Informed Consent

In compliance with the Health Information Portability and Accounting Act (HIPAA) of 1996, the following information must be filled out *by each patient* ***annually***. Please initial each statement at your discretion:

1. I authorize Nexus Specialty Clinic to release and receive my medical or insurance information as necessary to process my medical claims and coordination or manage my healthcare.

   Initials: _____

2. In the event that a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Nexus Specialty Clinic and its physician, providers, or employees my permission to discuss freely my condition, treatment, diagnosis, or pregnancy with that person

   Initials: _____

Patient Contact Numbers:

☐ Home:	☐ Cell:
☐ Work:	☐ Other:

May we leave a message at one or more of the numbers listed above regarding appointments and test or lab results? If YES, check the box by the number above

☐ **YES** ☐ **NO**

With whom may we discuss or release information about your care, treatment, diagnosis or pregnancy?

Name	Relationship to Patient	Phone #

3. I voluntarily consent to the rendering of medical care, treatment and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment.

   Initials: _____

4. I understand that treatment may involve risks. I understand that emergency or major procedures will not be performed on me until I have had the opportunity to discuss such procedures and the risks associated to my satisfaction with my physician or other health care provider and have consented to such procedure. Further, I understand that medical,

nursing, and other health care personnel may participate in my care and treatment as part of the procedure.

Initials: _____

5. I understand that Nexus Specialty Clinic will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic and paper format.

Initials: _____

6. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results or outcomes of the treatments or examinations by the providers of Nexus Specialty Clinic or their designees.

Initials: _____

7. I hereby assign to Nexus Specialty Clinic the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Nexus Specialty Clinic. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Initials: _____

8. I understand that Nexus Specialty Clinic may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary for claim processing.

Initials: _____

9. I authorize Nexus Specialty Clinic to release my medical information, including complete medical records, test results, and insurance information, to medical professionals, including my referring physician/practitioner, primary care physician, and/or medical care institutions that I may be referred to for treatment to improve coordination of care.

Initials: _____

10. I authorize Nexus Specialty Clinic to request my medical information, including complete medical records, test results, and insurance information, from medical professionals that I have received treatment from, including my referring physician/practitioner, primary care physician, specialists, and/or medical care institutions that may be necessary to improve coordination of care.

Initials: _____

11. This facility may staff and use nurse practitioners or physician assistants to assist in the delivery of pulmonology care. A nurse practitioner or physician assistant have both received advanced education and training in the provision of healthcare. I consent to the services of a nurse practitioner or physician assistant. I understand that at any time I can refuse to see a nurse practitioner or physician assistant and can request to see the physician.

Initials: _____

12. I understand that insurance may not pay the full amount of my charges, and I acknowledge that I am financially responsible and agree to pay my bill for non-covered services, as well as any deductibles, copays, or co-insurance. If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

Initials: _____

13. I agree that all copayments, coinsurances, or remaining deductibles due are due at the time services are rendered or promptly upon billing. Therefore, I do hereby voluntarily consent to medical treatment and/or diagnostic testing under the providers of Nexus Specialty Clinic, their assistants, or designees as is necessary in their professional judgment.

Initials: _____

14. I would like to receive medications prescribed by Nexus Specialty Clinic. The pharmacy below is my preferred location for filled prescriptions and would like to keep it on file:

Name		Phone #	
Address			

My signature below constitutes my acknowledgement that I have read and understood the above information, and that I agree to this consent of treatment, payment, and medical release as described herein.

Signature: Date:

My signature below constitutes my acknowledgement that I have read and understood the above information, and that I agree to this consent of treatment, payment, and medical release as described herein.

Parent/ Representative Name (print): Relationship:

Parent/ Representative Signature: Date:

Medical Records Request Form

NEXUS SPECIALTY CLINIC
21212 Northwest Freeway, Suite 265
Cypress, TX 77429

Dr. Sujatha A. Goli
Phone #: (281) 653-9123
Fax #: (281) 653-9175

To: Medical Records Department at

Phone #: Fax #:

Our mutual patient, _____, has authorized our office to obtain a copy of the following medical records from your office:

- Clinical Notes
- Laboratory Studies
- Radiographic Studies (CT, MRI, X-ray, US, etc.)
- Procedure details
- Anesthesiology and Surgery Reports
- Respiratory/Pulmonary Studies
- Cardiac Evaluations (EKG, Echo, etc.)
- Pathology & Cytology Studies
- **ALL MEDICAL RECORDS**

In case of any imaging studies, please provide a CD of the images along with the records.

First Name:

Last Name:

Date of Birth: SSN:

Address:

Phone #:

Signature Date

Fees Not Billable to Insurance

First Name: Last Name:

All major healthcare insurance plans are accepted by our providers and vendors. For certain services that healthcare plans have not defined or do not provide any coverage, the patient is legally responsible for the costs described below. Below please review and initial each statement to confirm understanding of fees you **MIGHT** be responsible for:

GENERAL PATIENT SERVICES

I understand that *cancellation within 24 hours **before** or **failure to attend** any* of our appointments is subject to a fee of ***$25,*** and ***repeated missed appointments*** may result in ***dismissal*** from the practice.

Initials: _____

I understand that outside forms provided to the medical professionals at the NEXUS SPECIALTY CLINIC (NSC) including but not limited to work disability forms require ***up to 72-hour processing time***. Fees of ***$25 per page completed*** by our clinicians at the NSC, ***not to exceed $250,*** will be collected at the time of the forms being submitted.

Initial: _____

I understand that NSC provides electronic version of my records ***(via email or electronic fax)*** at ***NO additional cost.***

Initial: _____

CREDIT CARD INFORMATION

Card Type	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
Card Holder (as shown on card):				
Expiration Date:	CVV:		ZIP:	

To ensure payment is collected the following credit card on file will be billed for in case of any of the above items (namely, processing: outside forms i.e. Disability or other forms; Medical Records; returned personal checks; no-show OR cancellation less than 24-hour from the appointment). **This credit card file will ONLY be used for this purpose, and you will be notified prior to processing fees**.

I, _____, authorize the NEXUS SPECIALTY CLINIC to charge my credit card above for the fee associated with items listed above. I understand that my information will be saved to file for future transactions on my account, within the scope defined above. The Texas Pulmonary Institute will NOT share this information with any third party, marketing, or any other agency.

_____

Signature Date

☐ Decline to keep on file.

21212 Northwest Freeway, Suite 265, Cypress, TX 77429
Phone: 281-653-9123 | Fax: 281-653-9175