Texas Midwest Gastroenterology Center, PA

www.texasmidwestgastro.com

Patient Demographic Information

Patient Name: _____

Age: _____ Date of Birth: _____ Gender: _____ Social Security Number: _____

Address: _____ Unit / Suite / Apt#: _____

City, State, Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer's Name: _____ Employer's Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Pharmacy Name, Phone & City: _____

I authorize Texas Midwest Gastroenterology Center, PA to communicate electronically with our pharmacy to obtain my prescription history? __ Yes __ No

Are you currently residing in a skilled nursing facility? Yes ___ No ___ If yes, please provide the contact information of the nursing facility.

Name of Facility: _____

Facility Address: _____ City/State: _____ Zip: _____

Insurance Information

Primary: _____ Policy#: _____ Group#: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____ SSN: _____

Secondary: _____ Policy#: _____ Group#: _____

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____ SSN: _____

Primary Care and Referring Physician Information

Primary Care Physician Name: _____ Primary Care Physician Phone: _____

Referring Physician Name: _____ Referring Physician Phone: _____

Authorization for Voicemail/Email Regarding Health Information

I hereby give permission to leave message(s) on my voicemail/email concerning my personal health information. **Initials:** _____
I further understand that this permission to communicate my personal health information will remain in effect until I request, in writing, to have this option of communication terminated.

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Texas Midwest Gastroenterology Center, PA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and responsible attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.

Texas Midwest Gastroenterology Center, PA frequently utilizes mid-level practitioners including: Nurse Practitioners and Physician Assistants to assist in the delivery of medical care. Mid-level practitioners are under the supervision of a physician and can diagnose, treat, and monitor common acute and chronic diseases. I hereby consent to the services of a mid-level practitioner for my healthcare needs. I understand that at any time I can refuse to see the mid-level practitioner and request to see a Physician.

_____ _____

Signature of Patient or Legal Representative *Date*

Texas Midwest Gastroenterology Center, PA

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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 physicians.
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

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General Consent to Use and Disclosure of Protected Health Information

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 my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my "protected health information".

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

- My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
- Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- My 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 my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying my Provider in writing that I revoke this Consent unless my 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's Representative *Date*

Texas Midwest Gastroenterology Center, PA

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Personal History

Today's Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____ Gender: ___Male ___ Female

Referred By: _____ Primary Care Physician: _____

Describe the reason for the visit: _____

_____

1) MEDICATIONS
List current medications (including herbal, supplements, and over the counter) and dosages:

_____ _____

_____ _____

_____ _____

Are you currently taking any blood thinners? __ Coumadin __ Plavix __ Warfarin __ Xarelto
__ Other_____

Are you currently taking any of the following aspirin/NSAIDS? __ Advil __ Aleve __ BC Powder
__ Goody's Powder __ Ibuprofen __ Naprosyn __ Other: _____

2) GI MEDICAL HISTORY – Please check all that apply.

__ Celiac Disease
__ Cirrhosis
__ Colon Cancer
__ Colon Polyps
__ Crohn's Disease
__ Diverticulosis
__ GERD/heartburn
__ Hepatitis A
__ Hepatitis B
__ Hepatitis C
__ Irritable Bowel Syndrome
__ Liver Disease
__ Stomach/Intestinal Ulcers
__ Ulcerative Colitis
__ Other: _____
_____

3) MEDICAL HISTORY – Please check all that apply

__ Anemia
__ Anxiety/Depression
__ Arthritis/Osteoarthritis
__ Asthma
__ Cancer: Type _____
__ Chronic Kidney Disease
__ Congestive Heart Disease
__ COPD/Emphysema
__ Coronary Artery Disease
__ Diabetes
__ End-Stage Renal Disease (ESRD)
__ Heart attack
__ HIV/AIDS
__ Hyperlipidemia/High Cholesterol
__ Hypertension
__ Hypothyroidism
__ Nerve/Muscle Disease
__ Osteoporosis
__ Pancreatitis
__ Seizures
__ Stroke (CVA)
__ Other _____

4) ALLERGIES
List any medication allergies. __ No known medication allergies

_____

List any environmental or food allergies. __ No known environmental allergies __ No known food allergies

_____

Patient Name: _____ Date of Birth: _____

5) SURGICAL HISTORY
Check all that apply including age and date of procedure or hospitalization:

__ Colonoscopy _____
__ Upper Endoscopy (EGD) _____
__ Appendectomy _____
__ Breast Surgery _____
__ C-Section _____
__ CABG/Heart Surgery _____
__ Colon Surgery _____
__ Defibrillator _____
__ Fracture Surgery _____
__ Gallbladder Surgery _____
__ Gastric Surgery _____
__ Hemorrhoid Surgery _____
__ Hernia Surgery _____
__ Hysterectomy _____
__ Abdominal or __ Vaginal
__ Joint Replacement _____
Type _____
__ Laparotomy _____
__ Liver Surgery _____
__ Obesity Surgery _____
Type _____
__ Pacemaker _____
__ Prostate Surgery _____
__ Small Intestine Surgery _____
__ Spinal Surgery _____
__ Stent Placement _____
Type _____
__ Thyroidectomy _____
__ Tonsillectomy _____
__ Transplant Surgery _____
__ Tubal Ligation _____
__ Valve Replacement Surgery _____
__ Other _____

6) HOSPITALIZATION HISTORY
Please list the facility, reason for hospitalization, and dates.
_____
_____

7) FAMILY HISTORY (1st degree relatives) Check all that apply.

