LIVER SPECIALISTS of TEXAS

Joseph S. Galati, M.D.
Medical Director
Houston Methodist Hospital
Center for Liver Diseases and Transplant

Welcome to Liver Specialists of Texas (texasliver.com). On behalf of the office staff and physicians, we are pleased you have chosen us to provide you with quality healthcare. Due to our specialty clinic, we have methods that differ from your primary care physician's 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 be available in approximately two weeks. **Kindly do not call the office asking about these results**. Results will be discussed in the office during the follow-up appointment or via your patient portal once we have a chance to review all of the reports. During this time, 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.

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

Depending on your medical condition, you will be given a follow-up appointment with our Certified Advanced Nurse Practitioners. Dr. Galati will have already approved all treatment plans.

Our office will verify your insurance benefits prior to your appointment. Based on the information provided to us by your insurance carrier, you may be required to pay a co-pay, a part or all of your deductible, or a percentage of your total bill depending on your specific benefits. If you have a balance on your account, you will be required to pay that balance upon your next visit to our office.

Our goal is to have the physician on time for your appointment. We care for very complex patients and emergencies may arise that we need to tend to, which may cause a delay in your appointment. Please be assured that when it is your turn, our physicians will show you the same attention and respect.

PATIENT INFORMATION				
NAME (LAST FIRST, MIDDLE)	SS#	DATE OF BIRTH:	SEX: ☐ Male ☐ Female	
		MARITAL STATUS: Married Single Divorced Separated Widowed		
LOCAL ADDRESS		SECONDARY ADDRESS (IF APPLICABLE)		
CITY, STATE, ZIP		CITY, STATE, ZIP		
CELL PHONE:		CELL PHONE:		
HOME PHONE:		HOME PHONE:		
E-MAIL ADDRESS:		**RESPONSIBLE PARTY INFORMATION UNDER 18:**		
PATIENT EMPLOYER/SCHOOL:		NAME:	DATE OF BIRTH:	
OCCUPATION:		ADDRESS:		
EMPLOYER/SCHOOL PHONE NUMBER:		CITY:	STATE:	Zip:

IN CASE OF EMERGENCY, WHO SHOULD WE NOTIFY	
NAME:	RELATION:
PHONE NUMBER:	

PRIMARY CARE PHYSICIAN		GASTROENTEROLOGIST	
NAME:		NAME:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:	FAX:	PHONE NUMBER:	FAX:

PHARMACY INFORMATION
NAME:
ADDRESS:
PHONE NUMBER:

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY:		POLICY #
NAME OF INSURED:	INSURED'S D.O.B:	GROUP #

SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY:	POLICY #
NAME OF INSURED:	GROUP #

I GRANT PERMISSION TO LIVER SPECIALISTS OF TEXAS TO RELEASE ANY PERTINENT INFORMATION TO THE ABOVE INSURANCE COMPANIES AND/OR GOVERNMENT AGENCIES. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO LIVER SPECIALISTS OF TEXAS IF ASSIGNMENT OF BENEFITS IS ACCEPTED FOR MY MEDICAL/SURGICAL SERVICES. A COPY OF THIS AUTHORIZATION CAN BE USED AS N ORIGINAL FOR INSURANCE PURPOSES. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES FULLY OR PARTIALLY DENIED BY MY INSURANCE COMPANY FOR REASONS OF NON-COVERED SERVICES UNDER MY PLAN BENEFITS, EXPERIMENTAL PROCEDURES, OR PROCEDURES DEEMED NOT MEDICALLY NECESSARY BY MY INSURANCE COMPANY.

SIGNATURE OF PATIENT/GUARDIAN:	**DATE:**

6560 Fannin, Suite 2050 Houston, Texas 77030 Tel (713) 794-0700; Fax (713) 794-0610
Located in the Scurlock Tower

LIVER SPECIALISTS of TEXAS

ADDITIONAL OFFICE POLICIES

Please read carefully and sign below to confirm that you understand the listed office policies of Liver Specialists of Texas. These policies have been established to provide all of our patients the highest level of care.

