Patient Information Packet

Date: _____

We know paperwork is not fun, but thank you so much for taking the time!

Last Name: _____First Name:_____M.I._____

Address: _____ Phone: _____

City_____ State: _____ Zip Code: _____ Mobile: _____

Date of Birth: __/__/_____ Social Security: ____-____-_____ Email: _____

Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Phone or Address: _____

Please Tell Us – How Did You Find Us?

☐ **Doctor Referral (Dr._____)**	☐ **Facebook**	☐ Friend or Family	☐ Pearland's Best Coupon Book
☐ **Google**	☐ **Our Website**	☐ **Magazine Ad**	☐ Other Ad
☐ Mailed Postcard	☐ Event (***ex:*** Senior Fest)	☐ E.R. Referral	☐ Drove by Our Office
☐ **Phonebook**	☐ **Other**: _____		☐ Self Referred

Employment Information

Employer Name: _____Phone:_____

Address: _____

City: _____ State: _____Zip: _____

Employment Status: (Check) ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Self Employed

Insurance Information

Please Check One

☐ Self Pay? (No Insurance) ☐ Insured? (Have Insurance)

Health History Information

Patient Name: _____ DOB: _____

Your Symptoms: Check **all symptoms** that apply to you – PLEASE read carefully!

What are you here to take care of today? _____

□ Weight Loss / Gain
□ Chills /Fevers
□ Fatigue / Lack of Energy

□ Dizziness
□ Insomnia
□ Seizure
□ Frequent Headache

□ Cough
□ Production of Sputum
□ Chest Pains
□ Wheezing

□ Dry Skin
□ Itchy Skin
□ **Hepatitis**
□ Jaundice
□ Blood Transfusion
□ Cirrhosis

□ Nausea
□ Vomiting
□ Heart burn / Indigestion

□ Excessive Salivation
□ Loss of Appetite
□ Fullness in Stomach
□ Vomiting of Blood
□ Abdominal Cramps
□ Pain after eating
□ Constipation
□ Diarrhea
□ Change of Stool Width/Diameter

□ Rectal Itching / Pain
□ Hemorrhoid
□ Painful Bowel Movement
□ Ribbon-Like Stool
□ Diarrhea After Eating
□ Visible Blood in Stool
□ Incomplete Bowel Movement
□ Low Thyroid
□ Muscle Pain
□ Stiffness of Joints

□ Excessive Burping
□ Bad Breath
□ Hoarseness of Voice

□ Palpitation of Heart
□ Shortness of Breath
□ Heart Murmur
□ Abnormal Heart Rhythm
□ **High Blood Pressure / Heart Issues**

□ Mental Disorders
□ Depression □ Anxiety

□ Forgetfulness
□ **Unusual** Early Morning Awakening

□ Painful Urination
□ Incomplete Urination
□ Frequent Urination
□ Problems with Kidney
□ Diabetes / Blood Sugar Issues
□ Mucus / Slime in Stool
□ Dark / Tarry Stool

□ Abdominal Swelling
□ Excessive Gas / Bloating
□ Dryness of Mouth

Very Important: Please answer Yes/No to the following

Yes	No	
□	□	1. Have you ever had blood pressure / heart issues?
□	□	2. To the best of your knowledge, do you have any allergies to anything?
□	□	3. Have you ever had any operations during your life? Please explain below:

_____ _____
_____ _____
_____ _____
_____ _____

□ □ 4. Please check if you take any medications, injections, or pills for the following:
□ Heart □ Kidney □ Lungs □ Diabetes □ Eye □ Blood Pressure

□ □ 5. Do you smoke? (If so, how many packs per day? _____)
□ □ 6. Do you drink? (If so, how frequently? _____)

Please List Any Allergies you have:

_____ _____

_____ _____

Medical Release Form

Patient: _____

Date of Birth: _____

Social Security #: _____

This paperwork is used so that we may obtain your medical records from your current or previous physician(s). You do have a right to decline signing this; however, if you agree with the checked items below, please sign so that we may receive medical history information from your other physicians.

Authorization Notice

This document authorizes you to provide a copy, summary, or narrative of my medical records as indicated by check mark(s) below or otherwise release any medically relavent confidential information.

