Thank you for choosing *Texas Gastro Consultants, P.A.* as your provider. We appreciate your confidence and goodwill. To ensure that we are able to serve you to our fullest potential and continue to provide medical services to the community and region, the following policies shall be enforced:

Self-Pay/Non-Contracted Plans:

- All charges are due and payable at time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Patients with insurance:

- We must obtain a copy of your valid insurance card & photo ID to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- TXGC will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay TXGC for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90 days from the date of service, both the insurance and patient portions of your account then become your responsibility. If we subsequently receive payment from your insurance carrier, we will credit your account the payment amount.
- It is the patient's responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If you do not obtain a referral from your primary care physician prior to receiving services or a referral cannot be verified by our office, you have the option of re-scheduling your appointment. If you keep your appointment and/or receive services in our office, it is with the understanding that your health plan may not pay for charges related to the services provided by Texas Gastro Consultants, P.A and that without a referral you will be responsible for payment of all charges.

No-Show and Cancellation Policy:

- If the patient fails to cancel his/her <u>office appointment</u> at least 24 hours in advance, the patient is responsible for a $30 fee which will not be applied to any copay, deductible or coinsurance.
- For a <u>procedure</u>, the patient must cancel at least 48 hours in advance or is responsible for $200 fee with same conditions.

Delinquent / Unpaid Account:

- We require patients with balances over $100 to make a payment at the time of visit. If you are unable to make the full payment towards the outstanding balance, please be sure to communicate this with the front desk and we will place a payment arrangement on your account.
- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts over 90 days will be referred to a collection agency unless a payment plan has been arranged.

Results for labs/procedures:

- In order to provide our patients with the highest standard of care, our medical staff will be **unable to provide results from labs or procedures over the phone**. Please keep in mind any follow up appointment can be vital for your health and cannot accurately be done over the phone or by email. Our physicians encourage that you make a follow up appointment within 48 hours after lab work or a procedure.

Prescriptions and Refills:

- Have your pharmacy call or fax our office for prescription refills**. There are no prescription refills after hours, also new medications cannot be prescribed over the phone.**

Email Policy:

- Email is a convenient and efficient way to communicate with our staff but understand the confidentiality of email exchanges cannot be guaranteed. The following may be discussed via email: appointment scheduling, non-urgent medical advice and/or questions about treatment plans, procedure preparation, or prep kits.

I, the patient/patient's legal representative, understand and agree to abide by the financial policy set forth.

Printed Name	**Signature of Patient (or Personal Representative)**	**Date**

Tomball
506 Graham Dr.
Ste 100
Tomball, Texas 77375

TXG
Texas Gastro

Main Phone (281) 351-6464 Fax (281) 351-6476

Methodist Willowbrook
18220 State Hwy 249
Ste.340
Houston, Texas 77070

Rajeshwar P. Abrol, M.D. Arvind C. Reddy, M.D. Somia Z. Mian, M.D.
Abraham P. Chacko, D.O. Susan C. Stuhr, N.P.

Patient Registration Form

Name:	Sex: ☐ Male ☐ Female	Marital Status:
Date of Birth:	Age:	SSN:
Address: (City) (State) (Zip)		
Mailing Address: (City) (State) (Zip)		
Phone: (Home) (Cell) (Work)		
Email:	Emergency Contact/Relationship:	

Race: (Circle) American Indian/Alaskan Decline Black or African American Asian Native Hawaiian or Other Pacific Islander Hispanic White Other/Multi.	Ethnicity: Hispanic or Non-Hispanic Preferred Language: _____
Primary Care Physician:	Referring Physician:

INSURANCE INFORMATION

Your specialist co-pay will be due upon check-in for appointment. This may be different from your primary care provider's copay

Primary Insurance
(PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK)

Insurance:	ID/Policy #:
Policy holder's name & Relationship:	Policy Group #:

Secondary Insurance

Insurance:	ID/Policy #:
Policy holder's name & Relationship:	Policy Group #:

Financial Responsibility for Physician Services

Texas Gastro Consultants, P.A. is committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. With your signature below, you hereby acknowledge and authorize the following:

1. Consent of treatment, administration of medications, and performance of any procedures that may be considered necessary or advisable.
2. Assignment of insurance benefits to *Texas Gastro Consultants, P.A*. This is to include private insurance and Medicare. In doing so, I authorize release of any information necessary to process claims on my behalf.
3. Financial responsibility. The undersigned agrees, in consideration of services render by *Texas Gastro Consultants, P.A.* to be responsible for payment in full. Due to regulations all co-payments, deductibles, or non-covered services must be paid at the time of service, unless a payment agreement has been established.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance and it is my responsibility to provide the practice with updated demographic and insurance information for accurate billing.