1. Laboratory, radiology procedures (ultrasound/CT scan, MRI), liver biopsy, endoscopy results will **NOT** be discussed by phone. These results will be discussed at the scheduled follow-up visit, where a complete assessment and discussion of these findings can be thoroughly discussed with you. All urgent or unexpected finding will be discussed immediately with you.

2. Radiology procedures (ultrasound, CT scan, MRI) will be scheduled directly by the patient, using the radiology scheduling form supplied and filled out by the office staff at the time of your visit. Our office will schedule liver biopsies that require radiology support.

3. As a courtesy, kindly alert our office when any radiological procedure is scheduled so we can obtain the results in a timely manner.

4. Phone calls will be returned based on urgency/priority. Non-emergent calls are returned within 24 hours. Visit our web site at **www.texasliver.com** for common questions and information.

5. Prescription refills must be requested by your pharmacy directly. Refill requests are answered in 3-5 working days. Patients must submit all mail-order prescriptions.

6. Requests for special letters from Dr. Galati can take up to two weeks to be prepared.

7. Clinical information will be relayed to your Primary Care Physician to facilitate completion of disability applications.

8. Our office does not complete disability applications.

9. It is the patient's responsibility to have copies of prior medical records forwarded to our office for evaluation.

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 all look forward to helping you and addressing the problems you may be experiencing.

Sincerely,
Joseph S. Galati, M.D.

I have read and agree to all of the office policies listed above:

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Date

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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.

Returned Checks:
Returned checks are subject to a $50.00 charge, returned checks older than 30 days may be subject to legal action.

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, Parent, Guardian or Responsible Party Date

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HIPAA COMPLIANCE AND CONSENT

FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREAMENT, 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: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ 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 Liver Specialists of Texas, 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 practice 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.

_____

Print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

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HEALTH HISTORY QUESTIONNAIRE

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

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

Primary AND/OR Referring Physician:

ALLERGIES TO MEDICATIONS

NAME OF DRUG	REACTION TO DRUG

LIST YOUR PRESCRIBED DRUGS AND OVER-THE COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

NAME OF DRUG	**STRENGTH/FREQUENCY**	**REASON**

SURGERIES / HOSPITALIZATIONS:

YEAR	REASON	HOSPITAL

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PATIENT PORTAL POLICY

Patient Consent for Use of E-Mail Communication

To better serve our patients, Liver Specialists of Texas has established a patient portal through which our patients can communicate with our staff, request refills, and access their lab results. Please allow **three days** for a response.

If you do not wish to sign up for the patient portal, please write DECLINE and all results will be mailed to you.

OUR PATIENT PORTAL IS **NOT** FOR EMERGENCY USE. IF YOU HAVE AN EMERGENCY CALL 911 OR GO TO YOUR LOCAL EMERGECNY ROOM.

To access your patient portal:

- *Our office will activate your patient portal and you will receive an email with your username and password*
- *Go to our website,* ***www.texasliver.com***
- *Click "Access your medical records"*
- *Login with your username and password given to you*

Please sign below if you would like us to activate your patient portal:

By signing below, you are agreeing that we may send medical related information to you via e-mail and that we may respond via email.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

E-mail Address or write DECLINE

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AUTHORIZATION FOR MEDICAL RECORD RELEASE

Patient's Name: _____

D.O.B: _____ Social Security: _____

I hereby authorize: _____
Doctor Facility Name

_____
Street Address

_____
City, State, Zip Code

- The purpose of this request is to start treatment or for continuity of care.
- To furnish a copy of **ALL** medical records, including labs, imaging studies, consultation, history and physical, progress notes, etc…
- HIV/AIDS I consent to the release of any positive test results for AIDS or HIV infections, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. _____ ***Initials.***
- Other _____

To be sent to:

Name: Liver Specialists of Texas

Address: 6560 Fannin St, Suite 2050

City, State: Houston, Texas 77030

Office: 713-794-0700 Fax: 713-794-0610

I hereby release you, your physicians, and employees from liability for following this authorization and request.
Authorization is valid for 90 days from date of signature.
Must have a letter in writing to **VOID**/**CANCEL** your request.

_____ _____ _____
Print Patient / Legal Guardian Name Signature Patient / Legal Guardian Date