Date: _____

PATIENT INFORMATION

Patient's Name _____ ☐ Male ☐ Female

Social Security # _____ Age _____ Date of Birth _____

Address_____ City _____State _____Zip_____

Best Telephone number to contact you: _____ ☐ Home ☐ Cell ☐ Work

Home # _____ Work # _____Cell_____

Employer Name _____ Retired: ☐ Yes ☐ No E-Mail _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Emergency Contact: _____

Who referred you to Dr. Mallat? _____

PRIMARY INSURANCE

- INSURANCE: _____PH# _____
- ID/POLICY # _____ GROUP #_____
- CARDHOLDER: _____ DOB _____
- EMPLOYER NAME: _____ RETIRED? ___ YES ____ NO

SECONDARY INSURANCE INFORMATION

- INSURANCE: _____PH# _____
- ID/POLICY# _____GROUP # _____
- CARDHOLDER: _____ DOB _____
- EMPLOYER NAME: _____

I understand that if any of the insurance information I have provide above, is incorrect, has changed, or I fail to notify the office of such changes, I am responsible for all physician charges and non-covered medical services.
I herby authorize the release of any medical information necessary to process my insurance claims. I herby assign all medical/surgical benefits to include major medical benefits to which I am entitled to, Premier Gastroenterology of Texas P.A. This assignment will remain in effect until revoked by me writing. A photocopy of this assignment is to be considered as valid as an original. I have received the Notice of Privacy Practices

SIGNATURE: _____ DATE: _____

PATIENT MEDICAL HISTORY

PLEASE COMPLETE USING BLACK INK

1) Patient's Name _____ Date _____ Med Record # _____

2) Date of Birth _____ Age _____ Height _____ Weight _____ ❑ Male ❑ Female

3) Who is your primary care physician? _____

4) By whom were you referred? _____

5) What gastrointestinal problem (chief complaint) are you having that led you to see us? _____

_____

6) When did the problem begin? _____

7) Have you had any of the following diagnostic tests related to your gastrointestinal problem?

Colonoscopy	❑ YES ❑ NO	CT Scan	❑ YES ❑ NO
EGD	❑ YES ❑ NO	Upper GI X-rays	❑ YES ❑ NO
Barium Enema	❑ YES ❑ NO	Ultrasound	❑ YES ❑ NO
Barium Swallow	❑ YES ❑ NO		

Other: _____

8) List all of your medical diagnoses such as hypertension, diabetes, heart disease, thyroid disorder, arthritis, or other conditions.

MEDICAL DIAGNOSES	YEAR DIAGNOSED

9) List all of your operations (surgeries).

YEAR	OPERATION	FACILITY	PHYSICIAN

PAST MEDICAL HISTORY

1) Do you have sleep apnea?	❑ YES ❑ NO	7) Do you have an artificial heart valve?	❑ YES ❑ NO
		Have you had a valve infection?	❑ YES ❑ NO
If Yes, has CPAP (breathing machine) been prescribed for you?	❑ YES ❑ NO	8) Are you allergic to latex?	❑ YES ❑ NO
2) Do you wear dentures?	❑ YES ❑ NO	9) Have you had a reaction to anesthesia?	❑ YES ❑ NO
3) Do you wear contacts?	❑ YES ❑ NO	Has a family member had a reaction to anesthesia?	❑ YES ❑ NO
4) Do you wear a hearing aides)?	❑ YES ❑ NO		
5) Have you been vaccinated for Hepatitis A?	❑ YES ❑ NO	If yes, please explain this reaction _____	
Have you been vaccinated for Hepatitis B?	❑ YES ❑ NO	_____	
6) Have you had rheumatic fever?	❑ YES ❑ NO	_____	
		_____	

10) Are you allergic to any medications? ❑ YES ❑ NO If YES, what reaction did you experience?

MEDICATION ALLERGIES	REACTION

11) Please list all of the medications you are CURRENTLY TAKING, including over-the-counter medications such as aspirin or ibuprofen, as well as any birth control pills, vitamins, and herbal remedies. Attach an extra sheet if it is necessary.

MEDICATION	DOSAGE	HOW OFTEN	PHYSICIAN WHO PRESCRIBED OR RECOMMENDED

Patient's Name _____ Medical Record # _____

SOCIAL HISTORY

1) Do you currently drink ALCOHOLIC BEVERAGES? If yes, number of drinks/day? _____ Did you stop drinking alcoholic beverages? If YES, when did you stop? _____ Number of drinks/day? _____ For how many years? _____	❑ YES ❑ NO ❑ YES ❑ NO	5) Do you currently live: ❑ Alone ❑ With Family ❑ In a nursing home/facility ❑ _____ 6) Do you work? ❑ YES ❑ NO ❑ Full time ❑ Part time Occupation? _____ If you are retired, what did you do previously? _____ _____
2) Do you currently SMOKE? Did you stop smoking? If YES, when did you stop? _____	❑ YES ❑ NO ❑ YES ❑ NO	7) What is your highest level of education completed? _____
3) Do you use RECREATIONAL DRUGS? If YES, what type? _____ _____ When? _____	❑ YES ❑ NO	8) Within the last year, have you traveled outside of Virginia? ❑ YES ❑ NO Outside of the U.S.? ❑ YES ❑ NO If so, to what country? _____ _____
4) What is your marital status? ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ _____		

FAMILY HISTORY

1) What diseases are common in your family?