Signature: Date:

TEXAS GASTRO CONSULTANTS, P.A.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO INDIVIDUALS

I authorize *Texas Gastro Consultants, P.A* to disclose and release medical or other information to the below listed individuals. I understand that this includes, but is not limited to information related to treatment, diagnosis, billing or any health care operations performed at this facility. This authorization also includes leaving voicemail messages on my home, work, and/or cell phone when I am unavailable

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that all information requested will be provided to these individuals and I release Texas Gastro Consultants, P.A. from all liability pertaining to the release of this information. I understand that this request can be changed at any time through a signed written request.

Printed Name	Signature	Date

REVIEW OF SYMPTOMS

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR **CURRENT** SYMPTOMS

Name: _____DOB:_____Date:_____

Reason for visit: _____

Smoking/Tobacco: Yes ☐ No ☐ How often? _____ Flu Shot: ☐ Yes ☐ No

Alcohol Use: Yes ☐ No ☐ How often? _____ Pneumonia shot: ☐ Yes ☐ No

Recreational Drug Use: Yes ☐ No ☐ How often? _____

GENERAL SYMPTOMS
_____ Change of weight
_____ Fatigue
_____ Fever

INTEGUMENTARY SYMPTOMS
_____ Itching
_____ Rash

ENDOCRINE SYMPTOMS
_____ Change in tolerance to heat/cold
_____ Diabetes

RESPIRATORY
_____ Coughing up blood
_____ Chronic Cough
_____ Shortness of Breath
_____ Wheezing/Asthma

CARDIOVASCULAR SYMPTOMS
_____ Chest pains
_____ High Blood Pressure
_____ Previous Heart Attack
_____ Shortness of Breath
_____ Swollen Ankles/legs

____No current symptoms

GASTROINTESTINAL SYMPTOMS
_____ Difficulty Swallowing
_____ Abdominal Pain
_____ Heartburn
_____Constipation
_____ Diarrhea
_____ Nausea
_____ Vomiting
_____ Blood in Stool
_____ Change in Bowel Habits

GENITOURINARY SYMPTOMS
_____ Blood in Urine
_____ Kidney Stone
_____ Painful Urination

NEUROLOGICAL SYMPTOMS
_____ Stroke
_____ Seizures
_____ Severe Headaches

PSYCHIATRIC SYMPTOMS
_____Memory Loss
_____Sad/Depressed

PLEASE TELL US IF ANYTHING IN YOUR MEDICAL HISTORY HAS CHANGED SINCE YOUR LAST VISIT
(Ex: New medications, hospitalization, ER visits, surgeries or new medical conditions)

_____

_____

Office Use only:

TEXAS GASTRO CONSULTANTS, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please remember that it is the patient's responsibility to obtain any medical records prior to the appointment. Patients may use this form to release/request patient medical information from any physician offices, hospitals or other healthcare facilities where they require patient written authorization.

Patient Name:_____ Date of Birth:_____SSN:_____

Address: _____ Phone:_____

I, _____, hereby authorize *Texas Gastro Consultants, PA* to release/request my protected health information as described below:

SEND RECORDS TO:

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

OBTAIN RECORDS FROM:

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

Information to be released:

□ Complete Records
□ Care Plan
□ Pathology Reports
□ Hospital Reports
□ History & Physical
□ Lab Reports
□ Treatment Record
□ Medication Record
□ Progress Notes
□ Operative Reports
□ Other (please specify below)

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization is effective until_____, from the date of my signature.

I agree to pay TXGC, for the cost of copying and mailing the said records. Such cost is calculated to be: $_____ ($25 for 1st 20 pages; $.50 per page over 20 pages and $15 for notarized copy. This charge does not apply if records are sent to a primary care physician or specialist.)

