1402 Medical Drive | Sulphur Springs, TX 75482
Phone: 903-558-2222 | Fax: 903-558-2225
txmoderngi.com. | info@txmoderngi.com

TEXAS MODERN
GASTROENTEROLOGY

PATIENT REGISTRATION FORM

FIRST NAME | LAST NAME | M.I. | DATE OF BIRTH

GENDER: *MALE/FEMALE/PREFER NOT TO ANSWER* | SOCIAL SECURITY NUMBER | PHONE NUMBER

HOME ADDRESS | CITY | STATE | ZIP CODE

MARITAL STATUS : | EMAIL ADDRESS:

EMPLOYER | OCCUPATION | WORK NUMBER

PRIMARY INSURANCE COMPANY | POLICY HOLDER NAME | DATE OF BIRTH

SECONDARY INSURANCE COMPNAY | POLICY HOLDER NAME | DATE OF BIRTH

PRIMARY CARE PHYSICIAN | ADDRESS | PHONE NUMBER

REFERRING PHYSICIAN | ADDRESS | PHONE NUMBER

EMERGENCY CONTACT | **PHONE NUMBER** | **RELATIONSHIP**

Texas Modern Gastroenterology will provide appointment reminders and contact you to keep you informed of any new services or upcoming events.

We text appointment reminders. If you prefer to opt out please indicate your preferred method:

☐Mailing Address ☐Work Phone ☐Home Phone ☐Email

Preferred Phone #:_____

Is it **OK** to leave a voicemail regarding labs/medical information? ☐Yes ☐No

Signature of Patient or Patient's Representative:_____Date:_____

TEXAS MODERN
GASTROENTEROLOGY

GENERAL MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____

REFERRING PHYSICIAN: _____

1. **What brings you in to see the physician today? How long have your symptoms been going on?**

2. **Have you ever had a Colonoscopy or an Endoscopy? (If so, please list when/where these were done).**

MEDICAL HISTORY

What medical conditions do you have?

☐ High Blood Pressure (Hypertension) ☐ History of Heart Attack ☐ History of Stroke ☐ Diabetes
☐ Seizure Disorder ☐ Atrial Fibrillation ☐ Abnormal Heart Rhythm ☐ Chronic Kidney Disease ☐ Dialysis
☐ High Cholesterol ☐ Asthma ☐ Sleep Apnea ☐ Recent Bone Fractures ☐ Pacemaker/Defibrillator
☐ Congestive Heart Failure ☐ History of Transplant
☐ Other: _____
☐ Other: _____

What previous Surgeries have you had?

☐ Hiatal Hernia Repair ☐ Weight Loss Surgery (Gastric Bypass, Sleeve, Lap Band) ☐ C-Section
☐ Hysterectomy ☐ Abdominal or Inguinal Hernia Repair ☐ Heart Bypass ☐ Vascular (Blood Vessel Surgeries) ☐ Colon Resection or Colon Surgery ☐ Hemorrhoidectomy
☐ Other: _____
☐ Other: _____

HOSPITALIZATIONS AND ALLERGIES

Please list any recent hospitalizations within the past 6 months or any gastrointestinal related hospitalizations.

_____
_____
_____
_____
_____
_____

What known food or drug allergies to you have?

☐ No known drug allergies ☐ No food allergies
☐ Drug Name: _____ Reaction: _____
☐ Drug Name: _____ Reaction: _____
☐ Drug Name: _____ Reaction: _____
☐ Drug Name: _____ Reaction: _____
☐ Drug Name: _____ Reaction: _____

MEDICATIONS

Please list your medications (including dosages). Please also note any herbal medications:

Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____
Drug: _____ Dose: _____ How often: _____

Do you take any of the following blood thinners or any blood thinners not listed?