Liver disease	❑ YES ❑ NO	Peptic ulcer disease	❑ YES ❑ NO
Stomach cancer	❑ YES ❑ NO	Inflammatory bowel disease	❑ YES ❑ NO
Heartburn/Reflux	❑ YES ❑ NO	Gallbladder disease/gallstones	❑ YES ❑ NO

2) Briefly indicate the general health status or the cause of death of the following relatives:

FAMILY MEMBER	COLON CANCER? Yes	COLON CANCER? No	COLON POLYPS? Yes	COLON POLYPS? No	DECEASED? Yes	DECEASED? No	AGE AT DEATH	DISEASES	CAUSE OF DEATH
FATHER									
MOTHER									
PATERNAL GRANDFATHER									
PATERNAL GRANDMOTHER									
MATERNAL GRANDFATHER									
MATERNAL GRANDMOTHER									
CHILD									
CHILD									
CHILD									
SIBLING									
SIBLING									
SIBLING									

Patient's Name _____ Medical Record # _____

PLEASE COMPLETE REVERSE SIDE

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

PREMIER GASTROENTEROLOGY OF TEXAS, P.A.

Consent for Medical Treatment

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed.

This form has been fully explained to me and I certify that I understand and accept its contents.
All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Patient's signature: _____

Date: _____

Acknowledgement of receipt of the Notice of Privacy Practices:

I have received the Notice of Privacy Practices.

Patient's Signature: _____

7777 FOREST LANE BLDG. C STE 204 DALLAS, TX. 75230
PHONE: 972-566-5266 FAX: 972-566-5245

PREMIER GASTROENTEROLOGY ASSOCIATES OF TEXAS, P.A.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name _____ Medical Record # _____
Date of Birth _____Social Security # _____
I authorize the following individual or organization to disclose the above named individual's health information: _____
This information may be disclosed TO and used by the following individual or organization:
Premier Gastroenterology Associates of Texas, P.A. Address: _____
For the purpose of: _____
Please release the following:
___Problem List ___X-Ray/Imaging Reports-from (date) _____ to (date) _____
___Progress Notes ___X-Ray Films _____ Immunization Record _____ Genetic Testing
___History/Physical Exam ___Laboratory Results-from (date) _____to (date) _____
___Medication List ___EKG Reports _____ Allergies
___Other (Specify) _____
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___Yes, I consent to the release of this information. ___ No, I do not consent to the release of this information.
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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. If I have questions about disclosure of my health information, I can contact _____.
Signature of Patient or Legal Representative Date_____
Relationship to Patient (If Legal Representative) Witness _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
Date request completed _____ # pages copied _____ Charged $ _____
Payment Method: Cash _____ Check _____ M.O. _____ Initials _____

PREMIER GASTROENTEROLOGY ASSOCIATES OF TEXAS, P.A.

Provider Request for Treatment Disclosure from another Covered Entity

Purpose of Authorization: A disclosure of protected health information (regarding the patient listed below) is requested for the purpose of treatment.

Date of Request: _____

Expirations or termination of authorization: This authorization is a one-time request for the listed purpose and will expire 14 days from the date of this request.

Entity Requesting Information: **Entity Providing Information:**
The patient information is being requested by:
Practice: Premier Gastroenterology of Texas, P.A. Practice: _____
Provider: _____ Provider: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

Patient Information - The requested information is for the following patient:
Patient Name Date of Birth Social Security Number:

_____

The patient has a scheduled Office Visit with our office on_____ at _____a.m. / p.m.

Description of information to be disclosed: – The information listed for disclosure is the minimum necessary for the purpose of treating the patient:
1. Last 2 Office Visit Notes
2. Last Blood Lab Results
3. Last CT / MRI /X-RAY
4. Last if any, Colon, EGD, ERCP, EUS Reports / Biopsies
5. Demographic information

Requesting Provider's Signature/Date: _____

Not required when records are being requested from the referring physician

Patient's Signature/Date: _____

Note: as stated in the Privacy Rule - (section 164.506(c) (2-4) Implementation Specification for Treatment, Payment or Healthcare Operations) – §164.506(2) **A covered entity may disclose protected health information for the treatment activities of a healthcare provider.** §164.506(3) A covered entity may disclose protected health information to another covered entity or a healthcare provider for the payment activities of the entity that receives the information. §164.506(4) A covered entity may disclose protected information to another covered entity for the healthcare operations of the entity that receives the information.
Re-disclosure: The providing entity has no control over the covered entity requesting the information. Therefore, the protected health information disclosed under this authorization will no longer be the responsibility of the entity providing the protected health information.

PREMIER GASTROENTEROLOGY OF TEXAS, P.A.

Cancellation Policy

Please inform us at least 48 to72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need to our care.

