



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)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hepatitis Type_____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Painful Swallowing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Flatulence / Gas | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Black Tarry Stool | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Jaundice (yellow skin/eyes) | <input type="checkbox"/> Belching / burping | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Fever | | |

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:

Name & Strength:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Drug Allergies: _____

Vaccine History / dates and type if available

- | | |
|---|---|
| <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> Tetanus (ie: TDAP) _____ |
| <input type="checkbox"/> Hepatitis B _____ | <input type="checkbox"/> BCG _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Yellow Fever _____ |
| <input type="checkbox"/> HPV _____ | <input type="checkbox"/> RSV _____ |
| <input type="checkbox"/> Flu _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Covid _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Meningitis A _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Meningitis B _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Shingles _____ | <input type="checkbox"/> _____ |

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| Heart Attack/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| UC/Crohn's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| Irritable Bowel Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| Cancer Type : _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Father | Mother | Brother | Sister | Child | Alive | Deceased |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> 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