The Liver Institute
METHODIST DALLAS MEDICAL CENTER

Methodist
TRANSPLANT SPECIALISTS

The Transplant Institute
METHODIST DALLAS MEDICAL CENTER

Instructions for Completing New Patient Paperwork

Thank you for choosing The Liver Institute / The Transplant Institute at Methodist Dallas Medical Center!

To streamline your first visit, we kindly request that you complete the following new patient paperwork in advance.

Completing the Forms

- Please write clearly and legibly
- Be sure to sign and date all forms where required

How to Return Paperwork

- Email: Send completed paperwork to MTSFrontOffice@mhd.com
- In-Office: Return your paperwork when you arrive for your appointment
- Mail to:

  Methodist Transplant Specialists
  1411 N. Beckley Ave, Ste 268, Dallas, TX 75203

Additional Information

- Please arrive 30 minutes ahead of your scheduled appointment time
- Identification: Please bring a valid government-issued ID (e.g., driver's license, passport)
- Insurance Card: Bring your insurance card(s) to verify coverage.
- Medication List: Bring a current list of your medications
- Co-payments, deductibles and coinsurances must be collected at the time of service unless other arrangements have been made in advance with our office.
  - We accept cash, personal checks, Visa, Master Card, Discover, American Express, and Touch Less payment such as GooglePay and ApplePay;
    *** Cash and Checks - Dallas office ***
- Appointments/ No Show: We request 24 hour notice for appointment cancellations.
  - Patients with three (3) missed appointments and/ or no shows annually will result in dismissal from the practice.

If you are unable to complete the forms in advance, please arrive early to allow sufficient time to fill them out before your appointment.

If you have any questions or need assistance with completing the paperwork, please don't hesitate to contact our office at **214-947-4400**.

We appreciate your cooperation in completing these forms. It helps us provide you with the best possible care.

Methodist Transplant Specialists

The Liver Institute / The Transplant Institute

1411 N. Beckley Ave, Pavilion 3, Suite 268, Dallas, TX 75203

214-947-4400

www.TheLiverInstituteTX.com

Methodist
MEDICAL GROUP

Welcome Information

Thank you for choosing our practice to take care of your health care needs! We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Registration: All patients must complete a patient information form before seeing their provider.

Charges: Full payment is due at the time services are rendered unless other payment arrangements have been made. For patients without insurance, payment is due at the time of service for both sick and well visits. Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process**. 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 a service, it is your responsibility to cover the charges, therefore, it is important to review your benefits with your insurance provider.

FMLA/ Paperwork: Any patient that needs paperwork completed by *Methodist Medical Group may be* assessed a processing fee. This must be paid in full before the paperwork can be picked up or faxed. Please inquire with our staff regarding specific fees prior to submission of your form(s).

NSF/ Closed Accounts: There will be a $35.00 charge added for returned checks.
Clinical Fees: There may be a processing fee for controlled medication refills and an additional fee to re-write if the prescription is not filled within the 21 day deadline. The voided prescription must be returned before a new prescription is issued.

There is a $25.00 fee for medical records up to 25 pages. Additional pages are $0.50 per page. All Medical Records are processed by HealthMark and take seven business days to process.

Appointments/ No Show: We request 24 hour notice for appointment cancellations. Patients with three (3) missed appointments and/ or no shows annually will result in dismissal from the practice. If you no show to your appointment you may be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled visit.

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 form the insurance company will be billed to the member. All patients must have a valid insurance ID card in order to utilize benefits.

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. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after office hours or on weekends.
Referrals: Allow 5 to 7 working days to process routine referrals.

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: Our phone message will provide patients with a number to call our answering service for urgent needs after hours. The answering service will notify the physician on call.

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.

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**

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PATIENT INFORMATION			
Name		Date of Birth	Sex
Address	City	State	Zip
Home Phone	Work	Cell	
Email Address		**Social Security Number**	
Referring Physician Name/Office Name: **Referring Physician City and State:** **Referring Physician Phone Number:**		**Primary Care Physician Name/Office Name:** **Primary Care Physician City and State:** **Primary Care Physician Phone Number:**	
Preferred Pharmacy (Name / Phone Number):			
Employer Name and Address:		Employment 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			
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**

AUTHORIZATION for TREATMENT, AND FINANCIAL AGREEMENT

1. **Consent to Treatment:** I voluntarily consent to medical care and treatment by Methodist Medical Group. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), physicians in post-graduate medical education training, and other health care providers or the designees under the direction of a physician, affiliated with Methodist Medical Group to perform such medical treatment(s) and/or diagnostic procedure(s).