☐ Plavix (Clopidogrel) ☐ Aspirin ☐ Coumadin (Warfarin) ☐ Eliquis (Apixaban) ☐ Pradaxa (Dabigatran) ☐ Xarelto (Rivaroxaban) ☐ Lixiana (Edoxaban) ☐ Ticagrelor (Brillinta) ☐ Prasugrel (Effient) ☐ Ticlopidine (Ticlid) ☐ Dypridamole/Aspirin (Aggrenox) ☐ Eptifibatide (Integrilin)
☐ Other: _____

Please list your preferred pharmacy:

Name: _____ City: _____
Phone Number: _____ Fax: _____

SOCIAL HISTORY:

What is your Occupation?

Do you smoke tobacco? ☐ Yes ☐ No **How many packs per day?** _____
How many years have you been smoking? _____ **Any plans to quit smoking?** ☐ Yes ☐ No

Do you use chewing tobacco? ☐ Yes ☐ No

How many alcoholic drinks (beer, wine, hard liquor) do you have per week? ☐ None ☐ 1-2 ☐ 3-4
☐ More than 5 ☐ Drink everyday **How many drinks do you have per day?** _____

Do you use marijuana?
☐ Yes ☐ No

Do you use e-cigarettes or vaping products?
☐ Yes ☐ No

Do you use or have you used any other illicit drugs?
☐ Yes ☐ No Please list: _____

FAMILY HISTORY

Do any of the following run in your family? Please note the relation.

☐ Colon cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Stomach cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Barrett's Esophagus	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Pancreas Cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Gallbladder Cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Liver Cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐ Colon Polyps	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Other Cancer	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Liver Disease	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐High cholesterol	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐High blood pressure	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Thyroid Disease	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Psychiatric Conditions	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Kidney Disease	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____
☐Heart Disease	*☐ Mother*	*☐ Father*	*☐ Brother*	*☐ Sister*	*☐ Son*	*☐ Daughter*	*☐ Other:* _____

Does anything else run in your family not mentioned above?

TEXAS MODERN
GASTROENTEROLOGY

1402 Medical Drive | Sulphur Springs, TX 75402
Phone: 903-558-2222 | Fax: 903-558-2225
txmoderngi.com. | info@txmoderngi.com

REVIEW OF SYSTEMS

Please check if you have had any of the following over the past 6 months.

GENERAL
[ ] Fever
[ ] Chills
[ ] Sweats
[ ] Involuntary Weight Loss
[ ] Anorexia
[ ] Excessive fatigue/weakness
[ ] Anorexia
[ ] Sleep disorder

EYES
[ ] Double vision
[ ] Blurring
[ ] Eye irritation
[ ] Eye discharge
[ ] Vision Loss
[ ] Eye Pain
[ ] Light sensitivity

EAR, NOSE & THROAT
[ ] Earache
[ ] Ear discharge
[ ] Ringing in ears
[ ] Decreased hearing
[ ] Nasal Congestion
[ ] Nose bleeding
[ ] Sore throat
[ ] Hoarseness

CARDIOVASCULAR
[ ] Chest pain
[ ] Bluish color lips/nails
[ ] Difficulty breathing with exertion
[ ] Palpitations
[ ] Swelling of legs
[ ] Fainting

RESPIRATORY
[ ] Cough
[ ] Cough with exercise
[ ] Difficulty breathing at rest
[ ] Excessive sputum production
[ ] Coughing up blood
[ ] Nighttime wheezing/cough
[ ] Wheezing

GASTROINTESTINAL:
[ ] Nausea
[ ] Vomiting
[ ] Vomiting Red Blood
[ ] Vomiting Black Blood
[ ] Diarrhea
[ ] Constipation
[ ] Change in bowel habits
[ ] Abdominal Pain
[ ] Dark, tarry stools
[ ] Bloody stools
[ ] Yellow skin color or yellow eyes
[ ] Gas or bloating
[ ] Indigestion/Heartburn
[ ] Difficulty swallowing
[ ] Anal leakage

GENITOURINARY:
[ ] Vaginal discharge
[ ] Incontinence
[ ] Painful urination
[ ] Blood in urine
[ ] Urinary Frequency
[ ] Pelvic pain
[ ] Abnormal bleeding

MUSCULOSKELETAL:
[ ] Back Pain
[ ] Joint Pain
[ ] Joint swelling
[ ] Muscle cramps
[ ] Muscle weakness
[ ] Muscle Stiffness
[ ] Arthritis
[ ] Low back pain
[ ] Restless legs

DERMATOLOGIC:
[ ] Rashes
[ ] Suspicious skin lesion
[ ] Itching
[ ] Dryness

NEUROLOGIC:
[ ] Frequent falls
[ ] Frequent headaches
[ ] Paralysis
[ ] Numbness in arms or legs
[ ] Seizures
[ ] Tremors
[ ] Poor balance

PSYCHOLOGICAL:
[ ] Anxiety
[ ] Depression
[ ] Obsessive behavior
[ ] Thoughts of suicide
[ ] Depression

ENDOCRINE
[ ] Cold/Heat intolerance
[ ] Excessive thirst
[ ] Excessive urination

HEMATOLOGY:
[ ] Abnormal bruising
[ ] Abnormal bleeding
[ ] Enlarged lymph nodes

ALLERGY:
[ ] Hives
[ ] Rash
[ ] Hay Fever

TEXAS MODERN
GASTROENTEROLOGY

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient.
All references to "patient", "me" and "my" in this document means: **(List Name of Patient(s))**

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the physicians at Texas Modern Gastroenterology and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, nurse practitioners, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.
_____ (Please initial)

Sharing Records for Treatment

We share medical records with other health care providers to allow and promote continuity of care among providers. If you visit another provider, they may have access to your medical record.
_____ (Please initial)

Acknowledgment of Financial Policy

I acknowledge receiving Texas Modern Gastroenterology's Financial Policy. This Policy explains my financial responsibility and how any past due balances will be handled. ***A copy may be obtained through the front desk, if you should have questions please contact our Billing Manager at (903)-558-2222.***
_____ (Please initial)

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Texas Modern Gastroenterology's Notice of Privacy Practices ("Notice"). The Notice explains how Texas Modern Gastroenterology may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. ***If you have questions about the Notice, please contact our Office Manager at (903)-558-2222.***
. _____ (Please initial)

Acknowledgment of Office Information & Policies

I acknowledge receiving Texas Modern Gastroenterology's Office Information and Policies. By acknowledging this, I am accepting the policies as stated. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.
_____ (Please initial)

Signature of Patient or Patient's Representative:_____ Date:_____

TEXAS MODERN
GASTROENTEROLOGY

NO SHOW POLICY

Thank you for entrusting your medical care to Texas Modern Gastroenterology. When you schedule an appointment with us, we set enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. Please see our policy below:

Any patient who failed to show up for an appointment and has not contacted our office will be considered a "No Show" and charged a $25.00 fee. The fee is charged to the patient, not the insurance company.

We understand that there may be times when an unforeseen emergency occurs, and you may not be able to keep your appointment. If this occurs, please call us at 903-558-2222 and we may be able to waive the "No Show" fee.

I have read an understand the Medical Appointment No Show Policy and Agree to its terms

_____ _____

Signature (Patient/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

TEXAS MODERN
GASTROENTEROLOGY

Financial Policy

Texas Modern Gastroenterology (TMG) is committed to the health and well being of our patients. Our goal is to build a physician-patient relationship with all our patients and provide them with top quality care. Communication is key to this relationship and we want to make sure you know and understand our financial policies. If you have any questions, a member of our billing staff will be happy to provide further clarification.

