The Liver Institute METHODIST DALLAS | Methodist TRANSPLANT SPECIALISTS | The Transplant Institute METHODIST DALLAS

PATIENT INFORMATION

Name		Date of Birth	Sex
Address	City	State	Zip
Home Phone	Work	Cell	
Email Address		**Social Security Number**	
Referring Physician Name: Referring Physician Address: Referring Physician Phone Number: Referring Physician Fax Number:		**Primary Care Physician Name:** Primary Care Physician Address: Primary Care Physician Phone Number: Primary Care Physician Fax Number:	
Preferred Pharmacy (Name / Address / Phone Number):			
Employer Name and Address:		Student Status: ○ Full Time ○ Part Time ○ N/A	
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify)*			
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide		Marital Status ○ Single ○ Married ○ Divorced ○ Widowed/Widower	
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):			Veteran ○ Yes ○ No

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

NAME		Date of Birth	Relationship to Patient
Address	City	State	Zip
Phone Home/Cell	Work	**Social Security Number:**	

PRIMARY INSURANCE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number		Group Number	
Address	City	State	Zip
Name of Insured **Date of Birth**		Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other	

SECONDARY INSURANCE IF APPLICABLE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number		Group Number	
Address	City	State	Zip
Name of Insured Date of Birth		Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other	

Which lab is your insurance co. contracted with? ○ LabCorp ○ Quest ○ CPL ○ Other (please define): _____

Please note, it is your responsibility to know which lab your insurance co. is contracted with. Please call your insurance co. prior to having blood work drawn to make sure that they will cover testing for the appropriate CPT codes. We are not responsible for third party bills related to services rendered.

I certify that I have carefully reviewed this document, understand and have filled out truthfully.

Signature of Patient or Guardian (Relationship to Patient, If not signed by the Patient) Date

General Office and Financial Policies

The Liver Institute at Methodist Dallas and/or The Transplant Institute at Methodist Dallas (Methodist Transplant Specialists) is delighted to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective health care, and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. The following are our general office and financial policies. If you have any questions regarding these policies, please discuss them with the office manager.

General Office Policies:

- **Appointments**: Please arrive on time for your scheduled appointment. Patients who present without co-pay, insurance card and state photo ID may be rescheduled. Please realize that it is each individual's responsibility to keep track of appointments made. Please understand that patients are reminded of scheduled appointments 48 hours before as a courtesy only. However, on occasion you may not receive a reminder call.
    - **Late Arrivals**: **If you are more than 15 minutes late, it may be necessary to reschedule your appointment for a later time.**
    - **Cancellations/No shows**: If you need to cancel an appointment, 24 hours' notice is required, so that another patient may be scheduled in the time slot reserved for you. For procedures, 72 hours' notice of cancellation is required. Patients with **three (3)** missed appointments and/or no shows annually may result in dismissal from the practice.
    - Methodist Transplant Specialists may charge you an administrative fee due to insufficient notice of cancellation for appointments and/or procedures. **Administrative "CANCELLATION/NO SHOW FEES" are not billed to your insurance company.**
      *** $25 Missed Appt * $100 Colonoscopy, EGD & Liver Biopsy * $250 ERCP**
- **FMLA or Disability Paperwork**: Any patient that needs paperwork completed by Methodist Transplant Specialists may be assessed a $50 processing fee. This must be paid in full before the paperwork can be picked up or faxed.
- **Medical Records Requests:** There is a $25.00 fee for medical records up to 25 pages. Additional charges are $0.50 per page. All medical records are processed by HealthMark and take seven business days to process.
- **Medication Refills:** All prescription refill requests should be called into your pharmacy at least five (5) working days before the last pill taken to allow adequate time for approval. Please allow at least two (2) business days for approval by your MTS provider. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after hours or on weekends. You may also submit refill requests through the patient portal, MyChart.
- **Behavior:** Physical and verbal abuse towards the office staff or other patients will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.
- **After Hours:** Please call 214-947-4400 and you will be directed to our answering service for urgent needs after hours. The answering service will notify on call personnel.
- **Feedback:** We appreciate all feedback provided. You will be receiving a patient satisfaction survey from Press Ganey. Please take time to complete this and let us know how we are doing.

