

STONE OAK GASTROENTEROLOGY

19284 Stone Oak #102; SATX 78258 * 3338 Oakwell Ct #205; SATX 78218 * 20540 Hwy 46 #103; Spr Br, TX 78070 * 1420 River Rd, #200; Boerne, TX 78006
SCHEDULING: (210) 268-0122 or (210) 268-0159 *** OFFICE: (210) 268-0124 *** FAX: (210) 268-0146 *** www.STONEOAKGI.com

Seema A. Dar, MD -- Desh B. Sharma, MD -- Chaithanya Mallikarjun, MD -- Christie L. Mannino, MD

Welcome To Our Practice

Patient Information

Date _____

Name (Last, First, MI) _____

Date of birth: _____ Soc. Sec: # _____ Gender: M[] F[]

Address _____ City, State, Zip: _____

Referred by _____ Primary Care Physician (PCP) _____

STATE REQUIRED ETHNICITY AND RACE QUESTIONNAIRE

Race _____ Ethnicity _____ Language _____

Telephone Numbers

Mobile (_____) - _____ Home (_____) - _____ Work (_____) - _____

Email Address _____

Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed [] Life Partner

Emergency Contact

Name _____ Relationship _____

Primary number (_____) - _____ Secondary number (_____) - _____

Insurance Information

*Primary insurance _____ Policy # _____ Group # _____

Policy holder's name _____ Date of birth _____ SS # _____

*Secondary insurance _____ Policy # _____ Group # _____

Policy holder's name _____ Date of birth _____ SS # _____

Pharmacy Information

Pharmacy _____ Address/Location _____

Telephone number (_____) - _____ Fax number (_____) - _____

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CONSENT OF UNDERSTANDING ON PATIENT RIGHTS AND PRIVACY NOTICE

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operation (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with STONE OAK GASTROENTEROLOGY.”

“It is our policy to provide a substitute health care provider, authorized by STONE OAK GASTROENTEROLOGY to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

If requested, we will disclose your health information to your insurance provider for the purpose of payment or health care operations.

I have read the Privacy Notice and understand my rights as a patient contained in the Notice.

By way of my signature, I provide **STONE OAK GASTROENTEROLOGY** with my authorization and consent to use and disclose my protected healthcare information, PHI, for the purposes of treatment, payments, and healthcare operations as described in the Privacy Notice.

A copy is available to take upon request.

SIGNATURE OF PATIENT/GUARDIAN/POA

PRINTED NAME

DATE

AUTHORIZED FACILITY SIGNATURE

PRINTED NAME

DATE

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AUTHORIZATION TO RELEASE MEDICAL CARE INFORMATION

(Healthcare Providers or Facility)

Name (Last, First MI) _____

Date of birth: _____ Soc. Sec: # _____ Gender: M [] F []

Address _____ City, State, Zip: _____

I hereby authorize _____, to release copies of my medical records concerning any
(Name of other Provider/Facility)
Illness, Treatment or recommendations while I was patient of the above listed medical Facility or Physician(s).

I understand that my medical records may contain copies of Information received from another health care facility or physician(s). I also understand that the above information may contain reference results (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party.

Information to be released:

_____ Chart Note

_____ Labs

_____ X Rays

_____ Procedure

_____ Medication

_____ ALL RECORDS

FAX TO: **STONE OAK GASTROENTEROLOGY**

Attn: Medical Records

19284 Stone Oak Pkwy #102

San Antonio, TX 78258

Phone: (210) 268-0124

Fax# (210) 268-0141

For the Purpose of: *CONTINUITY OF CARE*

Patient Signature/Guardian/POA

Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Family and/or Friend)

In accordance with the HIPAA law, it is required that you provide our office with the name of any person to whom you want the release of your personal health records; via over the phone, by fax, or e-mail. This does NOT include other healthcare providers you see. This is YOUR FAMILY MEMBER or FRIEND.

I hereby give permission for the following parties mentioned below to obtain information in regards to my medical records at Stone Oak Gastroenterology.

1. _____
NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER
2. _____
NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER
3. _____
NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER
4. _____
NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER
5. _____
NAME OF INDIVIDUAL RELATIONSHIP PHONE NUMBER

SIGNATURE OF PATIENT/ GUARDIAN / POA

PRINTED NAME

DATE OF SIGNATURE

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FINANCIAL RESPONSIBILITY

At Stone Oak Gastroenterology we are committed to providing you the best available medical care. We appreciate you choosing us as your Gastroenterology specialty provider. In the effort to ensure that all your needs are met, our billing department personnel is available to discuss our financial policies with you.

Our billing department will bill your insurance carrier for reimbursement for your care, but you are ultimately responsible for the entire bill, until paid by your Insurer. Please read and sign below, acknowledging you have read and understood our financial policy.

