Digestive System Healthcare

Rukan Daccak, MD, PA
Diplomate American Board of Gastroenterology

Patient Registration

Patient Information:

Marital Status:

□ **Mr.** □ **Ms.** □ **Mrs.** □ **Male** □ **Female** □ **Single** □ **Married** □ **Divorced** □ **Separated** □ **Widowed**

Last Name: _____ **First**: _____ **MI**: _____ **Suffix**:_____

Social Security Number: _____-_____-_____ **DOB**:_____ **Age**:_____

Race: (circle one)

Decline
American Indian or Alaskan Native Asian
Black or African American
Native Hawaiian or Other Pacific Island
White
Other race

Ethnic Group: (circle one)

Decline
Hispanic or Latino
Not Hispanic or Latino

Address: _____ **City/State/Zip**: _____

Mailing Address (if different from above)_____ **City/State/Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

E-mail Address: _____ **Driver Lic #** _____

Employed By: _____

Referred By: _____

Emergency Contact:_____ **Phone #:** _____**Relationship:**_____

Insurance Information:

Please list the name of your primary and secondary (if applicable) insurances below and give the Dr. Daccak's Staff your insurance card and Driver's License so they can make a copy.

Primary Insurance Company Name: _____

Insured's Full Name: _____ SSN: _____ DOB: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance Company: _____

Insured's Full Name: _____ SSN: _____ DOB: _____

Subscriber ID: _____ Group Number: _____

Please initial by each of the following statements and then sign below acknowledging that you have read and understand them.

The above information is true to the best of my knowledge. Initial: _____

I acknowledge receipt of **Rukan Daccak M.D.** Notice of Patient Information Privacy Practices. Initial: _____

I authorize my medical insurance benefits and/or government benefits be paid directly to the physician. Initial: _____

I understand that I am financially responsible for any charges not covered by my insurance company. Initial: _____

If I fail to meet my financial obligation, **Rukan Daccak M.D.** reserves the right to add a monthly interest of 1.5% to any outstanding balance after 60 days. If this account is referred for collections, I agree to pay all collection costs involved including reasonable attorney fees and court costs. Initial: _____

I also authorize **Rukan Daccak M.D.** or Insurance Company to release any information required to process my claim. Initial: _____

In addition, I authorize **Rukan Daccak M.D.** to release medical records to any physician or facility involved in the treatment plan of my condition, unless otherwise revoked in writing. Initial: _____

_____ _____

Patient or Legal Representative **Date**

Patient Name: _____ **DOB:** _____

Please list any doctors that you have seen in the past year.

	Primary Care Physician	Referring Physician	Gastroenterologist (previously seen)	Other Physicians (within last year)
Name				
Specialty				
Address				
City, State, Zip				
Phone #				
Fax #				

Primary Pharmacy for Prescriptions to be sent electronically:

Name of Pharmacy	Address	Phone Number

Preferred Laboratory (circle): LabCorp Or Quest

The following persons may contact Rukan Daccak M.D. regarding my medical care:

Name	Relationship to Patient	Phone Number

I give permission for Gastroenterology Center to discuss my health records with any of the above listed physicians and or persons in either verbal or written format.

Patient or Legal Representative Date

Office Policies

Professional Fees: The Office will bill your primary, secondary, and tertiary insurance companies for services provided by our office. Payment of all co-payments, co-insurances, deductibles, and charges for non-insured related services are

due at the time services are rendered. Surgical co-payments and deductible amounts for the **PHYSICIANS FEE ONLY** are collected at the time of your pre-op visit. Please keep in mind that the amount given for the physician's fee for the procedure is only an estimate. A quote of insurance benefits is not a guarantee of payment. Approval of payment is made upon receipt of the claim. **It is your responsibility to contact the hospital/facility where your procedure will take place to obtain amounts that you owed or may owe for the hospital/facility, anesthesia, and pathology services related to the surgical procedures. Initials: _____**

Additional Insurance/Disability Forms: There is a $15.00 charge for each insurance form completed. Please allow two weeks for completion of these forms.

Medical Records: Copies of your medical records will be furnished to another physician at no charge upon receipt of a properly executed medical records release form. Copies of your medical records for legal or insurance use are furnished upon receipt of a signed medical release and a prepayment of $25 for the first twenty pages and $0.50 per page for every copy thereafter. **Rukan Daccak M.D.** may retain the requested information until payment is received. Please allow 7 business days for your request to be processed.

Emergency Call: If you have an emergency after hours, please call the regular office number. The answering service will contact the appropriate person and your call will be returned as soon as possible.

Prescription Refills: Our office requires 48-hour notice for prescription refills. Please call your pharmacy if you need a refill and they will contact our office for approval.

I have read the office policies of Rukan Daccak M.D. I understand and agree to the above policies.

Patient or Legal Representative Signature Date

PATIENT CONSENT FOR DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications is made by alternative means, such as sending correspondence to the individual's office instead of the home.

1. Home Telephone ( ) _____

_____ Ok to leave message with detail information
_____ Leave message with callback numbers only

2. Work Telephone ( ) _____

_____ Ok to leave message with detail information
_____ Leave message with callback numbers only

3. Written Communication
_____ Ok to mail to my home address
_____ Ok to mail to my work/office address
_____ Ok to fax to this number ( ) _____

_____ _____
Signature Date

_____ _____
Print Name Date of Birth

Authorized person that can obtain my personal health information:

_____ _____
Print Name Relationship

RUKAN DACCAK MDPA HIPAA

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others (facilities/offices) that are involved in your care and treatment, patient health care bills to support the operation of the physician's practice and any other use required by law.

2. Treatment

We will use and disclose your protected health information to provide, coordinate, or managed care service providers. For example we will disclose your PHI, as necessary, to a home health agency. Another example would be disclosing your information to physicians that needs it to make the proper diagnoses or treatment.

3. Payment

Your **PHI** will be used as needed to obtain payment for your health care service. For example, obtaining approval for a hospital stay may require that your relevant protected health information may be used to obtain approval for the hospital admission.

4. Healthcare Operations

We may use or disclose your **PHI** from your primary physician's practice. This information includes, but is not limited to quality assessment, employee review, training of medical students, and licensing and conducting/arranging future business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your **PHI** to contact you to remind you of your appointment. We may use and disclose your protected health information for the following circumstances:

- Facility directories
- Marketing
- Emergencies

Psychotherapy notes (for TPO)
Others involved in your health care

We may use or disclose your protected health information in the following circumstances without your consent:

Required by law
Communicable diseases
Food and drug administration
Required uses and disclosure
Research
Workers compensation
Military activity and national security
Coroners, funeral directors, and organ donation

Public health
Health oversight
Abuse or neglect
Law enforcement
Inmates
Legal proceedings
Criminal activity

RUKAN DACCAK MDPA HIPAA

5. Rights

The following are your rights with respect to your protected health information and how you may exercise these rights:

- Request to receive confidential communications from us by alternative means or at an alternative location.
- The ability to receive certain disclosures we have made, if any, of your protected health information.
- Request a restriction of your protected health information
- Have your physician amend your protected health information
- Inspect and copy your protected health information

- Obtain a paper copy of this notice from us

6. Complaints

You may complain to us or to the Secretary of Health and Human Services if you feel your privacy rights have been violated by us.

I hereby acknowledge that I have been presented with a copy of Dr. Daccak's 4450 E. Sam Houston Pkwy S. Ste. H2, Pasadena, TX 77505's and/or 1618 W. Baker Rd., Ste. B, Baytown, TX 77521's Notice of Privacy Practices. If you have any objection to this, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number at (713)910-7779.

Print Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at

any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: