DATE ____________________

# Colon & Rectal Associates of Texas

☐SAID HASHEMIPOUR, M.D. ☐TODD ODOM, M.D. ☐SALIM JABBOUR, M.D. ☐JULIE LEVERTON, M.D

## Patient Information

**Sex:** ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Name:________________________DOB:____________SSN:________________

Address:________________________ City________________ State______ Zip________

Home Phone:________________ Cell:________________ Email:____________________

**Employment Status:** ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐ Student

Patient Employer:______________________________ Work Phone:________________

**Emergency Contact Name**:____________________ Relationship:____________________

Home Phone:____________________ Cell:________________ Other:________________

**Referring Physician:**____________________________ Phone:____________________

**Primary Care Physician:**______________________Phone:________________________

## Primary Insurance Information

Insurance Company:__________________________Phone:______________________

Member ID #:________________________________ Group #:____________________

Insured Party:________________________DOB:__________SSN:________________

Relationship to Patient:____________________ Employer:__________________________

## Secondary Insurance Information

Insurance Company:______________________________Phone:__________________

Member ID #:__________________________ Group #:____________________________

Insured Party:______________________DOB:______________SSN:______________

Relationship to Patient:__________________ Employer:____________________________

## Assignment of Benefits

**Please sign below and provide a copy of your insurance card(s) and photo I.D.**

I authorize the release of any medical information necessary to process insurance claims by mail or electronic transmission. I understand that payment is expected at the time services are rendered. The patient, **NOT THE INSURANCE COMPANY**, is responsible for co-pays, co-insurance, and deductibles. I understand it is my responsibility for any necessary authorizations or referrals required by my insurance company. I understand that I am financially responsible for any charges not covered by my insurance plan. **Colon & Rectal Associates of Texas** is not responsible for denied or disputed claims. I authorize my insurance company to make payment directly to **Colon & Rectal Associates of Texas.** Regulations pertaining to Medicare assignment of benefits apply. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________ ____________________

*Patient Signature* *Date*

Revised: 12/15/09

# Colon & Rectal Associates of Texas
## Financial Policy

**Patient Name:**____________________________________________ **DOB:**________________

Thank you for choosing **Colon & Rectal Associates of Texas**, as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you read and understand our financial policy.

### Insurance

Colon & Rectal Associates of Texas will bill your insurance carrier with the information that you provide to our office. It is the patient's responsibility to provide complete and accurate information for billing purposes. If your address, contact information or insurance coverage changes, please provide our office with updated information as soon as possible. If you fail to provide accurate insurance information, your insurance company may deny your claim. If your claim is denied, you will be financially responsible for the entire amount. If you are covered by a HMO/Managed Care Health Plan, it is your responsibility to know and understand your insurance plan. If a referral/authorization is required for a specialist visit, it is your responsibility to obtain the referral/authorization from your primary care physician. In the event you change your primary care physician during treatment with Colon & Rectal Associates of Texas, you will be responsible for obtaining a new referral/authorization from your current primary care physician. It is your responsibility to know and understand the level of services covered by your insurance company.

### Co-Pays/Co-Insurance/Deductibles

Co-pays, coinsurance and deductibles are due at the time services are rendered. Please be advised, that some services provided by our physicians may NOT fall under your office copayment amount. This amount may fall under your coinsurance or towards your annual deductible. Colon & Rectal Associates of Texas will file your claim with your insurance carrier; however based on your benefit plan and provisions you will be financially responsible for any balance due after your insurance pays.

### Uninsured/Private Pay/High Deductible Health Insurance Plans

If you do not currently have insurance or participate in a high deductible health insurance plan, and it is determined that you will require a surgical procedure, you will need to coordinate a payment plan with our business office. A payment agreement must be agreed upon prior to any surgical procedures. If you are a patient following up from the hospital and you do not have health insurance, you will need to coordinate a payment plan with our business office.

### Medicare Patients

Colon & Rectal Associates of Texas physicians are participating providers with the Medicare Program. We accept the Medicare Allowable as payment; however, you are responsible for any co-pays, coinsurance and or deductibles that apply. If you have a secondary or supplement insurance (Medigap), please provide our office with your insurance information so we can file with your secondary/supplement carrier. Please be advised that Medicare and secondary carriers do NOT cover some procedures. In this rare instance, you may be asked to sign a Medicare Waiver Form, which states that you understand you will be financially responsible for "NON-COVERED" services.

### Administrative Fees

Colon & Rectal Associates of Texas may assess an administrative fee up to $35.00 for administrative forms to be completed and signed by your physician. These forms may include disability insurance forms, return to work forms, and any other form requiring completion and a signature from your physician.

☐ **I ACCEPT the TERMS of the FINANCIAL POLICY**

______________________________ __________________

*Patient Signature* *Date*

# Colon & Rectal Associates of Texas
## Privacy Disclosure Policy

**Acknowledgement of Receipt Notice of Privacy Practices**

**Patient Name:**_______________________________________ **DOB:**______________________

I have received the Notice of Privacy Practices for Colon & Rectal Associates of Texas, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my personal records.

☐ **I accept the acknowledgement of receipt notice of privacy practices**

____________________________________ ____________________
*Patient Signature* *Date*

**Refusal to Sign**

☐ **Refusal to Sign Notice of Privacy Practices for Colon & Rectal Associates of Texas**

The above-named person has refused to sign their receipt of the Notice of Privacy Practices for the following reason(s):____________________________________________________________________________

____________________________________ ________________________
*Staff Signature* *Date*

**Permission to Give Health Information**

I, __________________________________ hereby authorize the physicians of Colon & Rectal Associates of
**Patient Name**
Texas to provide the following information regarding my health & well being:

The following information may be disclosed and/or picked up on my behalf by the individual (s) listed below.

