Gastro Health & Nutrition - Katy

PATIENT INFORMATION

DATE: _____

Last Name: _____ First Name: _____

Address: _____ SS#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

I give permission to release **appointment** information to whoever answers at my listed phone number: Yes __No__

Primary language: _____ Interpreter Services Required? Yes _____ No_____

Pharmacy Name: _____ Phone#: _____

Address: _____

PATIENT EMPLOYER INFORMATION

Company Name: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship: _____ Address: _____

HIPPA AUTHORIZATION

I give permission to my physician to discuss and/or release any medical information concerning my healthcare to the following family members / friends. I am aware that I may revoke or modify this permission at any time in writing.

Name: _____Phone#: _____Relationship: _____

Name: _____Phone#: _____Relationship: _____

Name: _____Phone#: _____Relationship: _____

Assignment of benefits; I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to the physician / facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I here by authorize said assignee to release all information necessary to secure the payment.

Authorization of treatment: I hereby authorize the physician of record, and associate(s) to treat the above patient.

Patient Signature: _____ Date: _____

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PATIENT INFORMATION FORM

Financial Agreement

1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    a. You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.
3. Please inform us, if for any reason you are not able to keep your appointment at least 24 hours in advance. In case of no show without notification, we will charge $25.00 to cover the cost incurred for the preparation of your visit.

Patient Authorization

I authorize Katy GastroHealth & Nutrition to submit insurance claims using my signature on the file below. I authorize the release of any medical information necessary in order to process this assignment on the claim, I authorize payment of medical benefits to be paid directly to Health and Wellness Solutions, PA: d/b/a/ KATY GASTRO HEALTH AND NUTRITION.

Patient Signature: _____ Date: _____

Katy GastroHealth and Nutrition Acknowledgement

At each visit, a distance summary will be provided. This would entail reviewing medications, physician instructions, diagnoses and follow up appointments. Please review and notify us of any discrepancy in a timely manner so that it can be rectified. By signing this agreement, you acknowledge the protocol of the char summary.

Patient Signature: _____ Date: _____

General Consent for Treatment

I hereby voluntarily consent for treatment to the facility. I permit the facility and it's employees, physicians, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for the treatment and/or test. I consent to examinations, blood tests (including blood test for communicable disease such as hepatitis and HIV/AIDS when healthcare providers have been exposed to my blood / fluids), laboratory and imaging procedures, medications, infusion, nursing care and other services or treatment rendered by the facility personnel under the instructions, order or direction of such physician(s).

Patient Signature: _____ Date: _____

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Patient History

Patient Name: _____ DOB: _____ Date: _____

_____Married _____ Single _____Divorced _____ Widowed:

Education: _____ Occupation: _____

Number of pregnancies/ Number of children: _____ /_____

Tobacco use: Yes / No How much? _____per day How long? _____ Date quit: _____

Alcohol use: Yes / No Caffeine: (Coffee, Tea, Colas) how much _____ per day

Describe briefly your gasto/colon problem: _____

Past illness of yourself (please circle):

Anemia / GI bleed	Asthma / COPD	Cancer / Tumor	Depression / Mental Illness
Diabetes	Epilepsy / Seizures	Heart Disease	Hepatitis / Jaundice
High Blood Pressure	High Cholesterol	HIV / Immune diagnosis	Kidney Disease
Liver Disease	Lung Disease	Osteoarthritis / Arthritis	Osteoporosis
Stroke	Thyroid Disease	Ulcer in GI Tract	Other: _____

Date of last colonoscopy: _____normal / abnormal

Date of last EGD: _____ normal / abnormal

Past Surgical History

Surgery name	Date (month / year)

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Medication list

Name	Strength	Dosage	Frequency	Time A.M. / P.M.

Medication allergies:

Medication Name	Reaction

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ROS: Please check either YES or NO

CONSTITUONAL	YES	NO	RESPIRATORY	YES	NO	HEMATOLOGY / LYMPH	YES	NO
Weight loss			Cough			Easy Bruising		
Fatigue			Coughing Blood			Gums Bleed Easily		
Fever			Wheezing			Enlarged Glands		
			Chills					
EYES	YES	NO	GASTRO	YES	NO	MSK	YES	NO
Glasses			Heartburn / Reflux			Joint Pain / Swelling		
Eye Pain			Nausea / Vomiting			Stiffness		
Double Vision			Black or blood BM			Muscle Pain		
Cataracts			Constipation			Back Pain		
			Diarrhea					
			Jaundice					
			Abdominal Pain					
ENT	YES	NO	GU	YES	NO	NEURO	YES	NO
Difficulty Hearing			Burning / Frequency			Loss of Strength		
Ringing Ears			Blood in urine			Numbness		
Vertigo			Erectile Dysfunction			Headaches		
Sinus Trouble			Abnormal Discharge			Tremors		
Nasal Stuffiness			Bladder Leakage			Memory Loss		
Frequent Sore Throat								
CARDIO	YES	NO	ALLERGIC/IMMUNOLOGIC	YES	NO	PSYCHATRIC	YES	NO
Murmur			Hives / Eczema			Anxiety		
Chest Pain			Hay Fever			Mood Swings		
Palpitations						Difficulty Sleeping		
Dizziness						Depression		
Fainting Spells								
Shortness of Breath								
Swelling of Ankles								

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Family History

(Circle all that apply)

Mother

- ○ Hypertension
- ○ Hyperlipidemia
- ○ Kidney Disease
- ○ Lung Disease
- ○ Diabetes
- ○ HIV
- ○ Thyroid Disease
- ○ Stroke
- ○ Cancer / Tumor
- ○ Asthma / COPD
- ○ Other: _____

Father

- ○ Hypertension
- ○ Hyperlipidemia
- ○ Kidney Disease
- ○ Lung Disease
- ○ Diabetes
- ○ HIV
- ○ Thyroid Disease
- ○ Stroke
- ○ Cancer / Tumor
- ○ Asthma / COPD
- ○ Other: _____

Any family history of colon cancer? Yes _____ No _____ Relationship to you: _____

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MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Social Security #: _____-_____-_____ Telephone: _____

Practice Authorized to Release my Health Information from the following physician / facility:

Name: _____

Address: _____

City, State and Zip: _____

Phone: _____ Fax: _____

Please release my medical records to:

Name: GastroHealth and Nutrition - Dharmendra Verma, MD Richard LaCamera, MD

Address: 1259 FM 1463, Ste. 500 Katy, TX 77494 Phone: 713-429-4550 Fax: 855-392-5941

Health information to be released:

☐ Entire record ☐ Labs ☐ Pathology Report ☐ Encounter form ☐ History & Physical

☐ Consultation ☐ Imaging/ X-rays ☐ Physician note ☐ Other _____

Health information that may be used/disclosed is limited to the following treatment dates: _____

Health information to be released to the above-named agency / individual is to be used/disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing/Claims Payment

"Health Information" identifies you (the patient) by name and includes other demographic information about you. "Health Information" may include but is not limited to: medical records, x-ray films, slides, tracing, strips, etc. I hereby discharge the releasing practice, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and / or psychiatric diagnoses compiled during my visit or encounter or make copies thereof in accordance with the policies of this practice.

Protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. I research-related Health information is used or disclosed for continued research purposes, an expiration date or event does not apply.

The authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specific event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the practice has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability and Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

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NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Signature: _____ Date: _____