Texas Midwest Gastroenterology Center, PA

www.texasmidwestgastro.com

Patient Demographic Information

Patient's Legal Name: ____ Date of Birth: ______________________ Gender: ____________

Address: ____ Phone: _________________________

Pharmacy Name, Phone & City: ____

I authorize Texas Midwest Gastroenterology Center, PA (TMGC, PA) to communicate electronically with our preferred pharmacy to obtain the patient's prescription history? _____ Yes _____ No

Parent/Guardian Information

Mother/Guardian Name: ____ Date of Birth: __________________________________

Home Address (If Different than Above): ____

Home Phone: ___________________________ Cell Phone: ____________________________ Email: ____________________________

Father/Guardian Name: ____ Date of Birth: __________________________________

Home Address (If Different than Above): ____

Home Phone: ___________________________ Cell Phone: ____________________________ Email: ____________________________

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? ______________

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/Pediatrician: ____ Phone: __________________________________

Referring Physician: ____ Phone: __________________________________

Authorization for Voicemail/Email Regarding Health Information

I hereby give permission to leave message(s) on my voicemail/email concerning the patient's personal health information. **Initials:** ______
I further understand that this permission to communicate 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 certify the above information is correct. I consent for the patient to be treated by the staff and providers of TMGC, PA and its affiliates. I hereby give authorization for payment of insurance benefits to be made directly to TMGC, 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. TMGC, 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 Parent/Guardian *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*

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:

____ ____

____ ____

____ ____

____ ____

Is the patient currently taking any of the following aspirin/NSAIDS? __ Advil __ Aleve __ BC Powder
__ Goody's Powder __ Ibuprofen __ Naprosyn __ Other: ____

2) GI MEDICAL HISTORY

__ Celiac Disease
__ Colon Polyps
__ Crohn's Disease
__ GERD/heartburn
__ H. pylori
__ Inflammatory Bowel Disease
__ Irritable Bowel Syndrome
__ Liver Disease
__ Pancreatitis
__ Ulcerative Colitis
__ Ulcers
__ Other: ____________________________

3) MEDICAL HISTORY – Please check all that apply

__ ADHD
__ Allergies
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Autism
__ Cerebral Palsy
__ Congenital Heart Disease
__ Depression
__ Diabetes
__ Eczema
__ Migraines
__ Seizures
__ Thyroid Disease
__ Other: ________________________________

List additional medical problems or illnesses including cancers and psychiatric treatment: ______________________

____ ____

____ ____

4) ALLERGIES
List medication, food, environmental, and latex allergies including reactions to each:

____

Patient Name: ____ Date of Birth: __________

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

__ **Colonoscopy** ____________________ __ Heart Surgery ____________________
__ **Upper Endoscopy (EGD)** ________________ __ Hernia Surgery ____________________
__ Adenoidectomy ____________________ __ Myringotomy (Ear Tubes) ____________________
__ Appendectomy ____________________ __ Nissen Fundoplication ____________________
__ Brain Surgery ____________________ __ Small Intestine Surgery ____________________
__ Colon Surgery ____________________ __ Spinal Surgery ____________________
__ Fracture Surgery ____________________ __ Tonsillectomy ____________________
__ G-tube ____________________ __ Transplant Surgery ____________________
__ Gallbladder Surgery ____________________ __ Other ____________________

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

____

____

7) SOCIAL HISTORY
List all people that live in the same home as the patient ______________________________________

____

____

Is the patient adopted? __ Yes __ No Is the patient in foster care? __ Yes __ No
What grade? _________ Is patient missing school? __ Yes __ No If yes, how many days per month? _____
Is patient missing school activities? __ Yes __ No If yes, list school activities: ____________________
List any recent travel (list destination and dates) ______________________________________
List the types of animals patient is around regularly ______________________________________
List any family stressors (Ex. Financial, marital, death, school issues) ____________________
Alcohol (beer, wine, liquor) __ Never __ Former __ Current (Every Day) __ Current (Some Days)
Tobacco (cigarettes, cigars, chewing tobacco) __ Never __ Former __ Current (Every Day) __ Current (Some Days)