Financial Policies:

- **Insurance**: Insurance cards must be available prior to each visit. Please notify our office if there is a change in your insurance plans or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to the contracted insurance company for the member. Any dispute for unpaid charges from the insurance company will be billed to the member. All patients must have a valid insurance ID card in order to utilize benefits.
- **Charges**: Full payment is due at the time services are rendered unless other payment arrangements have been made. Copay balances are expected at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for all non-covered and allowable charges. Delays in insurance processing occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering care. Whenever insurance denies payment for service, it your responsibility to cover the charges, therefore, it is important to review your benefits with your insurance provider.
- Methodist Transplant Specialists will bill your health plan for all physician services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from your physician.
- For your convenience, Methodist Transplant Specialists accept cash, check, debit card, VISA, MasterCard, Discover, and American Express. Some of our satellite clinics do not accept cash payments.
- For all services rendered to minor patients, the adult accompanying the patient and the parent or guardian with custody will be responsible for payment.
- A $35.00 NSF fee will be charged for returned checks.
- Accounts not paid by the 90th day following the date of service will be turned over to an outside collection agency, unless arrangements have been made in advance. If you have multiple delinquent accounts, you may be asked to transition your care to another office.

I have read and understand the above general and financial policies, and understand and agree to the terms herein. I understand that this office will file an insurance claim on my behalf. I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company to the extent permissible under state and/or federal law.

Patient Signature **Date**	**Witness/Translator Signature (Relationship to Patient)**
Print Patient Name	**Print - Witness/Translator**

Advanced Practice Provider (APP) Consent
(Physician Assistant and Advanced Practice Nurse)

This facility has on staff Advanced Practice Providers (Physician Assistants and Advanced Practice Nurses) to assist in the delivery of medical care.

An Advanced Practice Provider (APP) is not a doctor. They are graduates of a certified training program and are licensed by the Texas state board. Under supervision of a Physician, an APP can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising Physician, but rather overseeing the activities of the extender and of accepting responsibility for the medical services provided.

An APP may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Obtaining histories and performing physical exams.
- Developing and implementing a treatment plan.
- Monitoring the effectiveness of therapeutic interventions.
- Offering counseling and education.
- Supplying sample medications and writing prescriptions.

I understand that at anytime I can refuse to see the Physician Assistant or Advanced Practice Nurse and request to see a Physician. **I also understand that should I make this request at the time of my visit, my Physician may not be readily available and my appointment may need to be rescheduled.**

I have read the above and hereby consent to the services of an Advanced Practice Provider for my health care needs.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____

WitnessSignature - Patient under 18 years of age

_____

Witness (Print Name)

_____

Translator (Signature)

_____

Translator (Print Name)

The Liver Institute METHODIST DALLAS | Methodist TRANSPLANT SPECIALISTS | The Transplant Institute METHODIST DALLAS

Patient Acknowledgement of Independent Practice

I, the undersigned patient (or patient representative), hereby acknowledge and understand that The Liver Institute at Methodist Dallas and/or The Transplant Institute at Methodist Dallas is/are an outpatient clinic of Methodist Dallas Medical Center (MDMC) where several independently practicing physicians and physician groups provide liver transplant and/or liver transplant related medical services, gastroenterology, general hepatology and surgical services. Specifically, I acknowledge and understand that Methodist Transplant Specialists, Digestive Health Associates of Texas, P.A., Dallas Nephrology Associates, Dallas Renal Group, and any health care provider employed or otherwise engaged by any such groups including, but not limited to, Irfan Agha, M.D., Maisha Barnes, M.D., Jose Castillo-Lugo, M.D., Stephen Cheng, M.D., Richard Dickerman, M.D., Ed Dominguez, M.D., Kosunarty Fa, M.D., Carlos Fasola, M.D., Adil Habib, M.D., Randy Hunter, PhD, Parvez Mantry, M.D., Alejandro Mejia, M.D., Hector Nazario, M.D., Mangesh Pagadala, M.D., Vichin Puri, M.D., Silvi Simon, M.D., Zahid Vahora, M.D. and Jeffrey Weinstein, M.D. (collectively all such named groups and individuals are referred to as "Providers") are not agents, employees or representatives of The Liver Institute, of MDMC or of Methodist Health System (MHS). I further acknowledge and understand that The Liver Institute, MDMC and MHS have no right to control the details of the medical services provided by any Provider.

