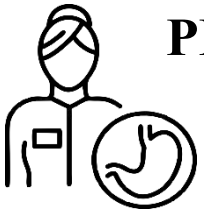

PLEXUS GASTRO PLLC
ROJA RAMISETTY

Board Certified in Internal Medicine
& Gastroenterology/Hepatology
Address: 9025 Pardee Rd, Taylor, MI 48180
PH: (313) 315-1422 F:(313) 435-0535
Address: 29201 Telegraph Rd, Southfield, Michigan 48034
PH: (248) 372-9575 F: (248) 856-1260

NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

PATIENT PHONE:_____

EMERGENCY CONTACT NUMBER:_____

EMERGENCY NAME:_____ RELATIONSHIP:_____

EMAIL ADDRESS: _____

SOCIAL SECURITY#:_____

PHARMACY NAME:_____

PHONE:_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

PRIMARY CARE NAME (PCP): _____

PHONE:_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIPCODE: _____

Consent to Physicians, Office, Clinic, outpatient services

Consent to Treat:

This purpose of this consent form is to obtain your permission to perform the evaluation necessary to identify any condition(s) that might require treatment as part of your plan of care. This consent provides us with your permission to perform reasonable and necessary medical examinations testing and treatment.

I voluntarily request a provider, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified.

You have the right to be informed about any condition identified and any/all recommended treatments including, but not limited to, imaging, labs, referrals. You may then decide whether or not to undergo any suggested treatment after being informed of the potential risks, benefits, and alternatives involved.

I agree with healthcare communication via email, phone call and or text messages. I understand may opt out of text and or email messaging by notifying any staff member.

By providing your phone number, you consent to receive text messages (SMS) from Plexus Gastro Pllc regarding appointments, reminders, and other healthcare-related information. Message and data rates may apply. You can opt out of receiving text messages at any time by replying STOP. Text messages are not a substitute for medical advice; please call our office directly for urgent concerns.

I understand that if additional testing, invasive or interventional procedures are recommended, will be asked to read and sign additional consent forms prior to the test (s) or procedure(s).

I certify that have read and fully understand the above statements and consent fully and voluntarily to its contents understand am responsible for additional fees that may occur.

If signing as a parent or guardian, I hereby represent that I am legally empowered to make such decisions.

By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing.

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

HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI)These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional Information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, administrative areas such as the front office, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2- It is the policy of this office to remind patients of their appointments. We may do this by telephone, -mail, mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications Informing you of changes to office policy and new technology that you might find valuable or informative

3- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to but must agree to abide by the confidentiality rules of HIPAA

Consent to Patient Responsibility for Payments and Deductibles

I,* _____*, acknowledge **that I am responsible for any and all charges related to the medical care and services rendered by your office. This includes but is not limited to:**

1. **Copayments: I understand that I am responsible for making any required copayments at the time of service.**
2. **Deductibles: I acknowledge that my insurance plan may have a deductible, and I am responsible for meeting and paying any applicable deductible amount before my insurance coverage takes effect.**
3. **Non-Covered Services: I understand that certain services may not be covered by my insurance plan, and I am responsible for the full payment of such non-covered services.**
4. **Balances Not Covered by Insurance: In the event that my insurance does not cover the full cost of the medical services, I agree to pay any remaining balance promptly.**

I understand the importance of timely payment and agree to settle any outstanding balances within the specified time frame established by your office. I also understand that failure to make payments may result in additional fees or consequences as outlined in your office's financial policies.

By signing below, I acknowledge that I have read and understand the financial responsibilities outlined in this letter. I agree to cooperate with your office in facilitating the billing process and promptly addressing any financial obligations related to the medical services provided to me.

Patient's Signature: _____ ***Date:*** _____

If the patient is a minor or unable to sign, the legal guardian or representative should sign on their behalf.

Legal Guardian/Representative Signature:_____

Relationship to Patient:_____
Date:_____

PLEASE LIST ANY FOOD OR DRUG ALLERGIES:

1-

2-

3-

4-

5-

MEDICATION LIST:

NAME OF MEDICATION	DOSAGE	FREQUENCY OR DIRECTIONS