Mukhtar Anees, MD

Home Office: 701 E. Rendon-Crowley Road, Burleson, Texas 76028
Satellite Office: 1200 Crawford Avenue Suite A Granbury, Texas 76048

Phone: (817) 293-9292
Fax: (817) 551-0616
Website: www.swgiclinic.com

PATIENT INFORMATION

Today's date: _____-_____-_____ Who Is your family physician: _____

Whom may we thank for referring you? _____Pharmacy Name/Address_____

Name: _____ Birthdate ____-____-____ Age: _____

last first middle initial

Sex: M F Race: Caucasian African American Hispanic Asian Other:_____

Email address: _____

Home address: _____

City: _____ State: _____ Zip code _____

Home phone: _____ Work phone: _____ Ext._____

Social Security #_____ Marital status (circle one) Single Married Divorced Widowed

Employer: _____ Address: _____

Patient's occupation: _____

Name of spouse: _____ Spouse's SS# _____ Birthdate ____-____-____

Spouse's employer: _____ Address: _____

Work phone: _____ Spouse's occupation: Warehouse Staff

In case of emergency, contact: _____ Phone: _____

Relationship: _____

INSURANCE INFORMATION

Primary insurance: _____

Insured's name: _____ Birthdate: _____-_____-_____

Claim form address: _____ City: _____ State: _____ Zip: _____

Insured's ID # _____ Group # _____ Phone: _____

Secondary insurance: _____

Insured's name: _____ Birthdate: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Insured's ID # _____ Group # _____ Phone: _____

1. I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, I am responsible for all physician charges. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to the SOUTHWEST GASTROENTEROLOGY CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
2. I have reviewed and if requested, received the Notice of Privacy Practices.

Patient's signature: _____ **Date:** _____

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Name: _____ **Date:** _____

BRIEFLY DESCRIBE YOUR SYMPTOMS:

_____

_____

DATE SYMPTOMS BEGAN: _____

CURRENT MEDICATIONS:

NAME DOSE FREQUENCY

_____

_____

_____

LIST ALLERGIES TO MEDICATIONS:

_____

_____

_____

ALLERGIES TO EGGS? [ ] yes [ ] no
ALLERGIES TO SOY? [ ] yes [ ] no

HAVE YOU BEEN TREATED FOR OR BEEN TOLD YOU HAVE:

DIABETES [ ] yes [ ] no **Type 1 [ ] Type 2 [ ]**
CANCER [ ] yes [ ] no
ANEMIA [ ] yes [ ] no
HIGH BLOOD PRESSURE [ ] yes [ ] no
HEART DISEASE [ ] yes [ ] no
BREATHING PROBLEMS [ ] yes [ ] no
Other: _____
DO YOU SMOKE? [ ] yes [ ] no
HOW MUCH PER DAY: _____
FOR HOW LONG: _____

DO YOU DRINK ALCOHOL? [ ] yes [ ] no
HOW MUCH DAILY: _____
HOW MUCH WEEKLY: _____

DO YOU WEAR DENTURES? [ ] yes [ ] no

HAVE YOU EXPERIENCED:

A CHANGE IN APPETITE… [ ] yes [ ] no
Increase _____ **decrease** _____
DIFFICULTY IN SWALLOWING [ ] yes [ ] no
Liquids…… [ ] yes [ ] no
Solids…… [ ] yes [ ] no
ABDOMINAL PAINS…… [ ] yes [ ] no
FREQUENT INDIGESTION/
HEART BURN…….. [ ] yes [ ] no
CHANGES IN BOWEL HABITS IN PAST ONE MONTH
Constipation…… [ ] yes [ ] no
Diarrhea…… [ ] yes [ ] no
CHANGE IN YOUR WEIGHT……. [ ] yes [ ] no
Increase _____ **decrease** _____

HAVE YOU EVER HAD:

AN ULCER…… [ ] yes [ ] no
BLACK TARRY STOOLS…… [ ] yes [ ] no
RECTAL BLEEDING…… [ ] yes [ ] no
YELLOW JAUNDICE…… [ ] yes [ ] no
HEPATITIS…… [ ] yes [ ] no
ANY TYPE OF LIVER TROUBLE [ ] yes [ ] no
GALLSTONES…… [ ] yes [ ] no
GALLBLADDER PROBLEMS… [ ] yes [ ] no
VOMITED BLOOD…… [ ] yes [ ] no
ANY BLOOD DISORDER…… [ ] yes [ ] no
STOMACH OR INTESTINAL PROBLEMS
OTHER THAN LISTED ABOVE [ ] yes [ ] no
DO YOU CONSIDER YOURSELF A
NERVOUS PERSON…… [ ] yes [ ] no

***** MUST ANSWER THE FOLLOWING: *****

PREVIOUS COLONOSCOPY? [ ] yes [ ] no
If yes, when, why, and where?

_____

Previous EGD? (Throat scope) [ ] yes [ ] no
If yes, when & where?

