

Houston Gastroenterology Associates

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

PATIENT PRIVACY STATEMENT:

Houston Gastroenterology Associates takes the privacy of our patients very seriously. We take the necessary steps to ensure all of our patient's privacy is kept confidential. We will not release any medical or financial information without an **original signature** from the patient or patient's representative. This is not a release of information form.

FINANCIAL RESPONSIBILITIES STATEMENT:

You have been/will be scheduled to have a procedure by one of our physicians. Our office collects any copay, co-insurance and deductibles prior to your procedure. The facilities we use have fees for their services **in addition to ours**. It is in your best interest to contact the facility where you are scheduled for an appointment to make financial arrangements prior to your procedure date.

I have read and understand the above notifications.

Patient Signature

Date

INFORMED CONSENT:

I have read the colonoscopy brochure and understand the risks, benefits and alternatives of colonoscopy. I understand that it is mandatory to arrange for a responsible adult, either **friend** or **relative**, to drive me to and from the facility. I realize that my procedure will not be performed unless these arrangements have been made.

Patient Signature

Date

If you should have any questions regarding the above, please contact the Practice Development Coordinator, before signing, at (713) 906-5750.