19255 Park Row, Suite-104
Houston, TX 77084
Phone: (281) 945-5190
Fax: (855) 324-3438
Info@katystomachdr.com

PRE-COLONOSCOPY DIRECT ADMIT FORM

Patient Demographic Information

Full Name ____ Date of birth _________________

Age _______ Gender __________ Ethnicity ________________ Social Security # _____-_______-_____

Address _____________________________________ City ____________ State _______ Zip Code______

Primary Phone # ____________________________ Secondary Phone # ___________________________

Email Address _______________________________ ❑ I do not have an email address

Referring Physician __________________________ ❑ I do not have a referring physician

Emergency contact __________________________ Relation to you _____________ Tel._____________

Pharmacy name ____________________________ Address ______________________Tel.____________

Insurance Information

Insurance Name ___________________________ Provider / Costumer service pone #________________

Member ID Number_______________________ Group Number __________________________________

Subscriber Name __________________________ Subscriber date of birth __________________________

Secondary Insurance Name _________________ Provider / Costumer service pone #________________

Member ID Number_______________________ Group Number __________________________________

Subscriber Name __________________________ Subscriber date of birth __________________________

I have been seen by Dr. Maher in the past ❑ Yes ❑ No

❑ **Check here if you do not have health insurance and you am willing to cover expenses by yourself**

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Patient Medical History

1. **Height** _____ ft ______ in **Weight** ___________ lbs

2. **Do you Smoke** ❑ Yes ❑ No if you smoked in the past, when did you quit? ___________________

3. **Do you Drink** ❑ Yes ❑ No If **YES**, for how many years_____yrs Number of drinks___________

4. Are you allergic to any medication ❑ Yes ❑ No

If **YES**, list all medications and reactions____

____

5. **Medications: Please List all current medications (Prescription / OTC)**

Name & Strength:	Dosage	Name & Strength:	Dosage
1. ____________________	__________	6. ____________________	__________
2. ____________________	__________	7. ____________________	__________
3. ____________________	__________	8. ____________________	__________
4. ____________________	__________	9. ____________________	__________
5. ____________________	__________	10. ____________________	__________

6. **Within the last week have you taken any of the following medication?**

❑ Aspirin ❑ Ibuprofen ❑ Advil ❑ Aleve ❑ Naproxen ❑ Similar anti-inflammatory medications

❑ Warfarin ❑ Heparin ❑ Plavix (Clopidogrel) ❑ Levonox (Enoxaparin) ❑ Pradaxa ❑ Eliquis (apixaban)

❑ Ticlid ❑ Phentermine

7. **Have you ever been treated for any of the following conditions?**

Asthma	❑ Yes ❑ No	Loss of consciousness	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Irregular heart beat	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	abnormalities in blood	❑ Yes ❑ No
Heart attack	❑ Yes ❑ No	Clotting problems	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Crohn's disease	❑ Yes ❑ No
Sleep apnea	❑ Yes ❑ No	Ulcerative colitis	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No

Surgical History

8. **Have you had any of the following abdominal surgeries?**

❑ Appendectomy ❑ Hysterectomy ❑ Hernia repair ❑ Cholecystectomy (Gall bladder removal)

❑ C-section ❑ None ❑ other not listed (describe briefly) ______________________________

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9. **Have you had any of the following hearth surgeries?**

❑ Heart Stent ❑ Pacemaker placement ❑ Artificial valve placement ❑ Artery bypass

❑ Aneurism repair ❑ None ❑ other not listed (describe briefly) ________________________________

10. **Have you ever had a colonoscopy with sedation**? ❑ Yes ❑ No

If **YES**, did you have any complications including?

❑ Abdominal pain ❑ Abdominal gas/bloating ❑ Fever ❑ Nausea ❑ Vomiting ❑ Rectal bleeding

❑ Bowel Perforation ❑ other (describe) ____

11. **Have ever had polyps removed during a colonoscopy**? ❑ Yes ❑ No

If **YES**, how many polyps were removed at last colonoscopy ______________________________

12. **Have you ever been diagnosed with colorectal cancer?** ❑ Yes ❑ No

If yes, date of when diagnosis was made ____

13. **Have you ever been diagnosed and treated for any cancer of an abdominal organ (including but not limited to prostate, ovary, uterus, pancreas, liver, gallbladder, small bowel, stomach and lymphoma)?**

❑ Yes ❑ No If **YES**, What organ(s) was/were involved? _______________________________________

14. **Do you have a family history (first degree relatives) of colon cancer**? ❑ Yes ❑ No

If **YES**, check all the relatives that apply:

❑ Mother, at age_____ ❑ Father, at age_____ ❑ Brother, at age ______ ❑ Sister, at age _______

❑ Child, at age________

Please, carefully review all your answers above**. If you are uncertain about some of the answers, leave the space blank or place a question mark. You will have the opportunity to clarify these issues later, during a short interview with a member of our staff.**

I have reviewed the above Pre-Colonoscopy Direct Admit Form, and I have answered all the questions to the best of my knowledge. I understand that incomplete or false information may result in unexpected complication related to the colonoscopy procedure itself or to the conscious sedation. These complications, which may happen even when one is in excellent health, may include but not limited to bowel perforation, abdominal pain, rectal bleeding and adverse reaction to the sedation. I also understand and accept that my colonoscopy may not be completed if I have an inadequate preparation of my colon, I experience an adverse reaction to the medication used for conscious sedation, or I present excessive risk for complications as determined by
Dr. James A. Maher, M.D. before or during the procedure. In such case, I understand that may reschedule my colonoscopy or may take into consideration the different options suggested by Dr. James A. Maher, M.D. at that time.