   I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

2. **Risks of Treatment:** I understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to surgical, medical, and/or diagnostic procedures planned for me. I realize that common surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death.

   I agree and acknowledge that Methodist Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Methodist Medical Group facilities.

   I understand I have the right to discuss the treatment plan with my provider about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my health care provider, I understand I am encouraged to ask questions.

3. **Financial Agreement:** In consideration of Methodist Medical Group furnishing services and supplies to the above named patient, I agree to pay Methodist Medical Group, its agents and assigns, all sums of money which shall become due on the account of the patient receiving services made the subject of this consent in accordance with Methodist Medical Group's regular rates, including costs related to COVID-19 Testing. I understand it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by my insurance at the time of service.

4. **Consent for Wireless Calls, Mail, and Email:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the clinic, agents, and independent contractors, including servicers and collection agencies regarding the services rendered, or my related financial obligations. I consent to receive information about Methodist Medical Group events such as: upcoming health fairs, health and wellness updates, new locations and services via email and mail. In addition, I understand Methodist Medical Group patient portal will use my email address in order to access the patient portal, MyChart.

5. **Authorization to release information:** I authorize Methodist Medical Group to furnish requested information from the patient's medical and other records to (1) any insurance company or third party payor for the purpose of obtaining payment on the account of Methodist Medical Group, (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, and 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 record for purposes of conducting any medical audits, utilization reviews, or quality assurance reviews. I authorize Methodist Medical Group to release information or copies of the patient's medical record to any referring physician.

6. **Assignment of insurance Benefits:** In consideration of services rendered, I hereby transfer and assign to

AUTHORIZATION for TREATMENT, AND FINANCIAL AGREEMENT

Methodist Medical Group and to all individuals or groups who perform services for my care and treatment at Methodist Medical Group all right title and interest in any payment due me for services described herein as provided in any health insurance or similar policy or employee benefit plan until revoked by me in writing. I understand that I am responsible for providing to Methodist Medical Group all insurance information at the time of service to allow for verification prior to my appointment, and that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and items supplied. In the event a procedure, service or item provided is deemed experimental or investigational or for any other reason is deemed not covered by my health plan, responsibility for payment falls solely to me and the patient and/or patients guarantor.

7. **Medicare/Medicaid Assignment of Benefits:** I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) 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 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/Medicaid.

   Medicaid: I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, initial 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 time of discharge.

8. **Disclosure of Health Care Information:** The Notice of Privacy Practices provides information about how Methodist Medical Group may use and disclose protected health information about you. Copies of the current Notices are available through our website, methodisthealthsystem.org. The notices contain on the first page, in the top right corner, the effective date. As provided in the Notices, the terms of the Notices 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.

9. **Additional Provision for Minors:** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient and have legal authority to consent to the treatment to be provided to said patient and understand, acknowledge and agree to be responsible for the cost of all care provided to said patient.

10. **Financial Assistance Program:** Methodist Medical Group maintains an established policy to provide health care services to those unable to pay. Information and application forms are available upon request. Please ask to speak with an Office Manager for more information or to answer any questions.

11. **Welcome Information Packet:** I acknowledge receipt of the welcome information packet on my initial visit at Methodist Medical Group.

I, the undersigned, as the patient or legal agent of and responsible for the patient, hereby certify I have read, and fully and completely understand this Authorization for Treatment and Financial Agreement, and that I have signed this Authorization for Treatment and Financial Agreement knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services provided or to be provided. If insurance coverage is insufficient, denied altogether or otherwise unavailable, I agree to pay all charges not paid by the insurer.

