Demographics

Patient Information

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

Mailing Address: _______________________________________**City/State/ZIP**: ______________________

Home Telephone #: ________________________ **Cell Telephone #**: _____________________________

Gender:
❑ Female ❑ Male

Ethnicity:
❑ Hispanic ❑ Not Hispanic

Race:
❑ American Indian or Alaskan Native ❑ Asian ❑ African American ❑ Hispanic ❑ Indian
❑ Native Hawaiian or Pacific Islander ❑ Indian ❑ White

Marital Status:
❑ Single ❑ Married ❑ Divorced ❑ Widowed

How did you hear about Dr. Maher? ❑ Internet How: _____________ ❑ Referred by: ___________
❑ Insurance Company:______________ ❑ Other :__________________ ❑ Dr. Mahers website

Emergency Contact

Name: ______ _________________________________ **Home/ Cell Phone #**:__________________________

Relation to patient: ___________________________ **Work Phone #**: ______________________________

Healthcare Provider Information

Primary Care Physician (PCP): _______________________ _______**Phone#**:_________________________

Referring Physician: ____**Phone#**: _________________________

Cardiologist: _____________________________ **Phone#:** _________________ **Fax#:** ___________________

Insurance information

Primary Insurance name ____

Member ID ____ **Group #** _______________________________

Insured Name ______________________________________ **Relation** _______________________________

Secondary Insurance Name ____

Member ID ____________________________________ **Group #** ______________________________

Insured Name __________________________________ **Relation** _____________________________

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 a 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 the internet. Participating patients with email addresses, 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: ____

(Please write legibly)

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 **<u>10 minutes</u>** 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 prepayment. At your request, a copy of service receipts provided will be given to you. There will be **an 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 the patient portal. Balance not paid prior to next office visit, will be collected at time of service. If no payment is collected within 90 days, the account will be sent to the 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. **<u>All prescriptions require a follow up appointment every 6 months.</u>**
- ***Medical Records/FMLA/Patient Forms:*** A reasonable fee of $25.00 shall be charged for the first twenty pages and $0.50 per page for every copy thereafter. **<u>Requests will be completed within 10-15 business days</u>**.
- ***We reserve the right to refuse service and/or dismiss a patient.*** If we do not accept their insurance plan. If the doctor feels the patient is not compliant with his medical recommendations. If the patient is disruptive towards our staff and/or doctor.

ADVANCE COLONOSCOPY NOTICE

The purpose of this note is to help you make an informed decision about whether or not you want to receive these services, knowing that you might have to pay for them yourself. **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 state that SCREENING COLONOSCOPY are covered at 100%, the benefits may change, and coverage will be subject to deductible and coinsurance when polyps are removed.

_____ YES, I agree to receive these services. ______ NO, I have decided not 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 I 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.

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

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

Current symptoms you are experiencing: (Check all that apply)

- ❑ Abdominal Pain
- ❑ Bloating
- ❑ Diarrhea
- ❑ Flatulence
- ❑ Jaundice
- ❑ Anemia
- ❑ Blood in stool
- ❑ Difficulty Swallowing
- ❑ Heartburn
- ❑ Loss of Appetite
- ❑ Belching
- ❑ Change in Bowel Habits
- ❑ Fatigue
- ❑ Hemorrhoids
- ❑ Nausea/Vomiting
- ❑ Black Tarry Stool
- ❑ Constipation
- ❑ Fever
- ❑ Hepatitis Type____
- ❑ Painful Swallowing
- ❑ Rectal Bleeding
- ❑ Weight Loss

Other: ____

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**: ______________________

Medications: Please List all current medications or (Prescription / Over the counter)

Name & Strength:		**Name & Strength:**	
1. ___________________________	____________	6. ___________________________	____________
2. ___________________________	____________	7. ___________________________	____________
3. ___________________________	____________	8. ___________________________	____________
4. ___________________________	____________	9. ___________________________	____________
5. ___________________________	____________	10. ___________________________	____________

Are you allergic to: Penicillin Sulfa Codeine Iodine Latex **Other**: ____

Past Medical History

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

❑ Dialysis Days done ________

Past Surgical History

❑ Appendectomy
❑Hysterectomy
❑ Hernia repair
❑ Cholecystectomy (Gallbladder removal)
❑ Heart Stent
❑Pacemaker placement
❑ Aneurysm repair
❑ Artificial valve placement
❑ Artery bypass

❑ other not listed (describe briefly) ____

❑ Pacemaker last checked ______________ ❑ Cardiac Stent date _____________________

Have you ever had a Colonoscopy? ❑ Yes ❑ No **Endoscopy**? ❑ Yes ❑ No **If so, when**? _______________________

Any Polyps Removed? ❑ Yes ❑ No

Family History

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: ______________________________ **Occupation: ____**

Tobacco Use: ❑ Current Smoker Number of years________ 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