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 – Tiffany Heese, PA-C

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 (______)__________-__________________

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 – Tiffany Heese, PA-C

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, acknowleding 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**

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 – Tiffany Heese, PA-C

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**

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 – Tiffany Heese, PA-C

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**

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 – Tiffany Heese, PA-C

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) 268-0146

For the Purpose of: *CONTINUITY OF CARE*

____ ______________________________

Patient Signature/Guardian/POA Date

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 – Tiffany Heese, PA-C

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. Spouses 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.

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**

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 – Tiffany Heese, PA-C

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: ___________						

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 – Tiffany Heese, PA-C

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.																	

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 – Tiffany Heese, PA-C

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

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 – Tiffany Heese, PA-C

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