_____

BRIEFLY DESCRIBE YOUR AVERAGE DAILY MEALS:

BREAKFAST: _____
LUNCH: _____
DINNER: _____

LIST MAJOR OPERATIONS YOU HAVE HAD & YEAR:

_____
_____
_____

FAMILY HISTORY:

	father	**mother**	**grandparents:** **Mother's side**- mother father **father's side-** mother father				**brother**		**sister**		**children**	
DIABETES:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
HIGH BLOOD PRESSURE:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
STROKE:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TUBERCULOSIS:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
HEART TROUBLE:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
CANCER:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
SIMILAR PROBLEMS:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

IF CANCER, DESCRIBE THE TYPE OF CANCER:

_____

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PATIENT AUTHORIZATION FOR CONTACT

Please print all information. Be sure to sign and date the form at bottom.
Type of authorization: telephone contact / facsimile contact

Patient name (please print): _____

Purpose of request: I authorize Southwest Gastroenterology Clinic and/or Southwest Endoscopy and Surgery Center to disclose my protected health information in the following manner:

Home telephone: _____
[ ] leave detailed messages on my answering machine / voicemail
[ ] leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Work telephone: _____
[ ] leave detailed messages on my answering machine / voicemail
[ ] leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Mobile telephone: _____
[ ] leave detailed messages on my voicemail
[ ] leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Facsimile number: _____
[ ] fax my Protected Health Information to this number
[ ] specify Protected Health Information:

_____

_____

[ ] fax general information (non-Protected Health Information) to this number

Expiration or termination of authorization: This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate the authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Southwest Gastroenterology Clinic
Attention: Privacy Manager
701 E. Rendon-Crowley Rd.
Burleson, TX 76028

Patient signature _____ **Date** _____

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Dear Patient,

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

PAYMENT GUIDELINES

1. You must pay any co-payments, co-insurance and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
2. We accept cash, checks, money orders and credit cards (VISA, MasterCard, Discover, American Express).
3. The remainder of your bill will be sent your insurance company for payment to our office.
4. If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. Please do not send payment back to the insurance company.

WHEN SHOULD YOU PRESENT YOUR INSURANCE CARD?

Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group number, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

WHAT IF YOUR INSURANCE COMPANY DENIES PAYMENT?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

- this is a pre-existing illness or condition that they do not cover
- you have not met your fill calendar year deductible
- the type of medical service required is not covered
- the insurance was not in effect at the time of service
- you have other insurance which must be filed first
- you have exceeded your maximum dollar/visit amount
- you did not have a referral number for your visit/service

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at (817) 293-9292.

Sincerely,

Mukhtar Anees, MD

PATIENT ACKNOWLEDGEMENT

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Southwest Gastroenterology Clinic and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

Patient signature:_____ **Date:**_____

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NOTICE TO PATIENTS

1. Due to multiple policy changes for the different insurance companies, our office is unable to keep up with the requirements for each patient's individual policy. There are multiple requirements stated in your policy, some of which are on the back of your insurance card and some of which are not. Some of the most common requirements are:
   - Pre-admission certification
   - Second opinion
   - Pre-admission testing
   - A.M. admissions
2. Our office checks on these particular requirements for our patients; however, if you do not ask the insurance company about a particular requirement point blank, they do not volunteer any information to you. We will be happy to assist you in accomplishing this task, but you are responsible for informing us of your insurance company requirements.
3. **IT IS THE RESPONSIBILITY OF THE PATIENT TO BE AWARE OF AND FULFILL ALL THE REQUIREMENTS OF THEIR INDIVIDUAL POLICY, INCLUDING ALL APPLICABLE DEDUCTIBLES AND COPAYMENTS.**
4. I understand that should the insurance information I have provided be incorrect and a claim is denied, I will be responsible for the bill.

Patient's signature _____ Date _____

PLEASE NOTE: Follow-up appointments after procedures are very important. This allows our physician to monitor your medical progress as well as give you any test results. It is not our policy to give this confidential information over the telephone.

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NOTICE OF PRIVACY PRACTICES

I have read THE NOTICE OF PRIVACY PRACTIES at this facility and understand how medical information about me can be used and disclosed, and how I can get access to this information.

I understand that is I pay for services "out of pocket" in full, and request that we not disclose private health information related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make disclosure.

Patient Signature_____ Date_____

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Notice of Privacy/Communication Authorization Form

Patient Name:_____ SS#_____

- I have been given the opportunity to read and/ or take a copy of the Southwest Endoscopy and Surgery Center Privacy Policies.
- When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. There is certain occasion when family members, friends, or others might be involved in your care. As a patient, you will want our staff to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.
- Please list below those individuals with whom you authorize our office to discuss aspects related to your care.

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

- I authorize the surgeon and/ or anesthesiologist providing my care to discuss the details of my procedure with immediate family members or the people accompanying me to the facility.
- Post- Op Call back

    - Speak to me only
    - May leave a message on machine
    - May speak with:_____

Phone: Home:_____ Work:_____ Cell:_____

Patient Signature:_____

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Have you traveled to, or been exposed to anyone traveling to any parts of Africa in the last 30 days?

YES NO

If answered yes, please answer the following questions:

1. Fever greater than 100.4F YES NO
2. Severe headache YES NO
3. Muscle Pain YES NO
4. Vomiting YES NO
5. Diarrhea YES NO
6. Abdominal pain YES NO
7. Unexplained Hemorrhage YES NO

Do you have Flu like symptoms

YES NO