Texas Midwest Gastroenterology Center, PA

www.texasmidwestgastro.com

Pediatric [Birth to 17 years old] - Patient Demographics

Patient's Name: _____ DOB: _____ ❑ Male ❑ Female SSN:_____ Race: _____

Address: _____ City: _____ State: _____ Zip: _____ Guardian E-mail: _____

Pharmacy Name: _____ Pharmacy Street: _____ Pharmacy City: _____
I authorize Texas Midwest Gastroenterology Center, PA to communicate electronically with our pharmacy to obtain my child's prescription history? ☑Yes ☐No

Parent/Guardian Name: _____ DOB: _____ Relation: ❑ Biological Parent ❑ Other: _____

Address: _____ Phone- H: _____ C: _____ W: _____

Parent/Guardian Name: _____ DOB: _____ Relation: ❑ Biological Parent ❑ Other: _____

Address: _____ Phone- H: _____ C: _____ W: _____

Minor Child Lives With: ❑Both Parents ❑Mother Only ❑Father Only ❑Other: _____

If parents are not married, who has primary legal custody? ❑Mother ❑Father ❑Other: _____

Are there legal documents indicating who is responsible for health coverage? ❑Yes ❑No If yes, who is responsible? _____

Minor Policy: Minor patients will need to be accompanied by a biological parent/legal guardian. Guardians will be required to provide court documents verifying the right to seek medical treatment. In the event you need to send a responsible adult in your place for an office visit, please contact our office directly for documentation guidelines. No exceptions.

Insurance

Primary: _____ Policy#: _____ Group#: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____ SS#: _____

Secondary: _____ Policy#: _____ Group#: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____ SS#: _____

Primary Care and Referring Physician

Primary Care Physician- Last Name:_____ First Name:_____ City:_____ Phone:_____

Referring Physician - Last Name:_____ First Name:_____ City:_____ Phone:_____

General Consent to Use and Disclosure of Protected Health Information

YOU MAY DISCLOSE MY HEALTHCARE INFORMATION TO THE FOLLOWING INDIVIDUALS OR ENTITIES:
(Please list names of family/friends **(INCLUDING PARENTS)** who may have access to medical information. PLEASE PRINT)

First and Last Name	Relationship to Patient	Phone Number

Advanced Directive

Does the patient have an advanced directive? Yes ☐ No ☐
[What is an advanced directive? A legal document that states what kind of treatment requested for end of life.]

Parent/Guardian Signature: _____ Date: _____

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Financial Policy

Name: _____ Date of Birth: _____

Texas Midwest Gastroenterology Center, PA (TMGC, PA) has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss financial options with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. Insurance – As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to TMGC, PA (that is, the insurance company will pay TMGC, PA directly). You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.
2. Referrals – You are required to 1) know whether or not your insurance requires a referral; and 2) obtain that referral before you are scheduled to see our providers. Our office will be happy to assist you in determining the status of our providers on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits.
3. No Insurance – Patients who do not have insurance are expected to pay for all services rendered. We will request a payment for outpatient procedures in advance of having the procedure performed.
4. Returned Checks – Your account will be charged a $50 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.
5. Past Due Accounts – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us before being seen by our providers.
6. Out of Network Services – TMGC, PA and Texas Midwest Endoscopy Center does not make any guarantees that any laboratory, anesthesiology or other professional services are in-network providers for your contracted insurance plan. You are responsible for any professional charges in conjunction with the services you receive at the facility whether these services are considered in or out of network with your insurance plan.
7. Non-Covered Services – You have scheduled a visit with one of our physicians or nurse practitioners that the physician believes to be relevant to evaluate, monitor and protect your health; however, Medicare and certain other insurance companies will only pay for services that ***they*** determine to be "reasonable and necessary." If Medicare or another insurance company determines that your visit with our physician or nurse practitioner is not "reasonable and necessary," then they will deny payment for that service. Sometimes insurance companies will not cover an office visit prior to a procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need to visit with the physician or nurse practitioner beforehand.

   An office visit prior to the performance of any procedure is necessary in order to evaluate the patient's general health. In addition, this will ensure that the patient is well informed about any recommended procedure and allow the opportunity to obtain Informed Consent for the procedure. We are required to inform you that your insurance company may not cover the office visit and that you will be responsible for payment.

