19255 Park Row STE 104, Houston, TX 77084 Phone #: 281-945-5190 Fax#: 281-945-5194

New Patient Demographics

Name: ____ Date of Birth: __________ Gender: ______

Social Security #:_________-__________-_____________ Marital Status:______________________

Address: ____

E-mail: ____

Race: ___________________ Ethnicity:_____________________ Language: ____________________

Primary Telephone #: ________________________ Secondary Telephone #: _____________________

Emergency Contact name: _____________________________________ Phone #:_________________

Relationship to Patient: _______________________ Is this person an existing patient: Yes No

Primary Care Physician: _______________________ Primary Care Phone#:_______________________

Referring Physician: __________________________ Referring Physician Phone #: ________________

Pharmacy Name/ Phone #: ____

Primary Insurance: _________________________________ Policy ID #: ___________________________

Secondary Insurance: ______________________________ Policy ID #: ___________________________

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Financial Policy

- ***Appointment Cancellation Policy***: There will be a ***$35.00*** fee for missed or canceled appointments without a 24 hour notice.
- ***Procedure Cancellation Policy:*** There will be a ***$200.00*** fee for missed or canceled procedure appointments without a one week notice.
- ***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 time that same day or moved to another day.
- **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 request, a copy of service receipts provided will be given to you or published to the 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 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 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

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Patient Portal Consent Authorization

Name: ____ **DOB:** _______________________

1. What is your best contact number? ________________________

2. Would you like to sign up for Portal Access? YES NO If yes, please provide

   Email address: ____

(***Patients 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. 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 to discuss results over the phone, you or authorized personnel must provide the personalized pin you have created.)

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:** _______________

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 / Gas
❑ Jaundice (yellow skin/eyes)
❑ Change in Bowel Habits
❑ Blood in stool
❑ Difficulty Swallowing
❑ Heartburn
❑ Loss of Appetite
❑ Belching / burping
❑ Fever
❑ Fatigue
❑ Hemorrhoids
❑ Nausea/Vomiting
❑ Black Tarry Stool
❑ Constipation
❑ Hepatitis Type____
❑ Painful Swallowing
❑ Rectal Bleeding
❑ Weight Loss
❑ Anemia

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 (Prescription /Over the counter)

Name & Strength:

1. ___________________________ ____________
2. ___________________________ ____________
3. ___________________________ ____________
4. ___________________________ ____________
5. ___________________________ ____________

Name & Strength:

6. ___________________________ ____________
7. ___________________________ ____________
8. ___________________________ ____________
9. ___________________________ ____________
10. ___________________________ ____________

Drug Allergies: ____

Vaccine History / dates and type if available

❑ Hepatitis A ________
❑ Hepatitis B ________
❑ Pneumonia ________
❑ HPV ________
❑ Flu ________
❑ Covid ________
❑ Meningitis A ________
❑ Meningitis B ________
❑ Shingles ________
❑ Tetanus (ie: TDAP) ________
❑ BCG ________
❑ Yellow Fever ________
❑ RSV ________
❑ Other ________
❑
❑
❑
❑

Past Medical History

- ❑ Nausea / vomiting
- ❑ Constipation
- ❑ GERD (Acid Reflux)
- ❑ H. Pylori infection
- ❑ Hepatitis (A/B/C/D/E)
- ❑ IBS(Bowel Syndrome)
- ❑ Crohn's Diseases
- ❑ Ulcerative Colitis
- ❑ Heart Attack / CAD
- ❑ Atrial Fibrillation
- ❑ Diabetes Mellitus
- ❑ Hypertension
- ❑ COPD/ Emphysema
- ❑ Stroke/ TIA
- ❑ Cancer (list type)
- ❑ Abnormal liver test
- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Fibromyalgia
- ❑ Stomach Ulcers
- ❑ Anemia
- ❑ Myasthenia Gravis
- ❑ Thyroid Problems
- ❑ Deep Vein Thrombosis / Blood clot
- ❑ Pulmonary embolism (PE)
- ❑ Kidney disease/Dialysis
- ❑ Other:

Past Surgical History

❑ Appendectomy ❑ Cholecystectomy (Gallbladder removal) ❑ Pacemaker ❑ Artery bypass

❑ Artificial valve placement ❑ Hysterectomy ❑ Hernia repair ❑ Heart Stent ❑ Aneurysm repair

❑ Other not listed (describe briefly) ____ ❑ Pacemaker / ICD placement

❑ Pacemaker last checked _______________ ❑ Cardiac Stent date _______________________

Have you ever had a Colonoscopy? ❑ Yes ❑ No , if so when? __________**Endoscopy**? ❑ Yes ❑ No If **so, When**?___________ **Any colon or stomach Polyps Removed?** ❑ Yes ❑ No

Family History

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

Other not listed: ____

Social History

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