__________________________ ___________

Patient's Signature **Date**

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CONSENT AUTHORIZATION

Name: ______________________________________ **DOB:** ______________________

1. What is your best contact number? ____
2. Email address: ____

(***Patients Portal***: The patient portal enables our patients to communicate with Dr. Maher, MA, and staff members easily, safely, and securely via internet. Participating patients with email address, will be given a secure user ID and temp password, **enabling them to access labs, test results, billing statements, appointment notification, request refills and much more**, all from the comfort of your home, at your convenience.)

3. Consent to discuss results via telephone? YES NO
4. Create your own Result pin: ______________________ (minimum **5** digits, Max 10 digits)
5. Access to Medical Records:

   ____
   Name Relation Phone Number

   ____
   Name Relation Phone Number

   **Create result pin for authorized personnel: __________________
   (In order for our office discuss results over the phone, you or authorized personnel must provide the personalized pin you have created.)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

We are ethically and legally required to maintain the privacy of protected health information we must provide individuals with notice of our legal duties and privacy policies with respect to protected health information. We must abide by the terms of our Notice of Privacy Practice currently in effect. We reserve the right to change our privacy practices that are described in the notice. We will post any revised notice in the waiting area and you may obtain a revised notice by forwarding a written request to our Chief Privacy Officer, at:

James A. Maher, M.D. Gastroenterology
19255 Park Row ste 104
Houston, TX 77084

With your consent, we may use and disclose protected health information about you to carry out treatment, payment, or healthcare operation. Treatment means the provision of health care and related services by one or more healthcare providers. For example, we may disclose protected health information to nurses providing healthcare under our direction. Payment means the activities we take to obtain reimbursement for the provision of healthcare. For example, your health insurer may require us to provide information about the services we furnished to you before the insurer pays for the services. Healthcare operations include many oversight functions, such as quality assessment, credentialing, and business management. For example, we may disclose protected health information to licensing officials in obtaining or renewing our professional licenses.

We are required by federal and state law to disclose protected information without your written consent or authorization for certain national priority purposes. The following is a brief description of these national priority purposes:

- Required by law i.e., Public health authority
- Person exposed to a communicable disease i.e., Hepatitis B
- Employer relation to workplace related illness (with notice to patient)
- Law enforcement purposes
- Health oversight agencies i.e., F.D.A.
- Court Order
- Subpoena, discovery request, Law enforcement purposes or other lawful process (with notice or protective order)
- Records requested by coroners, medical examiners, and funeral directors
- Organ donation purposes
- Research purposes i.e., bodies donated to science
- Military and veterans activity safety
- National security and intelligence activities
- Department of State medical suitability determinations
- Correctional institutions
- Eligibility for public health benefits i.e., Worker's compensation, Disability

We may use or disclose protected health information without your written consent or authorization for certain purposes unless you object. The following is a brief description of these purposes for which you have an opportunity to object:

- Directory of individuals in facility, limited: name, location in facility, condition in general terms, religious affiliation (Disclose only to clergy)
- Family members and persons responsible for care
- Progress notes sent to primary care physicians/referring physicians
- Disaster relief purposes

Except as otherwise stated here, we will use and disclose your protected health information only with your written authorization and you may revoke such authorization at any time.

You have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosure of protected health information, but we are not required to agree to your requested restrictions.
- The right to receive confidential communication of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy protected health information, subject to charges for the costs of copying, mailing, or other supplies associated with your request
- The right to amend protected health information

I have received a copy of the Notice of Privacy Practices

____________________________________ ____________________

Patient Signature Date

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CANCELLATION POLICY

There is a $100.00 Charge for all procedure appointments you no-show for, or that are not cancelled/ rescheduled within 48 hour notice.

I, _________________________, acknowledge the above statement and will honor this proposition by signing below.

Patient Signature: _______________________

ADVANCE BENEFICIARY NOTICE

NOTE: The propose of this note is to help you make an informed decision about whether or not you want to receive these services, knowing that might have to pay for them yourself. Before you make a decision about your option, you should READ THIS ENTIRE NOTICE CAREFULLY.

*A SCREENING COLONOSCOPY is no longer considered screening when polyps are removed for pathology during your procedure. If your insurance benefits states that covers SCREENING COLONOSCOPY at 100%, the benefits may change and coverage will be subject to deductible and co-insurance when polyps are removed.

- **Ask us to explain, if you do not understand why your insurance will not pay.**

Please choose one option. Sign and Date your choice.

❑ **YES**, I agree to receive these services.

I understand that this is a covered benefit however, depending on insurance guidelines, my level of coverage for this benefit may change or be null and void due to stipulations set forth by my insurance Company. Please submit my claims to my insurance Company. I understand that I may be billed for items or services and that may have to pay the bill while my insurance Company is making its decision. If my insurance Company denies payment, I agree to be personally responsible for payment. That is, I will pay personally out of pocket. I understand I can appeal my insurance company's decision.

❑ **NO**, I have decided not to receive these services

I understand that you will not be able to submit a claim to my insurance(s) and that will not be able to appeal your opinion that my insurance will not pay.

Date _______________________ Patient Signature ______________________________

NOTE: Your health information will be kept confidential. Any information that we collect about you on this forms will be kept as confidential in our office.