_____ _____

Patient Signature **Date**

_____ _____

Print Patient Name **(Relationship if other than the patient)**

_____

Witness/Translator Signature

_____

Print - Witness/Translator

Financial Policy

1. Authorization to Release Information:
I authorize **METHODIST TRANSPLANT SPECIALISTS** to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payer for the purpose of obtaining payment on account of (1) **METHODIST TRANSPLANT SPECIALISTS,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. Assignment of Benefits:
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.
If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.
I understand that I am responsible for providing **METHODIST TRANSPLANT SPECIALISTS** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **METHODIST TRANSPLANT SPECIALISTS**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

3. Medicare / Medicaid Assignment of Benefits: (Do not complete unless you receive Medicare/Medicaid health care benefits)
a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me. **Initial _____**

b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made. **Initial_____**

_____
Signature of Patient or Guardian (and relationship if not patient) Date

_____ [ ] Patient under 18 years of age
Witness

_____ _____
Translator (Print Name) Translator (Signature)

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Initial Patient Assessment / History

Patient Name _____ **Date** _____

Age _____ **Sex** _____ **Race** _____ **Referred by** _____(MD)

Primary Care / Family Physician _____ (MD)

History of Present Illness

Main reason for Visit _____

1. When were you first diagnosed with liver problems?

_____

2. What type of liver problems were you diagnosed with?

_____

3. Have you ever been treated for your liver problems (Circle One) Yes No

If so, what were you treated with? (Modifying Factors) (Check All that Apply)

☐ **Pegylated Interferon** ☐ **Ribavirin** ☐ **Interferon** ☐ **Steroids** ☐ **Phlebotomy** ☐ **Other**

_____

4. How did/does this treatment make you feel? Worse or Better

Date Treatment Started _____ **Date Ended/Stopped**

_____

Date Treatment Started _____ **Date Ended/Stopped**

_____

Date Treatment Started _____ **Date Ended/Stopped**

_____

Side effects experienced while on treatment

_____

_____

_____

_____

_____

5. Have you ever had a liver biopsy? (Circle One) Yes / No

If so, When? _____ Where? (Hospital) _____

6. Have you ever had any of the following tests?

			Date	Comment (Physician/Staff only)
Liver UltraSound	**Yes**	**No**	**_____**	
Abdominal CAT Scan	**Yes**	**No**	**_____**	
MRI of the Liver	**Yes**	**No**	**_____**	
Upper Endoscopy (EGD)	**Yes**	**No**	**_____**	
Colonoscopy	**Yes**	**No**	**_____**	

Comment (Physician/Staff only)

_____

_____

_____

Risk Factors for Liver Disease			Date	Comments
1. Have you ever used IV drugs?	**Yes**	**No**	**_____**	
2. Have you ever gotten a tattoo?	**Yes**	**No**	**_____**	
3. Have you had a blood transfusion?	**Yes**	**No**	**_____**	
4. Have you ever snorted cocaine?	**Yes**	**No**	**_____**	
5. Have you had any body-piercings?	**Yes**	**No**	**_____**	
6. Have you had multiple sex partners?	**Yes**	**No**	**_____**	

