**Dr. Adeeb Dwairy & Dr. Pragnesh Patel**

**Gastroenterology**

## DEMOGRAPHICS

NAME: ______________________________________ TODAY'S DATE: _________________________________

SOCIAL SECURITY #: __________________________ DATE OF BIRTH: ________________________________

REASON FOR VISIT: ___________________________ GENDER: ☐ MALE ☐ FEMALE

HOME ADDRESS: _______________________________________________________________________________________

(STREET) (CITY) (STATE) (ZIP)

PRIMARY PHONE: ____________________________ SECONDARY PHONE: ___________________________

EMAIL: _______________________________________________________________________________________________

PREFERRED CONTACT METHOD: ☐ PRIMARY PHONE ☐ SECONDARY PHONE ☐ EMAIL ADDRESS

PRIMARY LANGUARE: ☐ ENGLISH ☐ SPANISH ☐ OTHER:_______________________

RACE/ETHNICITY: ☐ WHITE ☐ HISPANIC/LATINO ☐BLACK/AFRICAN AMERICAN ☐NATIVE AMERICAN ☐ASIAN/VIETNAMESE ☐AMERICAN INDIAN/ALASKAN ☐UNKNOWN ☐DECLINED ☐OTHER: _______________________

## EMPLOYMENT

EMPLOYER: _______________________________________ DEPT/TITLE: ____________________________________

EMPLOYERS ADDRESS: ___________________________________________________________________________________

(STREET) (CITY) (STATE) (ZIP)

## REFERRING/PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _________________________________ PHONE: _______________________________________

ADDRESS: ____________________________________________________________________________________________

(STREET) (CITY) (STATE) (ZIP)

## EMERGENCY CONTACT

EMERGENCY CONTACT NAME: ______________________________________________________________________________

RELATIONSHIP: ___________________________________ PHONE: _______________________________________

## PREFERRED PHARMACY INFORMATION

PHARMACY NAME: _________________________________ PHONE: _______________________________________

PHARMACY ADDRESS: ___________________________________________________________________________________

(STREET) (CITY) (STATE) (ZIP)

## INSURANCE INFORMATION

PRIMARY: __________________________ POLICY/ID #: ___________________ GROUP #: ________________

NAME OF INSURED: _________________ DOB: __________________________ RELATIONSHIP: ___________

SECONDAY: _________________________ POLICY/ID #: ___________________ GROUP #: ________________

NAME OF INSURED: _________________ DOB: __________________________ RELATIONSHIP: ___________

NAME: _______________________________________ DOB: __________/__________/__________

**PAST MEDICAL HISTORY:** IF YOU ANSWER YES TO ANY OF THE FOLLOWING, INCLUDE DETAILS (IF KNOWN).

| | YES | NO | DETAILS | | YES | NO | DETAILS |
|---|---|---|---|---|---|---|---|
| CANCER | | | | HISTORY OF HIV | | | |
| COLITIS | | | | HISTORY OF MRSA | | | |
| COLON POLYPS | | | | HYPERTENSION (HIGH BP) | | | |
| CROHNS DISEASE | | | | KIDNEY DISEASE | | | |
| DIABETES | | | | LUNG DISEASE | | | |
| HEART DISEASE | | | | SEIZURE DISORDER | | | |
| HELICOBACTER PYLORI | | | | TUBERCULOSIS (TB) | | | |
| HEPATITIS A, B, OR C | | | | RHEUMATIC FEVER | | | |
| HIGH CHOLESTEROL | | | | ULCER DISEASE | | | |
| OTHER: | | | | | | | |

**SURGICAL PROCEDURE HISTORY:** IF YOU ANSWER YES TO ANY OF THE FOLLOWING, INCLUDE DETAILS (IF KNOWN).

| | YES | NO | DETAILS | | YES | NO | DETAILS |
|---|---|---|---|---|---|---|---|
| APPENDECTOMY | | | | LUNG SURGERY | | | |
| CESAREAN SECTION | | | | ORTHOPEDIC SURERY | | | |
| GALLBLADDER SURGERY | | | | STOMACH SURGERY | | | |
| HEART BYPASS | | | | TONSILLECTOMY | | | |
| HYSTERECTOMY | | | | COLONOSCOPY | | | |
| LAPAROSCOPY | | | | ERCP | | | |
| LIVER SURGERY/BIPOSY | | | | UPPER ENDOSCOPY | | | |
| OTHER: | | | | | | | |