	Mother	Father	Sister	Brother	Son	Daughter	Age at diagnosis (if known)
Colon Polyps	___	___	___	___	___	___	_____
Crohn's Disease	___	___	___	___	___	___	_____
Cancers							
Breast	___	___	___	___	___	___	_____
Colon	___	___	___	___	___	___	_____
Esophagus	___	___	___	___	___	___	_____
Lung							
Lynch Specific	___	___	___	___	___	___	_____
Pancreas	___	___	___	___	___	___	_____
Prostate	___	___	___	___	___	___	_____
Stomach	___	___	___	___	___	___	_____
Other _____	___	___	___	___	___	___	_____
Diabetes	___	___	___	___	___	___	_____
Heart Disease	___	___	___	___	___	___	_____
Liver Disease	___	___	___	___	___	___	_____
Ulcerative Colitis	___	___	___	___	___	___	_____

8) SOCIAL HISTORY
Provide details regarding current and/or past use of the following:
Tobacco (cigarettes, cigars, chewing tobacco) __ Never __ Former __ Current (Every Day) __ Current (Some Days)
IV or recreational drugs __ Never __ Former __ Current (Every Day) __ Current (Some Days)
Alcohol (beer, wine, liquor) __ Never __ Former __ Current (Every Day) __ Current (Some Days)

9) VACCINES
Have you ever had a pneumococcal (pneumonia) vaccine? __ Yes __ No

Have you ever had any of the following vaccines? __ Influenza (Flu) __ Hepatitis A __ Hepatitis B
Other _____

Patient Name: _____ Date of Birth: _____

10) LABORATORY TESTS (Please list when and where) If none, type N/A
Blood Work _____ Stool Study _____ Urine _____

11) IMAGING (Please list when and where) If none, type N/A
Barium Swallow _____ CT Scan _____ MRI _____
Ultrasound _____ X-ray _____ Other _____

12) SYSTEMS REVIEW
Are you experiencing any of the following? Please mark at least one in each category. If negative, choose none of the above.

ALLERGY/IMMUNOLOGY
__ Seasonal Allergies
__ None of the Above

CARDIOVASCULAR
__ Chest Pain
__ Leaky Heart Valves
__ Heart Murmur
__ Heart Racing/Skipping
__ Palpitations
__ None of the Above

CONSTITUTIONAL
__ Chills
__ Fatigue
__ Fever
__ Malaise (feeling ill)
__ Weight Gain
__ Weight Loss
__ None of the above

EYES
__ Blurred Vision
__ Visual Changes
__ None of the Above

EARS/NOSE/THROAT
__ Mouth Ulcers/Sores
__ Nose Bleeds
__ None of the Above

ENDOCRINE
__ Bruise easily
__ Excessive Thirst
__ Heat/Cold Intolerance
__ History of High/Low Blood Sugar
__ None of the Above

GASTROINTESTINAL
__ Abdominal Pain/Discomfort
__ Anal/Rectal Pain or Itching
__ Black Stool
__ Bloating, Belching, Gas
__ Change of Bowel Habits
__ Constipation
__ Diarrhea/Loose/Watery Stool
__ Difficulty in Swallowing
__ Fecal Incontinence
__ Heartburn/Esophageal Reflux
__ Hemorrhoids
__ Indigestion
__ Mucus in Stool
__ Nausea/Vomiting
__ Rectal bleeding (in stool, commode, toilet paper)
__ Urges to have bowel movements
__ None of the above

GENITOURINARY
__ Pregnant
Date of Last Period _____
__ Blood in Urine
__ Burning/Pain with Urination
__ Increased Frequency/During Night
__ Kidney Stones
__ Recent/Frequent Urinary Tract Infections
__ Urges to Urinate
__ Urinary Incontinence
__ None of the Above

HEMATOLOGY/LYMPHATIC
__ Bleeding Problems
__ Enlarged Nodes/Swollen Glands
__ Excessive Bruising
__ History of Anemia
__ None of the Above

MUSCULOSKELETAL
__ Back Pain
__ Joint Pain/Arthritis
__ None of the Above

NEUROLOGIC
__ Headaches
__ Dizziness/Vertigo
__ Numbness/Weakness
__ Seizures
__ None of the Above

PSYCHIATRY
__ Anxiety
__ Changes in sleep
__ Depression
__ Loss of Memory
__ None of the Above

RESPIRATORY
__ Chronic cough
__ Shortness of Breath
__ Wheezing or Asthma Symptoms
__ None of the Above

SKIN
__ Jaundice (yellow eyes/skin)
__ Rashes, bumps, sores
__ None of the Above

OTHER _____
_____
_____
_____
_____

Patient Signature: _____ Date: _____