Demographics

Patient Information

Name: _____ **SS#** _____ **Date of Birth**: _____/_____/_____

Mailing Address: _____**City/State/ZIP**: _____

Home Telephone #: _____ **Cell Telephone #**: _____

Work Telephone #:_____

Gender:
❑ Female
❑Male

Ethnicity:
❑ Hispanic
❑ Not Hispanic

Race:
❑ American Indian
Or Alaskan Native
❑ Asian
❑ African American
❑Hispanic
❑Indian
❑ White

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Emergency Contact

Name: _____ **Home/ Cell Phone #**:_____
Relation to patient: _____ **Work Phone #**: _____

Healthcare Provider Information

Primary Care Physician (PCP): _____ _____**Phone#**:_____
Referral Physician: _____**Phone#**: _____

Insurance information

Primary Insurance name _____
Member ID _____ **Group #** _____
Insured Name _____ **Relation** _____

Secondary Insurance Name _____
Member ID _____ **Group #** _____
Insured Name _____ **Relation** _____

____ New Patient Demographic
____ Medical History Forms
____ Financial Policy
____ HIPPA Notice of Privacy Practices Signature Form
____ Patient portal access permission
____ Consent Authorization

James Maher, M.D.
Board Certified
GASTROENTEROLOGY

19255 Park Row STE 104, Houston, TX 77084 Phone #: 281-945-5190 Fax#: 855-324-3438

CONSENT AUTHORIZATION

Standard Authorization of Use and Disclosure of Protected Health Information.

(By signing below, I agree that practice may disclose certain of my health information to a personal representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care).

_____ _____

Name of patient Date of birth

_____ _____

Signature Date

1. Consent to discuss results via telephone and patient portal? ❑ Yes ❑ No
2. What is your best contact number? _____

Persons to whom information may be disclosed:

Name	Relation	Phone Number	Email
Name	Relation	Phone Number	Email

Patient 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. Email address: _____

Dr. James Maher, M.D. 19255 Park Row STE 104, Houston, TX 77084

FINANCIAL POLICY

- ***Appointment Cancellation/ No-Show Policy***: If patient fails to cancel or reschedule His/her appointment at least 24 hrs in advance. Patient is responsible for a $35.00 fee which will not be applied to any copay, deductible or coinsurance.

- ***Procedure Cancellation Policy***: If patient fails to cancel or reschedule His/her appointment at least 48 hrs in advance. Patient is responsible for a $100.00 fee which will not be applied to any copay, deductible or coinsurance.

- ***Late Arrivals***: It is our office policy that patients who arrive more than **15 minutes** late to their appointments will be rescheduled to the next available date.

- ***All office visits are payable at the time services are rendered*****.** Cash, check, or credit card is accepted for copays, deductible, co-insurance, and procedure pre-payment. At your requested, a copy of service receipts provided will be given to you or published to portal. There will be **a NSF fee of $35.00 for all return checks**.

- ***Assignment & Release*****:** I assign my insurance directly to Dr. Maher all medical benefits payable for the services rendered. I understand I am financially responsible for all charges paid or not paid by my insurance. I authorized the signature on all my insurance submissions and release of any information to secure payment of benefits.

- ***Statements and Collections*****:** statements are mailed out monthly and published to patient portal. Balance not payed prior to next office visit, will be collected at time of service. If no payment collected within 90 days, account will be sent to collection agency. If you have any questions concerning your statement please contact our billing department PEREGRINE Tel. 1-877-910-3272

- ***Refunds:*** Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient's refunds will not be processed until all active or past due accounts are paid in full.

- ***Medication Refill Policy***: refills can only be authorized on medication prescribed by Dr. Maher. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 6 to 12 months.

- ***Medical Record:*** A reasonable fee of $25.00 shall be charged for the first twenty pages and $0.50 per page for every copy thereafter. Request will be completed within 10-15 business days.

If you have any questions concerning our financial policy or fees, or difficulty with making payment, please request to speak to office manager.

By signing this you acknowledge that you have reviewed, read, and understand the above statements.

_____ _____/_____/_____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
JAMES A. MAHER, M.D.
GASTROENTEROLOGY

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

James Maher, M.D.
Board Certified
GASTROENTEROLOGY

Date: ____/____/___

Name: _____ Date of Birth: _____/_____/_____

PHARMACY NAME / CROSS STREET: _____

PHARMACY PHONE #:_____ CITY, STATE: _____

PCP NAME: _____Tel: _____

Reason for Visit: (please circle one) Routine Colonoscopy, Consultation for Symptoms, PCP Referral

Other (Briefly describe reason of visit): _____

_____

_____

Have you done any labs, testing, or procedures in the past six months? ❑ Yes ❑ No
Location: _____
Have you been in the hospital within the past six months? ❑ Yes ❑ No
Hospital Name: _____
Cause of Admission: _____ Date: _____

Review of Systems

General:
- ❑ Loss of appetite
- ❑ Fever
- ❑ Fatigue
- ❑ Weight loss
- ❑ Weight gain