There will be a fee implemented for Missed, No-Show & Late Cancellations:

$50.00 for New Patient Appointments/Procedure(s)

$30.00 for follow up appointments

Our office staff will make every attempt to remind you at least 48 hrs prior to your appointment date.

By signing below, I understand that I am held responsible for remembering my appointment date and time. I will be billed for any no-show, missed appointments/procedures that I have not confirmed with the office. This applies to all appointments and procedures, scheduled on my behalf.

Patient Name: _____

Signature of Patient: _____ **Date:** _____

Signature of Guardian/Caretaker/POA: _____

Signature of Staff: _____ **Date:** _____

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS	YES	NO
Fever		
Weight loss		
Weight gain		
Generalized weakness		
HEAD & NECK	**YES**	**NO**
Any problems pertaining to your ears		
Ringing in your ears		
Vertigo or dizziness		
Any problems pertaining to your nose		
Nose bleeds		
Any problems pertaining to your mouth		
Any problems pertaining to your throat		
Painful swallowing		
Any problems pertaining to your sinuses		
CARDIOVASCULAR	**YES**	**NO**
Chest pain		
Trouble breathing		
Edema (swelling of the legs/feet)		
Palpitations (rapid heartbeat)		
GASTROINTESTINAL	**YES**	**NO**
Difficulty swallowing		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Rectal bleeding		
Constipation		
Diarrhea		
History of liver problems		
History of pancreas problems		
SKIN	**YES**	**NO**
Rash		
Skin cancer		

RESPIRATORY	YES	NO
Shortness of breath while at rest		
Shortness of breath with activity		
Chronic cough		
Painful breathing		
History of TB		
GENITOURINARY	**YES**	**NO**
Problems with urination		
Frequency		
Pain or burning		
Blood in urine		
Leakage		
FOR WOMEN, date of last menstrual period _____		
MUSCULOSKELETAL	**YES**	**NO**
Painful joints		
Back pain		
Arthritis		
NEUROLOGIC	**YES**	**NO**
Headaches		
Weakness anywhere in your body		
Numbness		
Seizures		
PSYCHIATRIC	**YES**	**NO**
Anxiety		
Depression		
Thoughts of suicide		
ENDOCRINE	**YES**	**NO**
Abnormal sensitivity to heat		
Abnormal sensitivity to cold		
Changes in skin		
Changes in hair		
HEMATOLOGIC/LYMPHATIC	**YES**	**NO**
Abnormal bruising or bleeding		
Anemia		
Enlargement of your lymph glands		

Patient's Name _____ Medical Record #_____

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed by Congress to address many healthcare issues. However, when people refer to "HIPAA" these days, they're often talking about a subsection under Accountability titled, Administrative Simplification. Its objectives are: *improve healthcare delivery*, *reduce administrative costs*, and *protect the security and privacy of certain personal health information.* To achieve these objectives, the Department of Health and Human Services (HHS) issued rules that establish standards how certain health information will be used and protected.

Privacy

HIPAA's Privacy Rule establishes patient privacy rights and privacy controls through standards about how to use and protect patient information. These requirements must met by April 14, 2003. Although patient privacy has been one our long-standing operational guidelines, we did enhance our on-going staff training, policies, procedures, information system applications and more to enhance privacy and comply with the standards. See our Notice of Privacy Practices or contact our Facility Privacy Official for more information about your rights and our privacy procedures.

Security

HIPAA's Security Rule establishes standards to protect not only the confidentiality of Protected Health Information, but also the availability and integrity of the information. The security standards complement the privacy standards. All security requirements and standards must be in place by April 2005. We have already satisfied many of the requirements and will meet others before the deadline. Also, our technical and administrative security processes will continue to be enhanced on an on-going basis.

Electronic Transactions and Code Sets

HIPAA's Electronic Transactions Rule establishes standardized transaction content, formats, diagnostic and procedure codes for eight transaction types (e.g. health care claim) and six medical code sets (e.g. ICD-9-CM). The compliance deadline is October 2003. As of April 2003, we have changed some information system applications or processes to meet the standards, and we have started testing with clearinghouses and payors to confirm processing is working correctly before the October deadline.

Why We Have HIPAA

The U.S. needs to continue to improve healthcare but cut costs at the same time. Americans spent $1.3 trillion on healthcare in 2000. That was 14.3 cents of every dollar of our Gross Domestic Product, and the percentage is growing. Healthcare is our economy's largest industry, yet it also has the highest administrative costs largely due to redundancies and lack of standards. For example, before HIPAA there were over 400 so-called "standards" for a health claim. HIPAA takes that to a single, money-saving standard.

The U.S. needs to improve the way we protect confidential patient information. Privacy, security and trust have always been important in the relationship between a patient and the healthcare system. However, there has not always been a consistent approach or safeguards to ensure this protection. This is especially true when this confidential patient information is in electronic format. HIPAA enables consistent and strong protection.

HIPAA Makes Sense

HIPAA is more than just about compliance with a law. It also makes good business sense. The standards and consistent approach will help the healthcare industry and our facility improve patient care and protect patient rights. And that's the point. It's the right thing to do. Protecting privacy and security gives our patients peace of mind, an important component of high quality patient care.