Patient Statement:

I have been informed of Texas Midwest Gastroenterology Center's financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit for the reasons stated above. If Medicare or my insurance company denies payment for any services rendered, I agree to be personally and fully responsible for payment.

_____ _____

Signature of Patient or Legal Representative *Date*

Texas Midwest Gastroenterology Center, PA

www.texasmidwestgastro.com

General Consent to Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I, _____, understand that Texas Midwest Gastroenterology Center, PA creates and maintains medical and related records that include personal healthcare information, including the patient's health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is the patient's "protected health information".

I understand and consent to the use and disclosure of the patient's Health Information by Texas Midwest Gastroenterology Center, PA for the following purposes:

- Treatment: This includes the provision, coordination, or supervision of the patient's healthcare and related services, including the coordination or management of the patient's care and consultation between healthcare professionals related to treatment, or the patient's referral to another healthcare professional.
- Payment for healthcare services provided to the patient: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to the patient, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to the patient.
- Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

- I have the right to review Texas Midwest Gastroenterology Center's Notice of Privacy Practices for Protected Health Information, which provides a much more detailed description of information uses and disclosures, prior to signing this Consent.
- Texas Midwest Gastroenterology Center, PA may change or modify its Notice of Privacy Practices for Protected Health Information at any time, and I have the right to obtain a revised Notice of Privacy Practices by accessing www. texasmidwestgastro.com website or requesting a revised copy in the office.
- I have the right to request restrictions as to how the patient's Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that the Provider is not required to agree to any restrictions that I may request, but if the Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying the Provider in writing that I revoke this Consent unless the Provider has used or disclosed my Health Information in reliance on this Consent.

YOU MAY DISCLOSE MY HEALTHCARE INFORMATION TO THE FOLLOWING INDIVIDUALS OR ENTITIES (PLEASE PRINT):

First and Last Name	Relationship to Patient	Phone Number

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Texas Midwest Gastroenterology Center, PA Representative *Date*

YOGESHKUMAR T. PATEL, MD
TEXAS MIDWEST GASTROENTEROLOGY CENTER, P.A

Pharmacy: _____

Reason for Office Visit: Nausea Vomiting Abdominal Pain Difficulty Swallowing Diarrhea Constipation IBS IBD GERD-heartburn Weight Loss Polyps Colon Cancer Screening Hepatitis Other: _____

Vital Signs: Wt: _____ BP: _____ Pulse: _____ Ht: _____ BMI: _____

Please fill out all information below:

Medical History: (Please **circle** if you have any of the following)

Anemia	Asthma	Arthritis
Alcohol Problems	Blood Disorder	Blood Transfusion
Bronchitis	CAD	Cancer
Colitis	COPD	Diabetes
Hypertension	Heart Attack	Heart Murmur
Hernia	Hepatitis	Hemorrhoids
Jaundice	Kidney Disease	Kidney Stones
Pneumonia	Polyps	Stroke
Stomach Ulcer	Colitis/IBD	Depression

Medications:
1.
2.
3.
4.
5.
6.
7.
8.
9.

Surgical History: (Please **circle** if you have any of the following)

Abdomen	Appendix	Arms/Legs
Back or Spine	Bowel or Colon	Breast
Chest	Eyes, Nose, Throat	Ears
Gallbladder	Head	Hernia
Heart	Hemorrhoid	Joint Replacement-knee/hip
Kidney/Bladder	Lungs	Neck
Pancreas	Prostate	Skin
Stomach	Uterus/Hysterectomy	Varicose
Ovary Removal	Tonsillectomy	Tubal Ligation
	C-section	

Allergies:
1.
2.
3.

Other: _____

Personal/Family History: Single Married Divorced Widowed Legally Separated
Do you have any children? Yes No How Many? _____
Do you chew/smoke tobacco? Yes No Do you drink alcohol? Yes No
Do you use any illicit drugs? Yes No If yes - Smoke Intravenous
Family History of Colon Polyps? Yes No Colitis/crohn's disease? Yes No

Prior Work-Up: Labs: _____ X-Rays: _____ CT Abdomen: _____
Colonoscopy Y/N When _____ Doctor: _____ Ultrasound: _____
EGD Y/N When _____ Doctor: _____

Communication Preference: Cell Phone Home Phone Email Letter Work Phone

Pediatric Patient's Only: Full Term/Premature/normal delivery/c-section
Birth Weight: _____ lbs _____ oz Passed stool first day after birth Y/N
NICU: _____ how many days ? _____