken for my medical record

I understand that this photograph is for the identification of the patient and for the physician's use only.

Patient

Date

Witness

Date



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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT,
PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

PATIENT:

X _____
Signature of Patient or Legal Representative Date Witness Signature



PATIENT RESPONSIBILITIES

Welcome to our specialized practice of liver and digestive diseases. In order to provide you with the highest level of medical care, we would like to outline several important features of our practice.

Good communications between our office and your referring physician is central to good care. We have listed below responsibilities that our office and your referring physician will share.

Please bring all medical records pertaining to this specialty with you when you come for your initial appointment; do not depend on your physician's office to mail or fax your records. **Service may be denied if records are not available at time of initial consultation.**

You must have a Primary Care Physician (PCP), Internist, or Family Physician that we communicate recommendations and treatment plans with. If you have referred yourself and do not have a primary doctor, you will need to establish with a physician of your choice.

Primary Care Physician / Other MD

(This information must be complete and current)

Name: _____

Address: _____

Phone:() _____ Fax:() _____

Gastroenterologist

Name: _____

Address: _____

Phone:() _____ Fax:() _____

Liver Specialists of Texas	Referring Physician
<ul style="list-style-type: none"> • Provide care for liver and digestive conditions 	<ul style="list-style-type: none"> • Provide routine healthcare
<ul style="list-style-type: none"> • Prescribe medications needed for your liver or digestive disorders and their refills, when necessary 	<ul style="list-style-type: none"> • Implement recommendations made at the time of the consultation
<ul style="list-style-type: none"> • Provide consultative reports and recommendations to your referring physician 	
<ul style="list-style-type: none"> • Will not refill medications originally written by other physicians 	<ul style="list-style-type: none"> • Information will be provided to your Primary Physician for determination of disability and completion of disability forms or any work-related forms.
<ul style="list-style-type: none"> • Will not manage medical problems outside our area of expertise 	
<ul style="list-style-type: none"> • Will not complete disability forms or any work-related form 	
<ul style="list-style-type: none"> • Provide return to work slips as needed 	

If you are a member of an **HMO**, your insurance company requires a referral. It is your responsibility to obtain this referral prior to your office visit. If a referral is not obtained, your appointment will have to be rescheduled. If you wish to be seen without a referral, payment in full will be required, accepting full financial responsibility for the visit.

Signature: _____

Date; _____



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REGISTRATION FORM

PATIENT INFORMATION

Date: _____

e-mail address: _____

Name: _____ Social Security No. / ID: _____
 Last First Middle

Address: _____ City / ST: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Social Security No. / ID: _____ Male / Female

Married Separated Divorced Single Widowed Partnered for _____ years

Patient Employer / School: _____ Occupation: _____

Employer / School Address: _____ Employer / School Phone: _____

In case of emergency, who should we notify? _____

Whom may we thank for referring you? _____

Primary Care Physician (address and phone number): _____

Gastroenterologist (address and phone number): _____

Race (please select only one):

- African American
 Alaska Native
 American Indian
 Asian
 Caucasian
 Hispanic
 Native Hawaiian
 Pacific Islander
 Other

Primary Insurance

_____ Name of Insurance Company
 _____ Name of Insured / Date of Birth
 _____ ID #
 _____ Group Name and #

Secondary Insurance

_____ Name of Insurance Company
 _____ Name of Insured / Date of Birth
 _____ ID #
 _____ Group Name and #



HIPAA COMPLIANCE AND CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name _____ Phone Number _____

Name _____ Phone Number _____

3. Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home. (This address should be the address submitted for our demographics about you.)

4. Please indicate the telephone number where you want to receive calls about your appointments, test results, and other health care information if other than your home phone number (I am fully aware that a cell phone is NOT a secure and private line):

5. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voice mail?

YES _____ NO _____

Assignment of Benefits and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr.Galati all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Original Date: 10/25/2003
Revised: 03/27/2009



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ M **DOB:** _____
(Last, First, M.I.) F

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: _____ **Occupation:** _____

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

Immunizations and Dates: Tetanus _____ Pneumonia _____
 Hepatitis _____ Chicken Pox _____
 Influenza _____ MMR _____
(Measles, Mumps, Rubella)

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries / Procedures:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion ?..... Yes No

Sex: Are you sexually active?..... Yes No
 If yes, are you trying for a pregnancy?..... Yes No
 If not trying for a pregnancy, list contraceptive or barrier method used: _____
 Any discomfort with intercourse?..... Yes No
 Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?..... Yes No

Personal Safety: Do you live alone?..... Yes No
 Do you have frequent falls?..... Yes No
 Do you have vision or hearing loss?..... Yes No
 Do you have an Advanced Directive and/or Living Will?..... Yes No
 Would you like information on the preparation of these?..... Yes No
 Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?..... Yes No

Please remember that the following recommendations are very important to maintaining your health:

When in a car, wear your safety belt at all times.

When riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M		
					<input type="checkbox"/> F		
Mother					<input type="checkbox"/> M		
					<input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M				<input type="checkbox"/> M		
	<input type="checkbox"/> F				<input type="checkbox"/> F		
	<input type="checkbox"/> M				<input type="checkbox"/> M		
	<input type="checkbox"/> F				<input type="checkbox"/> F		
	<input type="checkbox"/> M			Grandparents (Mother's Side)			
	<input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M			<i>Female</i>			
	<input type="checkbox"/> F						
	<input type="checkbox"/> M			Grandparents (Father's Side)			
	<input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M			<i>Female</i>			
	<input type="checkbox"/> F						