NAME: ____________________________________ DOB: __________/__________/__________

**FAMILY HISTORY:** (SPECIFY RELATIONSHIP: I.E. MOTHER/FATHER/SISTER/BROTHER/GRANDMOTHER, ECT.)

| | YES | NO | RELATIVE | | YES | NO | RELATIVE |
|---|---|---|---|---|---|---|---|
| COLON CANCER | | | | HIGH BLOOD PRESSURE | | | |
| COLON POLYPS | | | | LIVER DISEASE | | | |
| CROHNS DISEASE | | | | PANCREATIC CANCER | | | |
| ESOPHAGEAL CANCER | | | | STOMACH CANCER | | | |
| HEART DISEASE | | | | OTHER | | | |

**CURRENT MEDICATIONS:** ☐ CHECK IF YOU ARE CURRENTLY ON NO MEDICATIONS

| NAME | DOSE | FREQUENCY | DATE STARTED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**DRUG OR MEDICATION ALLERGIES:** ☐ NO KNOWN DRUG ALLERGIES

LIST: ______________________, ______________________, ______________________, ______________________

**SOCIAL HISTORY:**

MARRITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐WIDOWED ☐ OTHER: ________________________

ALCOHOL: ☐ NEVER CONSUMED ☐ SOCIAL DRINKER ☐ LIGHT CONSUMPTION ☐ HEAVY CONSUMPTION

TOBACCO: ☐ NEVER A SMOKER ☐ FORMER SMOKER ☐ SOCIAL SMOKER ☐ CURRENT EVERY DAY SMOKER

RECREATIONAL DRUGS: ☐ NEVER USED ☐ USED IN THE PAST ☐CURRENTLY USING ☐ HAVE BEEN TREATED

HRGI
HOUSTON REGIONAL GASTROENTEROLOGY

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## COMMUNICATION CONSENT

I authorize that your office may contact me in the following manner (check all that apply).

HOME TELEPHONE: (__________) __________ - __________
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member (Who) ____________________________

WORK TELEPHONE: (__________) __________ - __________
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with co-worker (Who) _____________________________

CELL PHONE: (__________) __________ - __________
- ☐ OK to leave message on voicemail with detailed message
- ☐ OK to leave message with callback number only

____________________________________________________ ______________________________________
Signature of patient or patients representative Date

____________________________________________________ ______________________________________
Printed name of patient or patients representative Relationship to patient

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## AUTHORIZED RELEASE TO DISCLOSE HEALTH INFORMATION

**Patient Information:**

Patient: ____________________________ DOB: _______/_______/_______ SSN: ________-________-________

Address: ______________________________________________________________________________________
(STREET) (CITY) (STATE) (ZIP)

**Information to be Released to:**

Name: _____________________________ Phone: ________________________ Fax: _________________________

Address: ______________________________________________________________________________________
(STREET) (CITY) (STATE) (ZIP)

**What kind of Information would you like released**: (Check all that apply)

| | | |
|---|---|---|
| ☐ ALL RECORDS | ☐ PROGRESS NOTES | ☐ LAB REPORTS |
| ☐ DISCHARGE SUMMARY | ☐OPERATIVE REPORTS | ☐ RADIOLOGY REPORTS |
| ☐ HISTORY AND PHYSICAL | ☐ PATHOLOGY REPORTS | ☐ BILLING HISTORY |
| ☐ CONSULT NOTES | ☐ EMERGENCY REPORTS | ☐ OTHER |

**Purpose of Release: (Check all that apply)**

| | | |
|---|---|---|
| ☐ REFERRAL TO SPECIALIST | ☐ LEGAL | ☐ CONTINUING CARE |
| ☐ DISABILITY DETERMINATION | ☐ CHANGE OF DOCTOR | ☐ WORKERS COMP |
| ☐ INSURANCE | ☐ PERSONAL | ☐ OTHER |

**Patient Authorization**: I understand that:

- ✓ Information released may include information regarding the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness.

