Hospital Internists of TEXAS

CONSENT TO TREATMENT

I voluntarily consent to treatment by Hospital Internists of Texas physicians as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments or tests. I understand that if major diagnostic studies, treatment procedures such as surgery are required, I will be asked to give specific informed consent prior to the studies, treatment or procedure.

Patient or Responsible Party Signature

_____Date___/___/___

RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician, consulting physicians, and pharmacies related to the referral to Hospital Internists of Texas for such studies, treatments or procedures, and to its business associates as necessary to process insurance claims.

I authorize the above information to be released electronically.

Patient or Responsible Party Signature

_____Date___/___/___

NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the HIT Notice of Privacy Practices.

Patient or Responsible Party Signature

_____Date___/___/___

ELECTRONIC COMMUNICATIONS BETWEEN HOSPITALISTS OF TEXAS (HIT) AND ME:

HIT will accept e-mail communications for established patients on weekdays during the normal business hours of 8:00 a.m. to 5:00 p.m. E-mail communications will not be monitored during off-hours, holidays, or weekends. HIT will make every effort to read and respond to an e-mail from you within two (2) working days. However, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. IF YOU NEED IMMEDIATE ASSISTANCE or in the event of technological or equipment failure, please call the office at 512-482-0045. E-mails to or from patients concerning diagnosis or treatment will be printed out and made a part of your medical record. E-mail communications present risks and You acknowledge that these risks include, but are not limited to, the following e-mail:

- can be circulated, forwarded, and stored in numerous paper and electronic files.
- can be immediately broadcasted worldwide and be received by many intended and unintended recipients.
- senders can easily send an e-mail to the wrong address.
- is easier to falsify than handwritten or signed documents.
- backup copies may exist even after the sender or the recipient has deleted his/her copy.
- might be archived by employers.
- can be intercepted, altered, forwarded, or used without authorization or detection.
- can be used to introduce viruses into computer systems.
- can be used as evidence in court.

Taking into account these risks, HIT will use reasonable means to protect the security and confidentiality of e-mail communications as required by HIPAA, HITECH and Texas Law. However, it is impossible for us to guarantee the security and confidentiality of e-mail communications. Should confidential information be improperly disclosed, through no fault of HIT, HIT will not be liable for such disclosures.

DO NOT USE E-MAIL FOR MEDICAL EMERGENCIES. IN THE EVENT OF AN EMERGENCY—CONTACT 911 IMMEDIATELY.

By consenting to communicate with _____ through e-mail, you also agree to the following responsibilities:

- If you send an e-mail to _____ that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify _____ that the e-mail was received. You cannot assume that because it was not returned that it was received.
- You should mail, by certified mail, and NOT use e-mail to make disclosures about sensitive medical information such as:

  a. Substance Abuse
  b. AIDS/HIV
  c. Mental Health Disorders
  d. Sexually Transmitted Diseases

- It is your responsibility to inform HIT of any changes to your e-mail address.

Hospital Internists of TEXAS

PAYMENT POLICY

Medicare Patients: Hospital Internists of Texas physicians are participating providers in the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file claims with secondary/supplemental carriers on Your behalf.

HMO, PPO or other Managed Care Patients: You will be responsible for paying Your annual deductible, co-payment and charges for any non-covered, cosmetic services.

Commercial Patients: If You are covered by a private, commercial plan in which our physicians are not providers, You will be required to pay 50% of the total bill at the time of service. If our providers are covered by Your commercial plan, by signing below, You hereby assign to Hospital Internists of Texas all right to bill and receive third-party payments for services we rendered to You. You agree that only Hospitalists of Texas will bill and receive any fees for such services.

Patient or Responsible Party Signature

_____Date___/___/___

MEDICARE PATIENTS ONLY

This office is required to keep Your signature on file authorizing us to file claims to Medicare for You and to release information to the Medicare payor if required for proper consideration of a claim. By adding Your signature below, You authorize Hospital Internists of Texas to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carrier, necessary information needed for payment of Your Medicare claim. You permit a copy of this authorization to be used in place of the original and request payment of Your medical insurance benefits to Hospital Internists of Texas. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card

_____Date___/___/___

MEDIGAP or MEDICARE SUPPLEMENTAL PATIENTS ONLY

If You have a supplemental policy and it is a MEDIGAP policy to which Your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:
By adding your signature below, You request authorized MEDIGAP benefits be made on Your behalf for any services furnished to You by Hospital Internists of Texas. You authorize any holder of medical information to release to the Your MEDIGAP carrier any information needed to determine payment for services that You received from us.

Signature as it appears on Medigap Card

_____ Date___/___/___