7. Have you ever been stuck by a dirty or infected needle? Yes / No When?

_____

8. Do you drink alcohol or have you drank alcohol in the past? Yes / No

Amount: _____ **Type:** _____ **How often?**

_____

When did you start? _____ **When did you stop?** _____

9. Do you have any family history of liver disease? Yes / No

If so, relationship? _____ **Type:**

_____

Current Symptoms of Liver Disease

Do you currently **have any of the following symptoms?**

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Fatigue/Tiredness**	_____	
☐	☐	**Rash**	_____	
☐	☐	**Abdominal Pain**	_____	
☐	☐	**Joint Swelling**	_____	
☐	☐	**Joint Pain**	_____	

10. Rate your pain/other symptom from 1-10 scale 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

11. What is the quality of pain/other symptoms? (Mild / sharp / radiating / throbbing / cramping / tingling)

Symptoms of Severe Liver Disease

Have you ever had any of the following symptoms?

Yes	No		Date	Comment (Physician/Staff only)
☐	☐	**Itching**	_____	_____
☐	☐	**Ascites (fluid in abdomen)**	_____	_____
☐	☐	**Swelling of feet / ankles**	_____	_____
☐	☐	**Variceal Bleed (vomiting blood)**	_____	_____
☐	☐	**Jaundice (yellow skin/eyes)**	_____	_____
☐	☐	**Encephalopathy (mental confusion Forgetfulness / drowsiness)**	_____	_____

12. When do you feel these symptoms? Day / Night Constantly / Occasionally

Past Medical History **Comments**

Yes	No		
☐	☐	**Diabetes**	_____
☐	☐	**Diabetic Complications**	_____
☐	☐	**High Blood Pressure**	_____
☐	☐	**Heart Disease**	_____
☐	☐	**Kidney Disease**	_____
☐	☐	**Auto-Immune Disease**	_____
☐	☐	**Lung Disease (COPD, Asthma, Emphysema)**	_____

☐	☐	**Cancer**	_____
☐	☐	**HIV**	_____
☐	☐	**Seizure Disorder**	_____
☐	☐	**Thyroid Disease**	_____
☐	☐	**Chronic Low-back Pain**	_____
☐	☐	**Weight Loss**	_____
☐	☐	**High Cholesterol, High Lipids**	_____
☐	☐	**Other** _____	_____

Past Surgical History

Previous Surgery (Circle One) Yes No If yes, type of surgery and date performed.

Date/Procedure: _____
Date/Procedure: _____
Date/Procedure: _____

Past Family History

Has anyone in your family (blood relative) had the following?

Yes	No		
☐	☐	**Liver Disease**	_____
☐	☐	**Cancer**	_____
☐	☐	**Heart Disease**	_____
☐	☐	**Diabetes**	_____

Has your partner been tested for Hepatitis C? (Circle One) Yes No N/A
Has your partner been tested for Hepatitis B? (Circle One) Yes No N/A

Social History

Marital Status (circle one) Single Married Separated Divorced Widowed

Number of children _____

Are you currently employed? (Circle One) Yes / No If so, do you work full time? (Circle One) Yes / No

What type of work do you do? _____

Do you smoke? (Circle One) Yes / No
If yes, how much? _____ **How long have you smoked?** _____

Have you ever been in AA (Alcoholics Anonymous) or any other type of rehab program?

(Circle One) Yes / No If yes, when? _____

Psychiatric History

Do you suffer from depression and/or anxiety? (Circle One) Yes / No

Are you currently under the care of a psychiatrist? (Circle One) Yes / No

Do you currently have suicidal ideation? (Circle One) Yes / No

Have you ever been admitted to a hospital or institution for psychiatric reasons?

(Circle One) Yes / No If yes, when? _____

Medications:

Please list all medications you are currently taking, including all over-the-counter medications.

Medication Name / Dosage / How often

1) _____ **7) _____**

2) _____ **8) _____**

3) _____ **9) _____**

4) _____ **10) _____**

5) _____ **11) _____**

6) _____ **12) _____**

Allergies

Are you allergic to any medications? (Circle One) Yes No Unknown

Do you have environmental or food allergies? (Circle One) Yes No Unknown

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Symptoms (check all that apply)

Constitutional **Comments**

- ☐ Fever or Chills
- ☐ Fatigue _____
- ☐ Weight Loss
- ☐ Decreased Appetite _____
- ☐ Weight Gain
- ☐ Increased Appetite _____
- ☐ Trouble Sleeping

EYES

- ☐ Redness
- ☐ Yellowness _____
- ☐ Visual Changes _____

NOSE/THROAT

- ☐ Sore Throat
- ☐ Mouth Sores

_____

- ☐ Nasal or Sinus Inflammation / Infection _____

Respiratory

- ☐ Cough
- ☐ Difficulty Breathing _____
- ☐ Shortness of Breath (without exertion) _____

Heart/Cardiac

- ☐ Chest Pain
- ☐ Heart Palpitations _____
- ☐ Shortness of Breath (with exertion) _____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Abdominal Swelling _____
- ☐ Nausea
- ☐ Vomiting _____
- ☐ Diarrhea
- ☐ Constipation _____
- ☐ Vomiting Blood
- ☐ Rectal Bleeding _____
- ☐ Black or Pale Stool
- ☐ Heartburn _____

Reproductive / Urinary

- ☐ Blood in Urine
- ☐ Frequent Urination _____
- ☐ Burning with Urination
- ☐ Dark Urine _____

Skin/Integumentary

- ☐ Rash
- ☐ Itching _____
- ☐ Injection Site Reaction
- ☐ Hair Loss _____

Musculoskeletal

- ☐ Joint Pain
- ☐ Back Pain _____
- ☐ Swelling in Extremities _____

Neurological

- ☐ Headache
- ☐ Dizziness _____
- ☐ Weakness _____
- ☐ Tingling / Numbness in Extremities _____

☐ **ALL SYSTEMS NEGATIVE EXCEPT NOTED IN HPI**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: ____

Physician(s) Seen:

❒ Dr. Maisha Barnes ❒ Dr. Stephen Cheng ❒ Dr. Richard Dickerman ❒ Dr. Ed Dominguez ❒ Dr. Carlos Fasola
❒ Dr. Adil Habib ❒ Dr. Parvez Mantry ❒ Dr. Mangesh Pagadala ❒ Dr. Vichin Puri ❒ Dr. Alejandro Mejia
❒ Dr. Hector Nazario ❒ Dr. Zahid Vahora ❒ Dr. Jeffrey Weinstein

1. I authorize the following individual or organization to disclose the above named individual's health information:

   _____ Address: _____

2. This information may be disclosed and used by the following individual or organization:

The Liver Institute at Methodist Dallas
1411 N Beckley Ave., Pavilion III, Suite 268
Dallas, Texas 75203
PH: 214-947-4400 or 877-4A-LIVER
FX: 214-947-4404

The Liver Institute at Mansfield
2800 E. Broad Street, Ste. 404
Mansfield, Texas 76063
PH: 214-947-4400 or 877-4A-LIVER
FX: 682-242-8906

The Liver Institute at Methodist Fort Worth
914 Lipscomb Street; Ste. A
Fort Worth, Texas 76104
PH: 214-947-4400 or 877-4A-LIVER
FX: 682-242-8906

3. The type and amount of information to be used or disclosed is as follows: (Please Check)

   ___ Entire Health Record ___ Operative Procedures ___ Pathology Report ___ Echocardiogram ___ History & Physical

   ___ X-ray/Imaging Reports ___ X-ray Film ___ Laboratory Reports ___ Liver Biopsy ___ Other (please describe) _____

4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and/or drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s) (*please include the name and address of the individual or organization*): _____

6. This information is being disclosed for the following purpose(s): Continuity of Care

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: MedHealth, 3400 W. Wheatland Rd, Suite 453, Dallas, TX 75237. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   _____

   This authorization will expire 12 months from the date of signing.

9. I understand that my treatment, payment, or eligibility to file to insurance company will not be conditional on the completion and signature of this form.

10. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

11. I understand that I will be given a copy of this authorization form after signing.

_____

Signature of Patient/Responsible Party or Legal Representative (Relationship) Date

_____

Signature of Witness (Print) Date

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Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Is it permissible to:	**Yes**	**No**	**Please provide:**
Call your home?			**Home Phone #:**
Leave a message at home ?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Call your work ?			**Work Phone #:**
Leave a message at work ?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Call your cell phone ?			**Cell Phone #:**
Leave message on cell phone?			**Primary: [ ] Secondary: [ ] Third: [ ]**
Mail results to your home?			**Address:**
E-Mail results to your home?			**E-Mail Address:**

Communication to Family Members, Spouses or Other:

I, (print patient name) _____ DOB _____, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person(s):

Contact #1: _____
Relationship:_____
Home #:_____
Work#:_____
Cell:_____
Emergency Contact: (Y/N) ____

Contact #2: _____
Relationship: _____
Home #: _____
Work#: _____
Cell: _____
Emergency Contact: (Y/N) ____

Communication for Appointment Reminders and Appointment Follow-Ups:

Methodist Transplant Specialists ("MTS") may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives, If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MTS to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclosed based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give MTS your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MTS this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication

(*Initial all that apply*): _____ Email (If Applicable) _____ Phone _____ Text message (If Applicable) [1]
_____ Secure patient portal to be used in the manner described above.

Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

_____ (initial) I decline to give MTS consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be requires to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

Patient (Print Name)	Date of Birth
Signature of Patient or Guardian	Date

[1] Please note the text messaging service is a complimentary service provided by MTP, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.

Notice of Privacy Acknowledgement

Methodist Transplant Specialists Notice of Privacy Practices provides information about how *Methodist Transplant Specialists* may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is posted in the waiting room. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for **treatment, payment and health care operations**, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

This Privacy Acknowledgement does **not** give us consent to release records to anyone except to who is mentioned. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

_____ _____

Signature of Patient or Guardian Patient Date of Birth

_____ _____

Relationship to Patient, if not signed by the Patient Date

The Liver Institute METHODIST DALLAS | Methodist TRANSPLANT SPECIALISTS | The Transplant Institute METHODIST DALLAS

Consent to obtain Liver Biopsy Slides for Second Opinion

Your physician may request a second opinion for the reading of a liver biopsy you have had performed at an outside institution. Physicians of Laboratory Physicians Association (LPA) or Surgical Pathologists of Dallas (SPOD) will perform the second opinion and provide those results to your physician here at The Liver Institute, who has ordered the second opinion. A professional fee in the range of $80.00 - $150.00 will be charged for the second opinion. A technical fee may be charged, if special staining is required. The Liver Institute will provide health plan billing information to LPA/SPOD. However, this may be a non-covered health service. If benefit dollars are not payable for this service to LPA/SPOD, the remaining balance on the account will be your financial responsibility. The purpose of this document is to make you aware of this information and to obtain your consent to proceed with obtaining the second opinion.

I authorize the release of my liver biopsy slides to:

- ❒ **Dr. Maisha Barnes**
- ❒ **Dr. Stephan Cheng**
- ❒ **Dr. Richard Dickerman**
- ❒ **Dr. Ed Dominguez**
- ❒ **Dr. Carlos Fasola**
- ❒ **Dr. Adil Habib**
- ❒ **Dr. Parvez Mantry**
- ❒ **Dr. Alejandro Mejia**
- ❒ **Dr. Hector Nazario**
- ❒ **Dr. Mangesh Pagadala**
- ❒ **Dr. Vichin Puri**
- ❒ **Dr. Zahid Vahora**
- ❒ **Dr. Jeffrey Weinstein**

I have completed an Authorization to Disclose Health Information Form, a copy of which is attached hereto, authorizing the outside institution to release my biopsy slides to the above named physician.

I understand that I am financially responsible for all charges whether or not paid by my insurance.
My signature below signifies my understanding of and willingness to comply with this agreement.

_____ _____

Patient Signature **Date**