By signing this form, I authorize you to release or obtain confidential health information about me, my medical records, or a summary of narrative of my protected health information.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Relationship to Patient Print Name

Tomball
506 Graham Dr.
Ste 100
Tomball, Texas 77375

Methodist Willowbrook
18220 State Hwy 249
Ste.340
Houston, Texas 77070

Phone (281) 351-6464 Fax (281) 351-6476

TEXAS GASTRO CONSULTANTS, P.A.

DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Dr. Arvind Reddy, Dr. Rajeshwar Abrol and Dr. Abraham Chacko have ownership interest in Cy-Fair Ambulatory Surgery Center, Gessner Anesthesia Associates, Elite Diagnostics, Inc., United Pathology Associates and GALA Histology Lab.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health facility or healthcare providers other than Cy-Fair Ambulatory Surgery Center, Gessner Anesthesia Associates, Elite Diagnostics, Inc., United Pathology Associates and GALA Histology Lab. You may ask the front desk for a list of alternate facilities and/or healthcare providers in our area if you choose.
3. You will not be treated differently if you choose to obtain medical services at a facility or with healthcare providers other than those listed above.

If you have any questions concerning this notice, please feel free to ask your physician or a practice representative. We welcome you as a patient and value our relationship with you.

By Signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership.

_____

Signature of Patient/Guardian

_____

Print Name of Patient/Guardian

_____

Date

PAST MEDICAL HISTORY

Name:_____DOB:_____Date:_____

Pharmacy

Name:_____ Phone#: _____

Address:_____

PLEASE LIST CURRENT MEDICATIONS:

_____

_____

DRUG ALLERGIES:

_____

_____

_____

CARDIOVASCULAR	**GENITOURINARY**	**GASTROINTESTINAL**
_____Anemia _____Arrhythmias _____Murmur _____Peripheral Vascular Disease _____CAD (Coronary Artery Disease) _____CHF (Congestive Heart Failure) _____Mitral Valve Prolapse _____Hypertension _____Rheumatic Fever _____Valve replacement **RESPIRATORY** _____COPD _____Asthma _____Pneumonia _____Tuberculosis _____Cancer **Other**: _____	_____Renal Insufficiency _____UTI (Urinary Tract Infection) _____BPH (Benign Prostatic Hyperplasia) _____Kidney Stones _____Cancer **NEUROLOGICAL** _____Seizures _____Migraines _____CVA/Stroke _____TIA (transient Ischemic Attack) _____Cancer **ENDOCRINE** _____Hypothyroidism _____Hyperthyroidism _____Diabetes **MUSCULOSKELETAL** _____Arthritis _____Osteoporosis _____Lupus _____Paralysis	_____GI Bleed _____Dysphagia _____GERD _____Barrett's Esophagus _____Hiatal Hernia _____Peptic Ulcer _____Pancreatitis _____Gallstones _____Colitis _____Crohn's Disease _____Diverticulitis/Diverticulosis _____Colon Polyps _____Hemorrhoids _____Cancer **LIVER** _____Cirrhosis _____Hepatitis _____Hemochromatosis _____Cancer Other:_____
PAST SURGICAL HISTORY (list all surgeries / procedures you have had and the year) 1. _____Yr_____ 2. _____Yr_____ 3. _____Yr_____	Date of Last Upper Endoscopy:_____ Performing Dr.:_____ Date of Last Colonoscopy:_____ Performing Dr:_____ Polyps Removed? □YES □NO	**PAST HOSPITALIZATIONS:** REASON AND THE **YEAR** _____Yr_____ _____Yr_____ _____Yr_____

FAMILY HISTORY

Name:_____DOB:_____Date:_____

RESPIRATORY	ENDOCRINE	GYNECOLOGICAL
_____COPD _____Asthma _____Cancer	_____Hypothyroidism _____Hyperthyroidism _____Diabetes	_____Cervical Cancer _____Ovarian Cancer _____Uterine Cancer _____Breast Cancer

NEUROLOGICAL	LIVER	MUSCULOSKELETAL	CARDIOVASCULAR	GENITOURINARY
_____CVA/Stroke _____Cancer	_____Cirrhosis _____Hepatitis _____Hemochromatosis	_____Arthritis _____Osteoporosis _____Lupus	_____Hypertension _____Heart Disease	_____Bladder Cancer

GASTROINTESTINAL

_____Esophageal Cancer _____Stomach Cancer	_____Pancreatic Cancer _____Colon Cancer	_____Colitis _____Crohn's Disease

Other:_____

_____

_____