Karen Thampoe, MD
705 South Fry Road, Suite 105
Katy, Texas 77450

281-500-8176
866-650-4586 Toll Free
866-936-0677 Fax
www.whima.net

OFFICE POLICIES – PLEASE READ CAREFULLY

Payment is due at the time of service unless prior arrangements are made. We accept cash, credit cards and checks. Please note that there is a $25.00 penalty charge for all returned checks. In addition, there is a $25 penalty charge for missed appointments if the office is not notified of cancellation at least 24 hours in advance of appointment.

In order to control our cost of billing, we request that office visits be paid at the time that services are rendered. We are providers for several PPO and HMO insurance plans, and if we are listed under your plan, and we will file your insurance claim for you. Co-Payments are due prior to seeing the physician at the time of service. We will expect payment deductibles and the co-insurance amounts at the time of service or proof that your deductible has been met. You are also responsible for requesting necessary referrals prior to any specialist visits, and are responsible for all non-covered charges.

MEDICARE

West Houston Internal Medicine Associates P.A. will accept assignments for our Medicare patients. If you do not have a Medicare supplement and have not met your deductible at the time of service, we expect you to pay your 20%. Please sign here that you have read this office policy and agree to it. If there is a problem, please speak to the cashier before seeing the doctor.

____________________________________ ____________________

Patient's Signature or Legal Guardian Date

HIPPA POLICY OF COMPLIANCE

Please be sure that you have received a HIPPA policy & compliancy form and have read it over completely. If you have any questions, please address it with our front staff or with physician prior to being seen. Please sign below stating that you have received the forms, read over it, and understand the completely

____________________________________ ____________________

Patient's Signature or Legal Guardian Date

RELEASE OF INFORMATION

I hereby authorize **West Houston Internal Medicine Associates P.A.** to furnish medical information concerning my present illness or injury including HEPATITIS and HIV information to any specialist(s) or insurance companies for the purpose of obtaining payments. I further authorize any specialist(s) and other care providers to furnish all medical information concerning my present illness or injury to **West Houston Internal Medicine Associates P.A...** I agree to allow the faxing of this information when necessary.

____ ____________________

Patient's Signature or Legal Guardian Date

ASSIGNMENTS OF BENEFITS

I request payments of the medical benefits otherwise payable to me to be made to **West Houston Internal Medicine Associates P.A.** for services provided. I hereby authorize **West Houston Internal Medicine Associates P.A.** to furnish to my insurance carrier(s) all information acquired concerning me or my dependents illness or treatment. I understand this may include the release of my medical or other health information required in the processing of claims for payment. I understand that I am financially responsible to **West Houston Internal Medicine Associates P.A.** for charges not covered by insurance.

______________________________ ______________

Patient's Signature or Legal Guardian Date

CONCENT TO TREATMENT

I hereby authorize evaluation and treatments by **West Houston Internal Medicine Associates P.A**... I understand and agree that the signature and duties on this form will not expire without written notice or in the care that a minor becomes an adult and that a photocopy of this form is considered valid as the original.

______________________________ ______________

Patient's Signature or Legal Guardian Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I, (name of patient) ____ , acknowledge and agree that I have reviewed a copy of **West Houston Internal Medicine Associates P.A**. Notice of Privacy Practices Compliancy forms and understand them completely.

____ ______________________
Patient's Signature or Legal Guardian Date

COMMUNICATION / AUTHORIZATION TO SPEAK WITH FAMILY MEMBERS

Please let us know what person(s) we may share private information with and list them below (spouse, children, siblings, etc). **IF THEY ARE NOT ON THE LIST, WE CANNOT SPEAK WITH THEM REGARDING YOU**.

Name _______________________________________ Relationship _________________________________
Name _______________________________________ Relationship _________________________________
Name _______________________________________ Relationship _________________________________
Name _______________________________________ Relationship _________________________________
Name _______________________________________ Relationship _________________________________

May be leave private information (such as diagnosis, test results and/or medication information) on your:

Home Voice Mail yes no

Work Voice Mail yes no

Cell Phone Voice Mail yes no

____ ______________________
Patient's Signature or Legal Guardian Date