Demographics

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

Social Security #:_____-_____-_____ Gender: Female Male

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Telephone #: _____ Cell Telephone #: _____

Emergency Contact name: _____ Phone #:_____

Primary Care Physician: _____ Primary Care Phone#:_____

Referral Physician: _____ Referral Physician Phone#: _____

Insurance carrier: _____ Insurance ID #: _____

Hospital/ Urgent Care facility name: _____

____ New Patient Demographic

____ Medical History Forms

____ Financial Policy

____ HIPPA Notice of Privacy Practices Signature Form

____ Patient portal access permission

____ Consent Authorization

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

FINANCIAL POLICY

- ***Appointment Cancellation Policy***: There will be a ***$35.00*** fee for missed or cancelled appointments without a 24 hour notice.

- ***Procedure Cancellation Policy:*** There will be a ***$100.00*** fee for missed or cancelled procedure appointment without a 48 hour 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 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 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

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

Name: _____ **DOB:** _____

1. What is your best contact number? _____
2. Email address: _____

(***Patients 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. 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 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

Dr. James A. Maher, M.D. Gastroenterology
Medical History

Date: ____/____/___

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

PHARMACY NAME / CROSS STREET: _____

PHARMACY PHONE #:_____ CITY, STATE: _____

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

Other: _____

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

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

Other: _____

Have you ever had a Colonoscopy? _____ Endoscopy? _____ If so, when? _____

Any Polyps Removed? _____ Do you smoke? _____ Do you drink? _____

Have you been in the hospital within the past few months? _____

Have you had any labs, testing, or procedure in the past few months? _____ Location? _____

Any Surgeries? _____ If so, when? _____

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

Family History: List **significant** family history:

_____

_____

Medical History: List major illnesses, medical conditions, etc.

_____

_____

Medications: Please List all current medications.

Name & Strength:		**Name & Strength**:	
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____