8) VACCINES
Is the patient up-to-date on vaccines? __ Yes __ No

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

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

11) CURRENT DIETS
For Infants: __ Breastfed __ Formula Fed __ Both Current Formula ____________________
One year and older: __ Regular Diet __ Special Diet: ______________________________________

12) BIRTH HISTORY
Birth Weight: ________ Birth Length: ________ __ Full-Term __ Pre-Term Delivered at week # ________
Type of Delivery __ Vaginal __ C-section List any pregnancy or delivery issues: ____________________

____

Patient Name: ____________________ Date of Birth: ____________

13) SYSTEMS REVIEW Does the patient currently have or has recently experienced any of the following? Note, if a family member is experiencing or has any of the following. (Family members include parents, siblings, grandparents)

EYES	Patient	Relative	Relation
Visual Changes	___	___	_________
HENT			
Hearing Loss	___	___	_________
Mouth Ulcers, Sores	___	___	_________
Nose Bleeds	___	___	_________
Poor Dentition	___	___	_________
CARDIOVASCULAR			
Irregular Heartbeat	___	___	_________
Chest Pain	___	___	_________
Congenital Abnormalities	___	___	_________
Hypertension	___	___	_________
Mitral Valve Prolapse or Murmur	___	___	_________
RESPIRATORY			
Aspiration	___	___	_________
Asthma/Wheezing	___	___	_________
Cough	___	___	_________
Croup	___	___	_________
Cystic Fibrosis	___	___	_________
Pneumonia	___	___	_________
RSV	___	___	_________
Shortness of Breath	___	___	_________
Sleep Apnea	___	___	_________
GASTROINTESTINAL			
Abdominal Pain	___	___	_________
Anal Fissures	___	___	_________
Anal/Rectal Pain or Itching	___	___	_________
Black Stool	___	___	_________
Bloating/Belching/Gas	___	___	_________
Celiac Disease	___	___	_________
Colon Cancer	___	___	_________
Colon Polyps	___	___	_________
Constipation	___	___	_________
Crohn's Disease	___	___	_________
Diarrhea/Loose Stool	___	___	_________
Difficulty in Swallowing	___	___	_________
Gallstones/Gallbladder Disease	___	___	_________
Gastrointestinal Bleeding	___	___	_________
Hepatitis or Liver Disease	___	___	_________
Heartburn/GERD	___	___	_________
Intestinal Polyps	___	___	_________
Liver Disease	___	___	_________
Mucus in Stool	___	___	_________

GASTROINTESTINAL, continued	Patient	Relative	Relation
Nausea/vomiting	___	___	_________
Stomach Ulcers	___	___	_________
Ulcerative Colitis	___	___	_________
Unintentional Weight Loss	___	___	_________
GENITOURINARY			
Female patients, date of last period ____________________			
Burning with urination	___	___	_________
Recent/Frequent urinary tract infections	___	___	_________
SKIN			
Dermatitis or rash	___	___	_________
Eczema	___	___	_________
Itching	___	___	_________
Jaundice	___	___	_________
NEUROLOGIC			
Autism	___	___	_________
Developmental Delay	___	___	_________
Headaches/Migraines	___	___	_________
Hydrocephalus	___	___	_________
Seizure Disorder	___	___	_________
MUSCULOSKELETAL			
Joint Pain/Arthritis	___	___	_________
Lupus, scleroderma, related disease	___	___	_________
ENDOCRINE			
Diabetes	___	___	_________
Inborn Errors of Metabolism	___	___	_________
Thyroid Problem	___	___	_________
PSYCHIATRIC			
ADHD	___	___	_________
Anxiety	___	___	_________
Depression	___	___	_________
LYMPHATIC/HEMATOLOGY			
Anemia	___	___	_________
Bleeding Problems	___	___	_________
Cancer	___	___	_________
Enlarged Nodes/Swollen Glands	___	___	_________
ALLERGY/IMMUNOLOGY			
Environmental Allergies	___	___	_________
Frequent Infections	___	___	_________

OTHER ____

Parent / Legal Guardian Signature: ______________________________ Date: ____________________