STONE OAK GASTROENTEROLOGY

19284 Stone Oak #102; SATX 78258 * 3338 Oakwell Ct #104; SATX 78218 * 20540 Hwy 46 #103; Spr Br, TX 78070
SCHEDULING: (210) 268-0122 or (210) 268-0159 *** OFFICE: (210) 268-0124 *** FAX: (210) 268-0146 *** www.STONEOAKGI.com
Seema A. Dar, MD -- Chaithanya Mallikarjun, MD -- Christie L. Mannino, MD

General Demographics

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 _____ (for appt reminders only)

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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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 anestheisologist (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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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 purposed 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 GASTRONTEROLOGY** 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; Including Spouses, they are NOT automatic.*

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

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

SIGNATURE OF PATIENT/ GUARDIAN / POA	PRINTED NAME	DATE OF SIGNATURE
_____	_____	_____

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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 UNKOWN/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.																	
PATERNAL 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

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MEDICAL HISTORY

ULCERS – STOMACH/DUODENAL	YES ____	NO ____
ACID REFLUX/GERD	YES ____	NO ____
ESOPHAGEAL STRICTURE	YES ____	NO ____
LIVER DISEASE	YES ____	NO ____
ELEVATED LIVER FUNCTION TESTS	YES ____	NO ____
PANCREATITIS	YES ____	NO ____
ALCOHOLISM	YES ____	NO ____
COLON POLYPS	YES ____	NO ____
ANEMIA	YES ____	NO ____
ANGINA	YES ____	NO ____
HEART RHYTHM DISTURBANCE	YES ____	NO ____
HEART PALPITATIONS	YES ____	NO ____
HYPERTENSION	YES ____	NO ____
HYPERLIPIDEMIA	YES ____	NO ____
HEART ATTACK	YES ____	NO ____
CONGENITAL HEART DISEASE	YES ____	NO ____
CONGESTIVE HEART FAILURE	YES ____	NO ____
PACEMAKER/DEFIBRILLATOR	YES ____	NO ____
HEART VALVE REPLACEMENT	YES ____	NO ____
STROKE/TIA'S	YES ____	NO ____
SEIZURES	YES ____	NO ____
DIZZINESS/FAINTING	YES ____	NO ____
ASTHMA	YES ____	NO ____
SLEEP APNEA	YES ____	NO ____
COPD	YES ____	NO ____
DIABETES, TYPE I/II	YES ____	NO ____
KIDNEY DISEASE	YES ____	NO ____
GENITOURINARY DISEASE	YES ____	NO ____
THYROID/ENDOCRINE DISEASE	YES ____	NO ____
PSORIASIS	YES ____	NO ____
AUTOIMMINUE DISEASE	YES ____	NO ____
ARTHRITIS	YES ____	NO ____
GOUT	YES ____	NO ____
MENSTRUAL PROBLEMS	YES ____	NO ____
GYNOLOGICAL PROBLEMS	YES ____	NO ____
CANCER: _____	YES ____	NO ____
OTHER: _____	YES ____	NO ____

Pharmacy Information

Pharmacy_____

Address or Location_____

Phone #:_____

Fax #: _____

REVIEW OF SYMPTOMS

ARE YOU PREGNANT? **(IF APPLICABLE)**	YES ____	NO ____
DO YOU HAVE A FEVER?	YES ____	NO ____
EXCESSIVE FATIGUE?	YES ____	NO ____
UNINTENTIONAL WEIGHT LOSS?	YES ____	NO ____
LOSS OF APPETITE?	YES ____	NO ____
DEPRESSION?	YES ____	NO ____
ANXIETY?	YES ____	NO ____
TENDER LYMPH NODES?	YES ____	NO ____
SWOLLEN LYMPH NODES?	YES ____	NO ____
RECENT/RECURRENT INFECTION?	YES ____	NO ____
RASH?	YES ____	NO ____
SHORTNESS OF BREATH?	YES ____	NO ____
CHEST PAIN?	YES ____	NO ____
PRODUCTIVE COUGH?	YES ____	NO ____
SEASONAL ALLERGIES?	YES ____	NO ____

MEDICATION	DOSE	FREQUENCY

DRUG/FOOD ALLERGIES	REACTION
LATEX ALLERGY?	YES / NO