- ○ Complete record
- ○ Records of care from the dates: _____ to _____
- ○ Records of the following condition(s): _____
- ○ Other (please specify): _____

HIV/AIDS: I hereby consent to release any positive or negative test results for HIV OR AIDS infection, antibodies for AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

(x) Patient Signature:_____ Date:_____

Release to

This information may be released to the following person(s)/entity:

- ○ Dr. N. Meah
  109 Parking Way
  Lake Jackson, TX 77566
  Fax: (979)292-0488

- ○ Family / Spouse: _____
- ○ Other (please fill in if relevant):_____

The reasons or purpose of this release of information are as follows:

_____

_____

_____

Patient Signature: _____ Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for furnishing this information may be charged to the requesting patient according to rulings set forth by the Texas State Boards of Medical Examiners.

Medical Information

Patient Name: _____ DOB: _____
Today's Date: _____
Pharmacy Name: _____
Pharmacy Location: _____

List of Current Medications & Dosages

Acknowledgement of Privacy Practice Notice

Patient Name: _____ Date: _____

Please Read and Check All Items

I have filled out the information package.

- ☐ I have received and reviewed my Patients Rights and Responsibilities package. This document discusses my rights as a patient.
- ☐ I have received and reviewed the Notice of Privacy Policies. This document discusses how my medical information will be used. I understand that it is my responsibility to provide this medical center with all necessary referrals.
- ☐ I have authorized this facility to receive payments of benefits for services rendered to me. Any medical information needed to determine the eligibility or payments of benefits to process my claim can be provided. I understand that some medical services that are deemed necessary by my physician may not be deemed necessary by my insurance company. In such cases, it is my responsibility to provide the payment. I understand that some of the services may or may not be in network.
- ☐ I give my permission for this facility to examine me and permit them to perform any necessary physical or lab test deemed necessary for my treatment.
- ☐ I have read and understand the notices observable in the patient areas.
- ☐ **I understand that if my physician is unavailable, I will be seen by a nurse practitioner. I understand that Nurse Practitioners (here forth known as NP's) are not doctors and are registered nurses with special advanced training that allows them to function on behalf of my physician. I understand that my NP will be overseen by my physician and I consent to the services of an NP or Physicians Assistant as needed for my health care needs.**
- ☐ I understand that if I would like to, I can refuse treatment and services by a nurse practitioner and schedule an appointment with a physician instead.
- ☐ I understand that my email and other information may be used to send newsletters and other solicitations/updates from time to time from this entity or other affiliated entities.

By signing below, I acknowledge that I have received, reviewed, and understand the information read above.

Patient Signature: _____ Date: _____

Name of Legal Representative: _____

Relationship of Representative: _____

This form is legally required:

Patient Name: _____
Date of Birth: _____
Date: _____

1. Have you had your flu shot this year?	Yes	No
2. Have you had your pneumonia shot in the last five years?	Yes	No
3. Do you suffer from depression?	Yes	No

For Women Only

1. Are you up to date on mammogram?	Yes	No
2. Do you have any problem with urinary incontinence?	Yes	No
3. Do you have osteoporosis?	Yes	No
4. Have you had a bone density test?	Yes	No

Toll Free: 888-292-0010
www.YourGICenter.com

Patient Name: _____

Date of Birth: _____

Tell us about your family history

Son alive and well?	YES	NO
Son alive with problems?	YES	NO
Son deceased?	YES	NO
Daughter alive and well?	YES	NO
Daughter alive with problems?	YES	NO
Daughter deceased?	YES	NO
Mother alive and well?	YES	NO
Mother alive with problems?	YES	NO
Mother deceased?	YES	NO
Father alive and well?	YES	NO
Father alive with problems?	YES	NO
Father deceased?	YES	NO

Assignment of Insurance Benefits

I assign payment of anesthesia benefits directly to **Apogean Anesthesia PLLC.**

I understand that my insurance contract is between the insurance company and myself, and that Apogean Anesthesia PLLC does not set the amount to be paid by the insurance company, or determine if any payment will be made.

I understand that verification of insurance benefits is not a guarantee of payment from the insurance company.

