CENTRAL TEXAS GASTROENTEROLOGY CONSULTANTS

Reset Form

PATIENT UPDATE FORM

Appointment Date _____

Full Name _____ **Date of Birth** _____ **Phone #** _____

Address Changes _____

Primary Insurance _____ **Secondary Insurance** _____

Primary Care Provider _____

• What is the reason for your visit today?

_____

_____

• Please indicate by checking the box if you have or have had any of the following.

- ☐ Asthma
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Lung Disease
- ☐ Coronary Artery Disease
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Anemia
- ☐ Stroke / TIA
- ☐ Sleep Apnea
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Hepatitis Infection (A, B, or C)
- ☐ HIV Infection
- ☐ Anxiety / Depression / Bipolar
- ☐ Any Other Conditions?
- ☐ Pancreatic Disease
- ☐ Anxiety / Depression / Bipolar

• Please list any major surgeries you have undergone since last visit. _____

_____

• PLEASE LIST ALL MEDICATION ALLERGIES. _____

_____

• Please attach or list below ALL current medications you take. Please include all prescription and non-prescription medications, vitamins and supplements.

Name	Dosage	How Often Taken?

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ANNUAL PRACTICE COMPLIANCE NOTIFICATION

FINANCIAL AGREEMENT:

I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments and coinsurances as services are rendered. I understand my insurance is a contract between myself and my insurance company and Central Texas Digestive Disease will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization is required by my insurance company, I will assist Central Texas Digestive Disease in obtaining the referral and/or preauthorization. I understand that I am ultimately responsible for any balance on my account.

ASSIGNMENT OF BENEFITS:

I hereby assign to Central Texas Digestive Disease such insurance benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION:

I hereby allow Central Texas Digestive Disease to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

CONSENT FOR TREATMENT:

I hereby authorize Central Texas Digestive Disease to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary.

PRIVACY PRACTICES:

Central Texas Digestive Disease is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individual with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information below.

I am 18 years or older and authorize release of this information to my parents and/ or children: ☐ Yes ☐ No

Please check one: ☐ No restrictions ☐ Restrictions_____

PHYSICIAN DISCLOSURE OF OWNERSHIP:

I, Chang/Derbes/Gray/Pham/Moore MD, may and/or have recommended that you receive medical treatment and/or services from the Central Texas Endoscopy Center, LLC and hereby inform you that I have an ownership interest in this facility. You should be aware that alternative health care facilities may be available to you. Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, Consent for Treatment, and Physician Disclosure of Ownership as listed above. My signature below indicates that I have also received a copy of the Central Texas Digestive Disease Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Scanned signatures suffice as originals.

_____

Patient or Responsible Party Signature **Date**

_____

Person Signing on Behalf of Patient (Print Name) **Relationship to Patient** **Phone Number**