***Patient Signature:** _____ ***Date:** _____

Witness: _____ 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: [o] Secondary: [o] Third: [o]**
Call your work ?			**Work Phone #:**
Leave a message at work ?			**Primary: [o] Secondary: [o] Third: [o]**
Call your cell phone ?			**Cell Phone #:**
Leave message on cell phone?			**Primary: [o] Secondary: [o] Third: [o]**
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.

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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 any time 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)

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, Dallas Nephrology Associates, Dallas Renal Group, and any health care provider employed or otherwise engaged by any such groups including, but not limited to, Maisha Barnes, M.D., Jose Castillo-Lugo, M.D., Richard Dickerman, M.D., Ed Dominguez, M.D., Kosunarty Fa, M.D., Carlos Fasola, M.D., Connor Griffin, M.D., Christie Gooden, M.D., Adil Habib, M.D., Wael Hanna, M.D., Randy Hunter, PhD, Amna Ilahe, M.D., Lori Kautzman, M.D., Ashwini Mehta, D.O., Parvez Mantry, M.D., Alejandro Mejia, M.D., Hector Nazario, M.D., Mangesh Pagadala, M.D., Vichin Puri, M.D., Muhammad Qureshi, M.D., Silvi Simon, 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

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Physician(s) Seen:

- ☐ Dr. Maisha Barnes
- ☐ Dr. Jose Castillo-Lugo
- ☐ Dr. Richard Dickerman
- ☐ Dr. Ed Dominguez
- ☐ Dr. Kosunarty Fa
- ☐ Dr. Carlos Fasola
- ☐ Dr. Connor Griffin
- ☐ Dr. Christie Gooden
- ☐ Dr. Adil Habib
- ☐ Dr. Wael Hanna
- ☐ Randy Hunter, PhD
- ☐ Dr. Amna Ilahe
- ☐ Dr. Lori Kautzman
- ☐ Dr. Ashwini Mehta
- ☐ Dr. Parvez Mantry
- ☐ Dr. Alejandro Mejia
- ☐ Dr. Hector Nazario
- ☐ Dr. Mangesh Pagadala
- ☐ Dr. Vichin Puri
- ☐ Dr. Muhammad Qureshi
- ☐ Dr. Silvi Simon
- ☐ Dr. Jeffrey Weinstein

1. I authorize the following individual or organization to disclose the above named individual's health information:
Name/Office: _____ Address: _____
Phone Number: _____ Fax Number: _____

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

☐ **Kidney/Pancreas Transplant Program at Methodist Dallas**
1411 N Beckley Ave., Pavilion Ill, Suite 261
Dallas, Texas 75203
PH: 214-947-1800 / Fax: 214-947-1828

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

- ☐ Entire Health Record
- ☐ X-Ray/Imaging Reports
- ☐ Operative Procedures
- ☐ X-ray Film
- ☐ Pathology Report
- ☐ Laboratory Reports
- ☐ Echocardiogram
- ☐ Liver Biopsy
- ☐ History & Physical
- ☐ Other (please described)

_____

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)

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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. Richard Dickerman**
- ☐ **Dr. Ed Dominguez**
- ☐ **Dr. Carlos Fasola**
- ☐ **Dr. Connor Griffin**
- ☐ **Dr. Christie Gooden**
- ☐ **Dr. Adil Habib**
- ☐ **Dr. Lori Kautzman Dr.**
- ☐ **Parvez Mantry Dr.**
- ☐ **Ashwini Mehta Dr.**
- ☐ **Alejandro Mejia Dr.**
- ☐ **Hector Nazario Dr.**
- ☐ **Mangesh Pagadala Dr.**
- ☐ **Vichin Puri**
- ☐ **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**

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**

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Initial Patient Assessment / History

Patient Name _____ DOB _____

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

Yes	No		**Comments**
☐	☐	**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

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

EYES

- ☐ Redness
- ☐ Visual Changes
- ☐ Yellowness

NOSE/THROAT

- ☐ Sore Throat
- ☐ Nasal or Sinus Inflammation / Infection
- ☐ Mouth Sores

Respiratory

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

Heart/Cardiac

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

Gastrointestinal

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

Reproductive / Urinary

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

Skin/Integumentary

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

Musculoskeletal

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

Neurological

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

Comments

_____

_____

_____

_____

_____

_____

_____

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