Gastro Health & Nutrition

PATIENTS INFORMATION

Last Name:_____First Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Date of Birth:_____Social Security #:_____
Home Phone:_____Cell Phone:_____
Driver's License #:_____Email:_____
Pharmacy Name & Address:_____

PATIENTS EMPLOYER INFORMATION
Company Name:_____
Company Address:_____
City:_____State:_____Zip:_____
Phone #:_____EXT:_____
Occupation:_____

EMERGENCY CONTACT
Name:_____
Relationship:_____
Address:_____
City:_____State:_____Zip:_____

Interpretive Service Needs:

Primary Language:_____

Interpreter Services Required: Yes ☐ No☐

Assignment of benefits; I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to the physician/facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Authorization of treatment: I hereby authorize the physician of record, and associates to treat the above patient.

Patient Signature:_____Date:_____

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Medication Record

DATE	MEDICATION	DOSE GIVEN	FREQUENCY (i.e. 2x/day)	TIME	AM PM

Katy GastroHealth & Nutrition Patient History

Date: Name: DOB:_____

__Married__Single__Divorced__Widowed: Occupation_____Education_____

No. of Pregnancies/Children:_____Tobacco Use: Yes/No How much?_____/Day

How long?_____Date Quit?_____Alcohol use: Yes/No____Caffeine (Coffee, Tea, Colas)/day

Describe briefly your gastro/colon problem:

Past illness of yourself (Please circle):

-Anemia/GI bleed
-Asthma/COPD
-Cancer/Tumor
-Diabetes
-Depression/Mental Illness
-Epilepsy/Seizures
-Heart Disease
-High Blood Pressure
-Kidney Disease
-Liver Disease
-Hepatitis/Jaundice
-Lung Disease
-Osteoarthritis/Arthritis
-Osteoporosis
-Stroke
-Thyroid Disease
-Ulcer in GI Tract
-High Cholesterol
-HIV/Immune DX
-Other:_____

-Date of last colonoscopy:_____Normal/Abnormal

-Date of last EGD:_____Normal/Abnormal

-Any family history of history of Colon Cancer?_____

Past Surgical History

PATIENT SURGERIES	DATE (MONTH/YEARS)

Family History

(please circle all that apply)

MOTHER

-Hypertension
-Hyperlipidemia
-Kidney Disease
-Liver Disease
-Lung Disease
-Diabetes
-HIV
-Thyroid Disease
-Stroke
-Cancer/Tumor
-Asthma/COPD
-Other:_____

FATHER

-Hypertension
-Hyperlipidemia
-Kidney Disease
-Liver Disease
-Lung Disease
-Diabetes
-HIV
-Thyroid Disease
-Stroke
-Cancer/Tumor
-Asthma/COPD
-Other:_____

Allergies to Medications:

MEDICATION	**REACTION**

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ROS: PLEASE CHECK EITHER YES OR NO

Constitutional	YES	NO	Respiratory	YES	NO	Hematology/Lymph	YES	NO
Weight loss			Cough			Easy Bruising		
Fatigue			Coughing Blood			Gums bleed easily		
Fever			Wheezing			Enlarged Glands		
			Chills					

EYES	YES	NO	GASTRO	YES	NO	MSK	YES	NO
Glasses			Heartburn/Reflux			Joint Pain/Swelling		
Eye Pain			Nausea/Vomiting			Stiffness		
Double Vision			Black or blood BM			Muscle Pain		
Cataracts			Constipation			Back Pain		
			Diarrhea					
			Jaundice					
			Abdominal Pain					

ENT	YES	NO	GU	YES	NO	NEURO	YES	NO
Difficulty Hearing			Burning/Frequency			Loss of Strength		
Ringing Ears			Blood in urine			Numbness		
Vertigo			Erectile Dysfunction			Headaches		
Sinus trouble			Abnormal Discharge			Tremors		
Nasal Scruffiness			Abnormal Discharge			Memory Loss		
Frequent Sore Throat			Bladder Leakage					

CARDIO	YES	NO	ALLERGIC/IMMUNOLOGIC	YES	NO	PSYCHIATRIC	YES	NO
Murmur			Hives/Eczema			Anxiety		
Chest Pain			Hay Fever			Mood Swings		
Palpitations						Difficulty Sleeping		
Dizziness						Depression		
Fainting Spells								
Shortness of Breath								
Swelling Ankles								

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PATIENT INFORMATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    a. You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.
3. Please inform us, if for any reason you are not able to keep your appointment at least 24 hours in advance. In case of no show without notification, we will charge $25.00 to cover the cost incurred for the preparation of your visit.

