



Texas Health Care, PLLC Privia Medical Group

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FOLLOW-UP COLONOSCOPY

Dear Patient:

Please fill out the attached paperwork and mail all forms back to our office, along with a copy of the front and back of your insurance card(s). Once the forms are received in our office, we will call you to schedule your procedure.

We will contact your insurance company. If for any reason there is a procedure deposit that is due, someone from this office will contact you. Deposits are due one week prior to your procedure.

When scheduling your colonoscopy, please make sure that you check your calendar in advance prior to scheduling. Please make sure that you will have transportation home for the date that the procedure is scheduled. It is very difficult for our scheduler to change your procedure date once it has been scheduled with the hospital or other facility.

- Dr. Castillo's procedure days are Mondays, Wednesdays and Fridays.
- Dr. Gordon's procedure days are Mondays, Thursdays and Fridays.
- Dr. Hooker's procedure days are Tuesdays, Wednesdays and Fridays.
- Dr. Lin's procedure days are Tuesdays, Thursdays and Fridays.

Your procedure will be scheduled at one of the following facilities, depending on the physician's schedule, your insurance, and the date that you choose:

Medical City Surgery Center, 909 Ninth Ave., Fort Worth, TX 76104	817-336-6060
Baylor Surgicare, 750 12th Ave., Fort Worth, TX 76104	817-334-5100
Fort Worth Endoscopy Center, 900 W. Magnolia Ave., Ft. Worth, TX 76104	817-332-6500
Baylor All Saints Medical Center, 1400 8th Ave., Fort Worth, TX 76104	817-926-2544
Harris Methodist Hospital, 1301 Pennsylvania Ave., Fort Worth, TX 76104	817-250-2000

Facility Fee: There will be a separate charge from the facility. The facility will contact you prior to your procedure. If a co-pay is due at the time on the service, you will be notified at the time of the call.

Pathology Fee: If biopsies are taken or if polyps are removed during your procedure, a pathology fee will be incurred. If there is a balance after your insurance has paid, he may receive a bill for these services.

Anesthesia Fee: Your physician may elect to provide you with an anesthetic administered by an anesthesiologist or a nurse anesthetist. If so, you will be given a short-acting drug which will provide you with a deep sleep and then allow you to wake up quickly after your procedure. If you have not met your deductible, you may be sent a bill for anesthesia services.

If you have any questions or concerns, please do not hesitate to call our office at 817-924-9002.

PLEASE KEEP THIS SHEET FOR YOUR RECORDS; THERE IS NO NEED TO RETURN IT TO US.

REQUEST FOR FOLLOW-UP COLONOSCOPY

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Home Phone: _____ Cell Phone/Alternate Phone: _____

Record of Disclosures

In general, the HIPAA privacy rule gives patients the right to request on uses and his closures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- Okay to call home or mobile telephone number.
 - Leave message with doctor’s name and callback number only on voicemail.
 - Okay to leave a message with detailed information on voicemail.
- Okay to call work telephone number: _____
 - Leave message with doctor’s name and callback number only on work voicemail.
 - Okay to leave a message with detailed information on work voicemail.
- When unable to contact me by phone, a written communication may be sent to my home.
- Other: _____

Health care providers must keep records of PHI disclosures. Information provided on test results, progress notes, or patient communication in question will be documented.

Release of Patient Information

I consent and authorize the release of my results to the following persons:

	NORMAL RESULTS	ABNORMAL RESULTS
Myself	<input type="checkbox"/>	<input type="checkbox"/>
Voice Mail: _____	<input type="checkbox"/>	<input type="checkbox"/>
My Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>
My Child(ren): _____	<input type="checkbox"/>	<input type="checkbox"/>
My Parent(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Date: _____

PLEASE COMPLETE THIS SHEET AND A COPY (FRONT AND BACK) OF YOUR INSURANCE CARD(S) TO:

Fort Worth Colon & Rectal
2000 Cooper Street, Suite 100B
Fort Worth, TX 76104