YourGICenter

PATIENT INFORMATION PACKET

Date: _____

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

Last Name: _____ Frist Name: _____ M.I. _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Mobile: _____

Date of Birth: _____ Social Security: _____ Email: _____

Gender: _____ Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Phone or Address: _____

Cardiologist: _____ 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)

PARENT OR GUARDIAN INFORMATION

Date: _____

Circle One: ○ MOM ○ DAD

Last Name: _____ Frist Name: _____ M.I. _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Mobile: _____

Date of Birth: _____ Social Security: _____ Email: _____

Gender: _____ Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Phone or Address: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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

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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 ☐ 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:

_____

_____

YourGICenter

MEDICAL RELEASE FORM

Patient: _____ DOB:_____ SSN#: _____

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.

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.

- o Complete record
- o Records of care from the dates: _____ to _____
- o Records of the following condition(s): _____
- o 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 ☐ Dr. U. Siddiqui ☐ Yuny Hwang, AGNP ☐ Hazel Aguda, FNP ☐ Lisa Schaubroeck, NP

109 Parking Way
Lake Jackson, TX 77566
Fax: (979) 292-0488

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Fax: (979) 292-0488

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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:

_____

_____

_____

(X) 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: _____ DOB: _____

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.

☐ **All patients will be evaluated and screened by a nurse practitioner (NP). I understand that Nurse Practitioner's are not doctors and are registered nurses with special advanced training that allows them to function on behalf of physicians. I understand that the NP will be overseen by my physician and I consent to the services of an NP as needed for my health care needs. We appreciate your understanding.**

☐ 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: _____

CLINICAL QUESTIONAIRE

This is safety information that we give to our surgery center so that if / when you have a procedure, all the appropriate precautions are taken.

We **sincerely** thank you fro taking the time out to fill out this paperwork.

QUESTIONS

		Yes	No
1	Have you had any problems with your blood pressure or your heart?	☐	☐
2	Do you have any loose, false teeth, dentures, bridges, or capped teeth?	☐	☐
3	Have you had any issues for breathing, or taken any medication for breathing issues?	☐	☐
4	To the best of your knowledge, are you allergic to anything?	☐	☐
5	Have you or any of your blood relatives had a reaction to local or general anesthesia?	☐	☐
6	Have you had any operations during your life? If yes, please list below: _____ _____ _____ _____	☐	☐
7	Have you ever had any serious illness during your life? _____ _____ _____ _____	☐	☐
8	Do you take medication for any of the following issues? Please circle which, if yes. ☐ Heart ☐ Kidney ☐ Lungs ☐ Diabetes ☐ Eyes ☐ Blood Pressure	☐	☐
9	Do you smoke? How many packs per day? _____	☐	☐
10	Do you drink? How frequently? _____ How much? _____	☐	☐

Office Use Only Below this Point

Reviewed by Endoscopy Center?

Date Reviewed: _____

Any Patient Changes? ☐ Yes ☐ No

ASSIGNMENT OF INSURANCE BENEFITS

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

I hereby assign payment of my anesthesia benefits directly to **Apogean Anesthesia PLLC** and agree that Apogean willsubmit their charges to my insurance company for payment.

I understand and agree that after charges for my procedure have been submitted to my insurance carrier, and theinsurance company has made payment to **Apogean Anesthesia, PLLC,** I am responsible for any remaining balance.

I understand that an Apogean contact person is available to answer questions for me regarding my specific insurance planand the benefits payable. The contact number is 979-213-4033. I understand that verification of insurance benefits is nota guarantee of payment by my insurance company. I understand that if Apogean Anesthesia, PLLC is out of network, Imay have a higher co-pay or deductible that would be the case if **Apogean Anesthesia, PLLC** is in network. I acknowledge that it is my responsibility to inquire about my network benefits and financial obligations.

I understand that Dr. Meah has an ownership interest in this entity and that as an Owner, he may indirectly receivecompensation for the services I receive from **Apogean Anesthesia, PLLC.** I nonetheless wish to have **Apogean Anesthesia, PLLC** provide anesthesia services to me.

benefits.

Signature of the insured and/or the patient

Date

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

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 **Meah ASC Management, LLC**. 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).

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

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.

I hereby assign payment of my benefits to The Endoscopy Center ('Center") and agree that the Center will submit their charges to my insurance company for payment. I understand and agree that after charges for my procedure have been submitted to my insurance company and the insurance company has made payment to the Center, that I am responsible for any remaining balance.

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

- **Digestive & Liver Center, PA** for the physician's professional services, which is provided during your procedure.
- **Meah ASC Management, LLC** for the use of the Endoscopy Center 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,** if a 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.
- **Anesthesiology** will be required for your procedure. The anesthesiologist will bill you separately for rendering his/her services at the time of the procedure.

I understand that a patient representative is available to answer my questions regarding my insurance plan and the general benefits payable. Their contact number is 979-292-0033. I understand that if any of the providers listed above are out of network, that I may have a higher co-pay or deductible than would be the case if they were in-network. I acknowledge that it is my responsibility to inquire about my benefits and financial obligations. Please contact your own insurance company about specific coverage for your procedure. Call the number listed on the back of your insurance card. If you have any questions regarding how you will be billed after your procedure, please discuss them **prior** to having your procedure.

If you decide or need to cancel your appointment, please give the front office 72 hour notice or you will be charged $200.00.

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 cash, check, money order, or credit card.

AUTHORIZATION:

I have read and agree to the terms and conditions listed above. I know that I have a choice about providers and where I have my 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 and the providers listed above. I understand that the Center is owned by Physicians who may indirectly receive compensation for the services I receive from the center. I understand that I am financially responsible for any deductible, co-pay, or coinsurance not covered by my insurance company.

Print Name _____ Signature _____

Witness _____ Date _____

ADVANCED DIRECTIVE NOTIFICATION

GI CENTER/ENDOSCOPY CENTER

As per state regulation, we are required to inform you about our Advance Directive policy. Our Center honors Advance Directives. It is our policy to perform emergency procedures as necessary to stabilize the patient and to transfer the patient to an acute health care facility for assessment and evaluation. If you have an Advance Directive, please bring it with you at the time you present for your procedure.

Please check each applicable box below:

o I have been notified of the Center's Advance Directive Policy and agree to the above statement.

o I have an Advance Directive and have provided a copy to the Center.

o I have an Advance directive but did not bring it with me.

o I do not have an Advance Directive.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

Reset Print Save