INSURANCE: We participate in many insurance plans. However, even within the same insurance company there are many versions of coverage. It is your responsibility to fully understand your plan benefits and any health savings accounts you have. We will submit primary insurance claims for you. As a courtesy, we will file secondary insurance claims as well if the information is provided in a timely manner. It is important that we have the most accurate and current insurance information prior to the service being provided. If you have a change of insurance, it is your responsibility to notify us of this change immediately. Our office cannot always tell you in advance whether or not each charge will be covered by your insurance plan. We are provided with an estimation of benefits, never a guarantee of payments. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is with your insurance carrier. Our office is not involved in the settlement of such disputes. The financial responsibility for the services provided to you is yours.

PAYMENT OF SERVICES: As required by all insurance plans, your co-pay, co-insurance, deductible, and non-covered services are due at the time of each service. We accept cash, personal checks, Visa, MasterCard, and Discover. Please note that in all instances, the patient or guardian is responsible for paying the patient portion at the time of service. If there are financial circumstances that preclude you from settling your account at the time of your visit, we are more than willing to work with you. We ask that you communicate this with our billing office prior to receiving services so that payment arrangements made be made. Please note that we keep a credit card on file for all patients, and

CREDIT CARD ON FILE POLICY: TMG requires a credit card on file in order to make the billing process simple and easy for the clinic and our patients. Your credit card information is stored within our secure electronic health record, which meets the strict HIPAA security standards. We swipe your card into the system, and only the last 4 digits of the card are visible to any staff at TMG. We will not write down or keep any written information about your card including the number, expiration date or security code on the back of the card. For any balances owed after a visit or procedure, we will send you a statement in the mail. Your card will be charged 30 days after the statement is mailed. If you wish to settle your balance by another payment method, please contact our office within those 30 days. We will send you a receipt after your card has been charged. If your card is declined, we will contact you via phone. If our call is not returned within one week, a $35 declined payment fee will be applied, and another statement will be mailed. Your account becomes delinquent if not paid within 90 days after the date of the original statement. Further delinquency will be subject to collection with additional finance fees. TMG reserves the right to terminate a patient from the practice if payment is not received according to the agreed upon payment arrangements. We understand that healthcare is often a large expense, and we are always willing to provide payment arrangements. These arrangements will require a credit card on file for monthly payments.

APPOINTMENT CANCELLATION POLICY Missed appointments or late cancelations represent a cost to us, to you, and to the patients who could have been seen in the time set aside for you. All cancellations must be made at least 24 hours prior to your scheduled appointment to avoid a $25 fee. Patients who have missed 3 or more appointments without a 24 hour cancelation notice in a one year time frame are subject to being discharged from the practice.

NON-PAYMENT POLICY AND OVERDUE ACCOUNTS
Patients with an outstanding balance 30 days past due must make arrangements for payment prior to scheduling their next appointment. We will make attempts to contact you to settle your account with us. When your account is 90 days past due with no payment arrangements made, we will assume you no longer want to be a patient of ours. We will send a certified letter to you letting you know that, by law, we will continue to provide emergency care for 30 days from date of notice. Should a patient need non-emergent medical attention within those 30 days, you will be required to settle your account prior to the visit.

By signing below, you acknowledge and agree to the Texas Modern Gastroenterology Financial policy. If the patient is not able to sign, the signer below is the legal guardian or responsible for the patient's account

Name: _____ Signature: _____ Date: _____

TEXAS MODERN
GASTROENTEROLOGY

1402 Medical Drive | Sulphur Springs, TX 75402
Phone: 903-558-2222| Fax: 903-558-2225
txmoderngi.com. | info@txmoderngi.com

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Requestor's Name and Phone Number: _____

I hereby authorize and request medical records from:

_____ _____
(Name of company/facility/agency/person) Phone Number

_____ _____
(Street/Address/CIty/State/Zip) Fax Number

Records to be released to:

_____ _____
(Name of company/facility/agency/person) Phone Number

_____ _____
(Street/Address/CIty/State/Zip) Fax Number

Check Information to be Released:
- ☐ Entire Record
- ☐ Endoscopy/Colonoscopy Reports
- ☐ Lab Tests
- ☐ Imaging Reports
- ☐ Physical Exams
- ☐ Discharge Summaries
- ☐ Billing Records
- ☐ Other (specify): _____

Reason for Request:
- ☐ Change of Physician
- ☐ Continuity of Care
- ☐ Personal Records
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Consultation
- ☐ Other (specify):

_____

I understand this information is confidential without the written authorization of the patient/patient representative. Multiple requests may necessitate a copying fee of $25.00. Please be aware that by state law, we have 14 days to comply with your request.

