Radha Tamerisa MD, PA|
25230 Kingsland Blvd Suite 102Katy, Texas 77494
P: (281) 869-3009 F: (832) 437-5182

Consent Form

Consent to Treat I hereby authorize Katy Integrative Gastroenterology, PLLC to examine me the patient and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate by today's standards. I authorize and give my consent to Katy Integrative Gastroenterology, PLLC to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for the named patient. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

Assignment of Benefits I hereby allow Katy Integrative Gastroenterology, PLLC to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned. Release of Information I authorize release and disclosure of all or any part of my medical record to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not limited to any private insurer, government program, workers compensation payer, employer, or family member. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care.

I also allow Katy Integrative Gastroenterology, PLLC to obtain medical records from other sources if needed for my medical care. A photocopy of this release shall be considered valid. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release. This release may not be revoked as to any records relating to services provided during this course of treatment.
Advance Beneficiary Notice, many insurance companies will ONLY pay for services that it determines to be "reasonable and necessary". Therefore, certain procedures are excluded from their program. I accept personal responsibility for payment of charges for services rendered to me by Katy Integrative Gastroenterology, PLLC.

I understand as a courtesy, Katy Integrative Gastroenterology, PLLC does file insurance claims for hospital charges and special procedures. However, this does not alleviate my obligation to settle the account in full in the event my insurance company delays or denies the charges. Statement of Ownership Disclosure, in order to allow you to make a fully informed decision about your health care, the physicians of Katy Integrative Gastroenterology, PLLC would advise you, the patient, that he/she may have a financial interest or ownership in one or more of the following healthcare providers: Memorial Hermann Kingsland Surgery Center, Zazen Surgery Center, MD Gastroenterology Anesthesia, Curbside Infusion, and Mangini-Lakhia & Associates.

At some point during your care, medical services, laboratory, pathology, anesthesia or other treatment may be performed by one or more of the providers previously listed.
From time to time, your provider may recommend supplementation based on clinical studies that have shown benefits in certain conditions. You are in no way obligated to utilize the recommended supplements or source or the supplements.

AI SCRIBE:
We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPPA) compliance guidelines to ensure your data is secured and protected. Ony the healthcare professionals involved in your care will have access to these notes.
These providers may or may not be in-network with your health plan. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare provider other than those listed above. You will not be treated differently by your physician if you choose to obtain healthcare services with another provider/facility.

CONSENT:
I acknowledge that I have discussed, or have had the opportunity to discuss, with my provider(s) the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for any future consultations or visits required.
PRIMARY CARE PHYSICIAN
Please note that **we are not your primary care physicians**. We recommend that you have a primary care physician. Please do not stop your prescription medications without consulting with your prescribing physician.
I have read the consent form and the above information and I accept the conditions.

Patient Name: _____ Date: _____ Patient Signature: _____