***(Please check the items you agree to have disclosed to the listed individual below.)***

☐ Appointment Time ☐ Test/Lab Results ☐ Written Prescriptions ☐ Medications
☐ Procedures ☐ Any information regarding my health

Name_________________________________________ Relationship: ______________________________

Name_________________________________________ Relationship: ______________________________

Name_________________________________________ Relationship: ______________________________

I understand, I may revoke this consent at any time by giving written notice to Colon & Rectal Associates of Texas regarding this disclosure.

____________________________________ ____________________
*Patient Signature* *Date*

**Communication Consent**

I hereby give permission to Colon & Rectal Associates of Texas to notify me regarding my health information (lab results, pathology results, radiology results, etc.) in the following manner:

☐ Home Phone ☐ Answering Machine ☐ Voicemail ☐ Email
☐ All of the above

____________________________________ ____________________
*Patient Signature* *Date*

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# Colon & Rectal Associates of Texas

## Patient Medical History Information

### Personal History

Patient Name____________________________________ Today's Date____________________

Date of Birth____________________ Age________________________ Sex: ☐ Male ☐ Female

Referring Physician______________________________ Primary Care Physician______________________________

**Reason for your visit**:____________________________________________________________

**Have you ever had this problem before**? ☐ **Yes** ☐ **No** **if yes, date of occurrence:**______________________________

**Do you have any drug allergies?** ☐ **Yes** ☐ **No** **if yes, please list the medication & the reaction:**_______________

____________________________________________________________________________________________

**Please list all medications you are taking (including over the counter medications**)__________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

### Social History

**Alcohol Consumption:** ☐ **Yes** ☐ **No** If yes, number of drinks per day/week:____________

**Tobacco use:** ☐ **Yes** ☐ **No** If yes, number of packs per day:________________

**Recreational Drug use:** ☐ **Yes** ☐ **No** If yes, please explain:___________________________________

### Current Medical Problems

*Please check (**YES)** or (**NO)** on all conditions*

| ***Present Condition*** | ***Ye*** | ***No*** | ***Present Condition*** | ***Ye*** | ***N*** | ***Present Condition*** | ***Ye*** | ***No*** |
|---|---|---|---|---|---|---|---|---|
| Diarrhea | | | Weight Loss/Gain | | | Trouble Urinating | | |
| Vomiting | | | Loss of Appetite | | | Leakage of Urine | | |
| Constipation | | | Fever/Chills | | | Arthritis | | |
| Change in Bowel Habits | | | Night Sweats | | | Asthma | | |
| Nausea | | | Dizziness | | | Lung Disease | | |
| Rectal Bleeding | | | Seizures | | | Hepatitis | | |
| Anal/Rectal Pain | | | Nerve Damage | | | Diabetes | | |
| Blood in Stool | | | Headache | | | Bleeding Problems | | |
| Mucus in Stool | | | Depression | | | Kidney Disease | | |
| Hemorrhoids | | | Anxiety | | | | | |
| Heart Disease | | | Tension/Stress | | | Female Only | | |
| Stroke | | | Muscle Weakness | | | Pregnant | | |
| Shortness of Breath | | | Non-Healing Lesions | | | Pelvic Pain | | |
| High Blood Pressure | | | Anemia | | | Vaginal Discharge | | |
| Stool Leakage | | | | | | | | |

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# Colon & Rectal Associates of Texas

## Patient Medical History Information

Name:______________________________________ DOB:________________________

## Past Medical History

*Have you ever had any of the following medical conditions? Please answer **(YES)** or **(NO)***

| ***Past Medical History*** | ***Yes*** | ***No*** | ***Past Medical History*** | ***Yes*** | ***No*** | ***Past Medical History*** | ***Yes*** | ***No*** |
|---|---|---|---|---|---|---|---|---|
| Colon Cancer | | | Ovarian Cancer | | | Shortness of Breath | | |
| Polyps | | | Uterine Cancer | | | Skin Problems | | |
| Hemorrhoids | | | Breast Cancer | | | Joint/Muscle Pain | | |
| Colitis | | | Mental Disorders | | | Difficulty Swallowing | | |
| Crohn's Disease | | | Lung Disease/Cancer | | | Bleeding Gums | | |
| Heart Disease | | | Prostate Cancer | | | Vision Changes | | |
| Heart Attack/Stroke | | | Problems w/Anesthesia | | | Asthma/COPD | | |
| Hypertension | | | Sleep Apnea | | | Arthritis | | |
| Aneurysm | | | Seizures | | | Osteoporosis | | |
| Bleeding/Clotting Problems | | | High Cholesterol | | | Diabetes | | |
| Other | | | Please explain | | | | | |

List all previous surgeries (include approximate dates):_____________________________________________

_____________________________________________________________________________________

## Past Family History

*Please answer **(YES)** or **(NO)** if you have a family history of the following:*

| Family History | Yes | No | Relationship | Age | Explanation (if needed) |
|---|---|---|---|---|---|
| Colon Cancer | | | | | |
| Polyps | | | | | |
| Cancer (specify) | | | | | |
| Heart Disease | | | | | |
| Diabetes | | | | | |
| Genetic Disorders | | | | | |
| Mental Disorders | | | | | |
| High Blood Pressure | | | | | |
| Asthma/COPD | | | | | |
| Bleeding/Clotting Disorders | | | | | |
| Lung Disease | | | | | |
| Kidney Disease | | | | | |
| Other problems | | | | | |

_______________________________________ ____________________

*Patient Signature* *Date*