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

www.texasmidwestgastro.com

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

www.texasmidwestgastro.com

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*

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	

Other: ____

Allergies:
1.
2.
3.

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