



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

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

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

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: _____

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 paid 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 \$20.00 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



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)

- | | | | |
|---|---|--|--|
| <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 | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Black Tarry Stool | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Belching | <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 / OTC)

- | | |
|------------------------------------|------------------------------------|
| <u>Name & Strength:</u> | <u>Name & Strength:</u> |
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

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

Past Medical History

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> IBS (Bowel Syndrome) | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Deep Vein Thrombosis | |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Fibromyalgia | |

Past Surgical History

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy (Gall bladder removal) | <input type="checkbox"/> Pacemaker placement | <input type="checkbox"/> Artificial valve placement |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Aneurism repair | <input type="checkbox"/> Artery bypass |
| <input type="checkbox"/> Hernia repair | | | |

other not listed (describe briefly) _____

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

Any Polyps Removed? Yes No

Family History

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