- Insurance is filed as a courtesy to our patients. You must bring your Insurance card to each visit. If you do not have your card, or we cannot verify your benefits, you are considered "Private Pay" until your benefits are verified and "Active."
- Your Insurance is a contract between you and the Insurance company. We are not part of that contract, therefore we will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance (COB), and "usual and customary" charges.
- If your insurance requires a referral/authorization for you to be seen at our office (or for a procedure), although we can assist you, it is your responsibility to ensure that this is done prior to your visit. Otherwise, you will be rescheduled. (All HMO's and "Managed Care" Insurances require an Authorization due to our Specialty.)
- All charges are your responsibility, until your insurance company pays. Not all charges are covered by Insurance.
- If the insurance company does not pay within 45 days, it is your responsibility to contact your insurer to ensure payment is made. If not, you are responsible for any unpaid charges.
- Fees for all services, including co-pays, co-insurance, deductibles, are due at the time of service. All unpaid balances are due upon receipt of statement. Returned checks will include a \$35 fee.
- Please be advised, after 4 statements, your account will be turned over to a collection agency, and you will become "Inactive" in our database. You will not be able to schedule any type of visit. Please talk to us before it comes to this.

We understand that unexpected financial problems may affect the timely payment of your balances. We encourage you to communicate any problems with the billing department so we can assist you in the management of your account.

SIGNATURE OF PATIENT/GUARDIAN/POA

PRINTED NAME

DATE

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APPOINTMENT & PROCEDURE CANCELLATION POLICY

Office Appointments are generally made for a time and location based on your needs. Therefore our providers and support staff will be where and when you need them. We know your time is valuable and we take this into consideration, we expect the same in return. We will staff our locations based on appointment times, therefore we ask that you give us a 24 hour cancellation notice for clinic visit.

When a Colonoscopy or Endoscopy procedure appointment is scheduled with us, we reserve a block of time especially for you. In that situation, it will include the MD, an anesthesiologist (CRNA) and multiple RN's, which all charge for time, irrespective of whether you show up or not. Also, if you do not appear for your procedure, that block of time is unavailable to someone else who is waiting for our care.

We require a **2 BUSINESS DAYS** to cancel or reschedule a procedure.

If you fail to give the required notice in the allotted time, you will be subject to a fee that will not be covered by your insurance.

Some examples of cancellation fees are as follows:

OFFICE VISIT (24 hr notice)	\$50 CANCELLATION FEE
COLONOSCOPY/ENDOSCOPY APPOINTMENT (48 hr notice)	\$200 CANCELLATION FEE
CAPSULE ENDOSCOPY (24 hr notice)	\$100 CANCELLATION FEE

*** Please give notice to avoid fee ***

Patients will only be exempt from the cancellation fee on emergency situations **ONLY**, i.e. **case-by-case basis**.

Please sign stating that you have read and understand our Procedure Cancellation Policy.

SIGNATURE OF PATIENT/GUARDIAN/POA

DATE

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NAME: _____

DATE: _____

DATE OF BIRTH: _____

REFERRING MD: _____

REASON FOR TODAY'S VISIT? _____

LIST OF SYMPTOMS						
	WHEN DID IT START? (# of days ago, months, etc.)	HOW OFTEN? (Constant, daily, weekly, monthly, etc.)	TIME OF DAY? (AM/PM or N/A)	RELATED TO DIET? (Describe or N/A)	SEVERITY (1-10 PAIN LEVEL)	ADDITIONAL DESCRIPTION(S)?
Right-Upper Abdomen Pain						Radiates to back? Y / N
Right-Lower Abdomen Pain						
Left-Upper Abdomen Pain						
Left-Lower Abdomen Pain						
Other Abdominal Pain: _____						
Diarrhea						
Constipation						
Fecal leakage						
Hemorrhoids						
Rectal Pain						
Rectal Bleeding						
Black/Tarry Stool						
Nausea						
Vomiting						Bloody Emesis? Y / N
Sour Taste in Mouth						
Excessive Belching						
Heartburn						
Acid Reflux/Regurgitation						
Sore Throat						
Difficulty Swallowing						FOODS SALIVA LIQUIDS PILLS
Sensation something is stuck in throat						
Other: _____						

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FAMILY MEDICAL HISTORY

PLEASE MARK THE APPROPRIATE BOX TO INDICATE WHICH MAY APPLY. IF NONE APPLY, MARK IN THE "HISTORY UNKNOWN/NONE" FIELD.	COLORECTALCANCER	COLORECTAL POLYPS	STOMACH CANCEER	CROHN'S DISEASE	ULCERATIVE COLITIS	PANCREATIC CANCER	LIVER CANCER	HEPATITIS	CIRRHOSIS	OVARIAN CANCER	PROSTATE CANCER	BREAST CANCER	UTERINE CANCER	OTHER CANCERS	HEART DISEASE	STROKE	HISTORY UNKNOWN/NONE
MOTHER																	
FATHER																	
SISTER(S)																	
BROTHER(S)																	
MATERNAL G.M.																	
MATERNAL G.F.																	
PATERANAL G.M.																	
PATERANAL G.F.																	

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MEDICAL HISTORY (CONTINUED)

SURGERIES/PROCEDURES	DATE OF SERVICE	HABITS
		SMOKING:
		PACKS DAILY: _____
		# OF YEARS SMOKING: _____
		# OF YEARS AGO, IF STOPPED: _____
		NEVER SMOKED: _____
		CAFFEINE: (SERVINGS PER DAY)
		COFFEE: _____
		SODA: _____
		TEA: _____
		ALCOHOL:
		TYPE: _____
		AMOUNT PER DAY: _____
		AMOUNT PER WEEK: _____
		AMOUNT PER MONTH: _____

RECENT LABS, TESTS, HOSPITALIZATIONS, MD VISITS	DATE/LOCATION	REASON