Skin:
- ❑ Itchiness
- ❑ Jaundice
- ❑ Lesion
- ❑ Rash

Musculoskeletal:
- ❑Back pain
- ❑ Joint pain
- ❑ Muscle cramps
- ❑ Neck pain
- ❑Neck stiffness

Gastrointestinal:
- ❑ Abdominal Pain
- ❑ Bloating
- ❑ Anemia
- ❑ Blood in stool
- ❑ Belching
- ❑Change in Bowel Habits
- ❑ Abdominal Pain
- ❑ Bloating
- ❑Diarrhea
- ❑ Flatulence
- ❑ Difficulty Swallowing
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Hepatitis Type_____
- ❑ Black Tarry Stool
- ❑ Constipation

Cardiovascular:
- ❑ Heart problems
- ❑ Chest pain
- ❑ Claudication
- ❑ Palpitation
- ❑ Heart murmur
- ❑ Irregular heart beat
- ❑ Hypertension

Respiratory
- ❑ Difficult to breath
- ❑ Asthma
- ❑ Cough
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Tuberculosis

Neurological
- ❑ Dizzines
- ❑ Loss of memory

Genitourinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Kidney Stone
- ❑ Urinary incontinence

Hematologic
- ❑ Anemia
- ❑ Blood transfusión Date:_____
- ❑ Easy Bleeding
- ❑ Easy Brusiing
- ❑ Enlarged lymph nodes

Allergic
- ❑ Food Allergies
- ❑ Seasonal allergies

Healthcare Maintenance

Vaccinations:

Influenza (FLU)	❑ Yes ❑ No	Date_____	Pneumococcal	❑ Yes ❑ No	Date_____
Hepatitis A	❑ Yes ❑ No	Date_____	Hepatitis B	❑ Yes ❑ No	Date_____
DTaP	❑ Yes ❑ No	Date_____	Shingles	❑ Yes ❑ No	Date_____

If you are 50 years of age or older, have you had the following test?

Colonoscopy	❑ Yes ❑ No	Date_____	Flexible sigmoidoscopy	❑ Yes ❑ No	Date_____
Barium Enema	❑ Yes ❑ No	Date_____	Stool test for blood	❑ Yes ❑ No	Date_____
Prostate exam and PSA	❑ Yes ❑ No	Date_____			
Upper Gi series	❑ Yes ❑ No	Date_____			

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

Name & Strength:		**Name & Strength**:	
1. _____	_____	7. _____	_____
2. _____	_____	8. _____	_____
3. _____	_____	9. _____	_____
4. _____	_____	10. _____	_____
5. _____	_____	11. _____	_____
6. _____	_____	12. _____	_____

Are you allergic to any medication and or medical instrumental? (Ex. Penicillin, Latex etc.**)**

Other: Name	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Past Medical History

❑ Asthma	❑ COPD	❑ Anxiety	❑ Bipolar Disorder	❑Stroke
❑ Constipation	❑ Diabetes Mellitus	❑ Crohn's Disease	❑ Deep Vein Thrombosis	❑ Thyroid Problems
❑Depression	❑ Heart Attack	❑ Ephysema	❑Fibromyalgia	❑ Ulcerative Colitis
❑ GERD (acid reflux)	❑ IBS (Bowel Syndrome)	❑ Hepatitis	❑ High Cholesterol	
❑ Hypertension		❑ Stomach Ulcers		
❑ Atrial Fibrillation				

Past Surgical History

❑ Appendectomy Date: _____ ❑ Hysterectomy Date: _____ ❑ Hernia repair Date: _____
❑ Gall bladder removal Date: _____ ❑ Heart Stent Date: _____ ❑ Artery bypass Date: _____
❑ Aneurism repair Date: _____ ❑ Pacemaker placement Date: _____
❑ other not listed (describe briefly) _____

Have you ever had a Colonoscopy? ❑ Yes ❑ No Date: _____ **Biopsy or polyps removed?** _____
Have you ever had an Endoscopy? ❑ Yes ❑ No Date: _____ **Biopsy or polyps removed?** _____

Family History

❑ **Patient is adopted**. Family history unknown.

Father's age: _____ if deceased, age at death and cause_____
Mother's age: _____ if deceased, age at death and cause_____
Total number of brothers and sisters you have: _____
If deceased, age at death and cause_____

Diabetes Mellitus	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Hypertension	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Heart Attack/Disease	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Crohn's Disease	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Irritable Bowel Syndrome	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Cancer Type: _____	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child
Stroke	❑ Yes ❑ No	Father	Mother	Brother	Sister	Child

Other not listed: _____

Social History

Marital Status: _____ **Ocupation: _____**

Tobacco Use:
❑ Current Smoker Number of cigarretes per day_____ Packs per year _____
❑ Previous smoker Year quit _____
❑ Never

Alcohol Use:
❑ Current Drinker Drinks per week _____
❑ Previous Drinker Year quit _____
❑ Never

Drugs Use:
❑ Current use Medical or Recreational (Circle one) Name of Drug(s) _____
❑ Previous user Medical or Recreational (Circle one) Name of Drug(s) _____ Year quit _____
❑ Never