_____ _____ _____
Signature of Patient/Patient Representative Printed Name Date

TEXAS MODERN
GASTROENTEROLOGY

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 read this notice carefully.**

Your Rights:

When it comes to your health information, you have certain rights. This section explains some of your rights and our responsibilities to you.

- **Get an electronic or paper copy of your medical record or health and claims record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or summary of your health information, usually within 30 days or your request. We may charge a reasonable, cost-based of fee.
- **Ask us to correct your medical record or your health and claims record.** You can ask us to correct health information. We may say "no" to your request, but we will notify you in writing.
- **Request confidential communications.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **You can ask us to limit what we share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may decline if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we have shared information**. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **A copy of this notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take this action.
- **File a complaint if you feel your rights are violated.** You can complain if you feel we have violated your rights by contacting us and asking for the Privacy Officer. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety. In these cases we never

share your information unless you give us written permission: Marketing purposes, sale of your information, or most sharing of psychotherapy notes.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

- **Treat you.** To treat you, run our organization, and bill for services. We can use your health information and share it with other professionals who are treating you. Ex. A doctor treating you for an injury asks another doctor about your overall health condition. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Ex. We use health information about you to manage your treatment and services.
- **Payment.** We can use and share your health information to bill and get payment from health plans or other entities. Ex. We give information about you to your health insurance plan so it will pay for your services.
- We are allowed to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- **Help with public health and safety issues.** We can share health information about your for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you: For workers compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will not sell your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Please let us know in writing.

TEXAS MODERN
GASTROENTEROLOGY

1402 Medical Drive | Sulphur Springs, TX 75402
Phone: 903-558-2222| Fax: 903-558-2225
txmoderngi.com. | info@txmoderngi.com

CODE OF CONDUCT

In an effort to provide a safe and healthy environment for staff and patients, Texas Modern Gastroenterology expects patients, accompanying family and friends to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or inflicting bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: Profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of Texas Modern Gastroenterology.

WE ARE MAKING EVERY EFFORT TO REDUCE WAIT TIMES AND MAKE ALL OF OUR PATIENTS' VISITS TO TEXAS MODERN GASTROENTEROLOGY AS STRESS-FREE AND ENJOYABLE AS POSSIBLE. TO ASSIST IN THAT GOAL, WE HAVE THE FOLLOWING EXPECTATIONS:

- Please communicate all issues that you wish to discuss with the doctor at the time **your appointment is scheduled**, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all of their patients the time and quality of care they deserve.
- Please arrive on time for your appointment. Arriving **more than 15 minutes late** may result in having to reschedule. When you arrive late you are taking up someone else's designated time. This has a domino effect on every subsequent visit and is a contributing factor in long wait times.
- Please provide **24 hours notice of cancellation** whenever possible. We understand that last minute situations arise. Any notification, even late notice is appreciated.
- **MISSING your appointment** without prior notification will result in a $25.00 charge being assessed to your account. Failure to give prior notice if you are unable to keep your appointment prevents someone else from being scheduled.
- Payment of co-pays and/or deductibles is expected at the time services are rendered. Failure to do so may result in having to reschedule your appointment.
- We encourage our patients and families to ask questions during the appointment and inform us of any obstacles that might affect your treatment plan. Once a treatment plan is developed with Dr. Ebrahim, we ask you to take medications as prescribed and return for any recommended follow up visits.