PATIENT AUTHORIZATION

I authorize Katy GastroHealth & Nutrition to submit insurance claims using my signature on the file below. I authorize the release of any medical information necessary in order to process this assignment on the claim, I authorize payment of medical benefits to be paid directly to Health and Wellness Solutions, PA: d/b/a KATY GASTROHEALTH AND NUTRITION.

X_____ _____
Patient Signature (or authorized representative) (Date)

PERMISSION SHEET

I_____, give permission to my physician at Katy GastroHealth &Nutrition to discuss and/or release any medical information concerning my healthcare to the following family members/friends. I am aware that I may change this permission form at any time.

1. _____
(FAMILY/FRIEND FULL NAME)
Relationship:_____Phone:_____

2. _____
(FAMILY/FRIEND FULL NAME)
Relationship:_____Phone:_____

3. _____
(FAMILY/FRIEND FULL NAME)
Relationship:_____Phone:_____

I give permission to release appointment information to whoever answers the phone at my listed phone number(s): YES / NO

X_____

Katy GastroHealth and Nutrition Acknowledgement

At each visit, a distance summary will be provided. This would entail reviewing medications, physician instructions, diagnoses and follow up appointments. Please review and notify us of any discrepancy in a timely manner so that it can be rectified. By signing this agreement, you acknowledge the protocol of the chart summary.

X_____ Date:_____

GENERAL CONSENT FOR TREATMENT

I hereby voluntary consent for treatment to the facility. I permit the facility and its employees, physicians, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for the treatment and/or test. I consent to examinations, blood tests (including blood test for communicable diseases such as hepatitis and HIV/AIDS when healthcare providers have been exposed to my blood/fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatment rendered by the facility personnel under the instructions, order or direction of such physician(s).

X_____ Date:_____

1259 FM 1463; Suite 500
KATY, TX 77494
TEL: 713-429-4550 / FAX: 832-397-6426

MEDICAL RECORD RELEASE FORM

Patient's Name:_____ Date of Birth:_____

Social Security #:_____

Please release my medical records from the following physician(s):

Name:_____

Address:_____
City:_____State:_____ZIP:_____

Phone #:_____
Fax #:_____

The release of my medical records is for the continuation of care.

_____
(patient's signature)

_____
(Today's Date)

Gastro Health & Nutrition

HIPPA Release Form

Gastro Health and Nutrition– Katy
1259 FM 1463 Suite #500
Katy, Texas 77494
T: 713-429-4550
F: 832-397-6426

Authorization to Release Protected Health Information
Dependents must complete this form to authorize the release of protected health information to the account holder

Last Name	First Name	MI
Street Address	City	State/ZIP
Email	Phone	SSN

HIPPA Release (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer or health care clearinghouse, and relates to (I) my past, present, or future physical or mental health condition; (II) the provision of the healthcare to me; or (III) the past, present or future payment for the provision of healthcare to me.

In accordance with provisions of the Health Insurance Portability and Accountability Act (HIPPA), I, the undersigned, grant permission to HealthEquity, Inc. to disclose protected health information (as define in HIPPA) to the following person or persons; _____

Purpose of authorization; ☐ At my request ☐ Family member assisting with healthcare ☐ Other ☐:_____

Any limitations that I impose on HealthEquity with respect to the authorization are declared below:

_____

This release will remain in effect until the closure of the health savings account (HSA), flexible spending account (FSA), or health reimbursement arrangement (HRA). In addition, I may revoke this release at any time by notifying HealthEquity of the revocation in writing and fax to 801.727.1005, Attn: Member Services.

If at any time you need to alter this release form, please contact HealthEquity at 866.346.5800.

Authorization of HIPPA Release (to be completed by dependent)

I understand that by granting this Release, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, this information would no longer be protected under HIPPA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Dependent Name (please print)	Dependent's Date of Birth (mm/dd/yyyy)
Dependent Signature	Today's Date

Note: If the person signing above is a personal representative of the named individual, attach a copy of the document granting authority to the personal representative.