This is a notice informing you that Dr. Meah has an ownership interest in this entity. As an Owner, he may indirectly receive compensation for the services you receive from this entity.

I understand and agree that after my insurance has been submitted, and the insurance company has made payment to Apogean PLLC, I am responsible for the remaining balance.

I understand that an Apogean contact person will answer questions for me regarding my specific insurance plan. The contact number is 979-258-1238.

I understand this entity may be billed wither in network or out of network depending O my insurance plan and it is my responsibility to inquire about my network benefits.

*** A photocopy of this approval shall be deemed as effective and valid as the original.***

_____ _____

Signature of the insured and/or the patient Date

Pre-Procedure Financial disclosure

Thank you for choosing the G.I. Center for your endoscopy needs.

Here at the G.I. Center, there are 2 facilities housed under one roof: **The Digestive & Liver Center** and **The Endoscopy Center**. Each facility operates independently and provides services for two different needs.

On the day of your procedure you will be entering **The Endoscopy Center**, which is housed under the G. I. Center. This center provides Colonoscopy and Esophagogastroduidenscopy (**EGD**) procedures. The Endoscopy Center and Digestive & Liver Center are two separate entities. Therefore, you will receive **different bills** and Explanations of Benefits (**E.O.B**) from your insurance company and from us regarding the procedure(s).

If you have insurance, in most circumstances we will file your insurance claim as a courtesy to you. You must realize, however, that your insurance is a contract between you and the insurance company. Payment to us is your responsibility. Please note that we pre-collect for the facility and physician charges. These are estimated charges. We will file with your insurance company; anything remaining will be billed, anything owed will be refunded. **Please consult with your billing specialist before services are rendered.**

There are **4 different areas** from which you might be billed after your procedure:

- **Digestive & Liver Center, PA** will bill you for the physician's professional services, which is provided during your procedure.
- **The Endoscopy Center** will bill you from the **Meah ASC Management, LLC** for the use of the facility to perform the procedure. This facility's charge is similar to what any hospital would charge a patient for the use of their hospital.
- **Laboratory/Pathology Center** might bill you is any biopsy is taken during your procedure and sent to them for evaluation. If no biopsy is taken then you will not be billed from any lab company.
- **Anesthesiologist** will be required for your procedure to administer the sedation. The anesthesiologist will bill you separately for rendering his/her services at the time of the procedure.

If you have any questions regarding how you will be billed after your procedure, please discuss them prior to having your procedure. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you decide or need to cancel your appointment, then please give us a 24 hour notice or you will be **charged $100.00**. If you need more information call the **office number at 979-292-0033**. On the day of your procedure we do encourage you to leave most of your valuables at home, but please bring your payment required for the procedure. We accept check, cash, money order, or credit card. **You will be expected to have someone drive you home after the procedure** and that person could hold your belongings during your procedure.

Authorization

I have read and agreed to the terms and conditions listed above and I know that I have a choice where I choose to have the procedure done. I hereby authorize the release of my medical information necessary to process my health insurance claim and request payment of my benefits to **Meah ASC Management**. I understand that this facility is owned by Physicians. I understand that I am financially responsible to the center for any deductible, co-pay, or coinsurance not covered by my insurance company as mandated by Texas Department of State Health Services.

_____ Print Name

_____ Signature

_____ Witness

_____ Date

Advanced directive notification

GI Center/Endoscopy Center

As per state regulation, we are required to inform you about our Advanced Directive policy. Our facility honors Advanced Directives to the extent allowed by our policies. Our policy at this center is to perform emergency procedures as necessary to stabilize the patient and to transfer the patient to an acute health care facility where an informed decision of the patient's well being can be made. If you have an Advanced Directive, please bring it with you at the time of your procedure. The facility can supply information regarding Advanced Directives upon request.

(Please check boxes)

- ☐ I have been notified of my Advanced Directive policy and agree to the above statement.
- ☐ I understand the full impact of this directive and I am emotionally and mentally competent to make this directive.
- ☐ I have been explained the Advanced Directive and how it corresponds to our policy.

Please sign below stating you have received notification of the Advanced Directive.

_____ _____

Patient Name (print) Date

_____

Patient Signature