________ Yes, I consent to the release of this information ________ No, I do NOT consent to the release of this information

- ✓ I have the right to revoke this authorization at any time, in writing. Revocation will not effect any actions already taken based upon this authorization.
- ✓ Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- ✓ Information released may contain notes that only a physician can interpret and I will not hold HRGI responsible for misinterpretation of the information as a result of not contacting my physician for interpretation.

Signature of patient or Legal representative: ______________________________________ Date: ______________________
Relationship to patient (if legal representative): ___________________________________
Authorization expires within 1 year of date signed.

# INSURANCE AND PAYMENT POLICIES

*Welcome and thank you for choosing Houston Regional Gastroenterology for your medical care.*

We are committed to providing you with quality care. Our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect the other areas physicians' charges. We are pleased to discuss any questions you may have concerning your bill. Providing quality care is our primary concern.

***Regarding Insurance***

Indemnity and private insurance policies: HRGI will file claims directly with your insurance carrier for services, which are covered benefits that have been verified. You authorize HRGI to release any medical information necessary to complete and process my insurance claims. Insurance verification doesn't guarantee your insurance will pay for the services. Payment of co-insurances, co-pays, deductibles and fees for non-covered services, when applicable, are required at the time of service.

***Contracted Managed Care Plans (HMO, PPO, POS, EPO, etc.)***

It is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referral needed. Verification of your plan benefits/coverage is required.

We allow 45 days from the date a claim was filled by the office for the insurance to pay. If the insurance company has not paid within this time, you are responsible for the entire balance and timely payment of your account. We will not become involved with disputes between you and your insurance company.

**Please note that your insurance plan may or may not consider the follow up visit as part of the procedure bill. Therefore, you may be responsible for a payment for the follow up visit after completing a procedure. Please contact your insurance carrier to review your plan for additional information.**

***Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. You might be referred to a facility or physician that is out of your network. There may be out of pocket expenses associated with a non-participating provider. You can confirm the participation status of the provider or facility with your insurance company.***

***Medicare and Medicaid***

HRGI accepts assignment of Medicare benefits. However, you may be asked to sign a waiver to acknowledge your understanding of your responsibility to pay for the services.

***Method of Payment***

HRGI accepts your personal check, cash, Visa, MasterCard, HSA, or Discover for payment of your medical services. Full payment is required at time of service. There will be a $25.00 returned check fee on all returned checks.

I am verifying that I have read and understand the above terms and conditions by giving my signature.

_______________________________________________ _____________________________

Signature Date

**CANCELLATION AND NO-SHOW POLICY**
**FOR APPOINTMENTS AND PROCEDURES**

1. *Cancellation/ No Show Policy for Appointment*

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.
   If an appointment is not cancelled at least 24 hours in advance, you will be charged a non-refundable $25.00 fee, which will not be covered by your insurance company.

   Due to the large block of time needed for Endoscopic Procedures, last minute cancellations or no shows can cause significant additional expenses for our office.

   If a Procedure is not cancelled at least 5 days in advance, you will be charged a non-refundable $50.00 fee, which will not be covered by your insurance company.

2. *Account Balances*

   We do require that patients with an outstanding balance pay the balance in full or make payment arrangements prior to receiving further services by our practice.
   If you have a question about your bill or would like to discuss a payment plan option, please call and ask to speak to one of our billing representatives.

I am verifying that I have read and understand the above terms and conditions by giving my signature.

_____________________________________________ _____________________________

Signature Date

RESULTS

Your medical provider may order lab work, imaging studies, stool studies, pathology testing or other important tests as part of your treatment. You are responsible for completing these timely and ensuring that the results are sent to and received by your provider's office.

Please call our office at: 832-707-5011 within 3 business days after completing a diagnostic test to ensure that we have received any and all results.

The provider will discuss the results of any studies during your follow-up appointment.

HRGI appreciates you taking a proactive approach to your health and making sure results are received timely.

I am verifying that I have read and understand the above requirements:

________________________________________ ______________________________
Signature Date