

North Houston Gastro Clinic, PA

Houston Colon Cancer Screening Center/The Infusion Center

Barry D. Winston, MD

We welcome you to our office. Our goal is to provide our patients the best care and service available.

In order to reduce confusion and misunderstanding between our patients and our billing office, we have adopted the financial policy described below. If you have any questions about the policy, please discuss this matter with our business office staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, **full payment is due at the time of service.** Acceptable methods of payments are cash, personal check and for your convenience we accept VISA, MASTERCARD, and AMERICAN EXPRESS credit cards.

Your Insurance

Know your insurance plan restrictions regarding the use of a specific laboratory or x-ray department. Unless you notify our office otherwise, for lab work, we send our patients to Quest Diagnostics or Lab Corp; for imaging studies, Northwest Diagnostics Imaging. If biopsies are necessary during your procedure, the specimens are sent to Plus Diagnostics for analysis.

In the event your health plan requires a **Referral** from your primary care physician and you arrive for your appointment without an authorized **Referral**, you will be responsible for the complete charge. To avoid this charge, you may reschedule your appointment to date after a referral can be obtained.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of the service. **Please Note: Your insurance carrier requires us to collect your co-payment at each visit.**

If your health plan determines that a service is not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

For all services rendered to minor patients, the adult accompanying the patient, the parent with custody or the legal guardian will be responsible for payment.

CANCELLATION POLICY

In an effort to best serve our patients; for office visits we will charge a fee of \$25.00 for the cancellation/failure to keep an appointment. The fee charged for the cancellation/failure to keep an appointment of a scheduled procedure will be \$150.00. Please make every effort to notify this office within 24 hours of your office visit or scheduled procedure if you must cancel or reschedule.

I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

Signature of Patient or Legal Guardian

Printed Name Of Above

Your Privacy

In compliance with the Medical Privacy Act of Texas (MPAT) and the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), we are unable, without the patient's written prior authorization, to release any information pertaining to a patient's treatment by this office to anyone other than the patient or other medical, billing or insurance personnel involved in matters directly related to that patient's care. As a patient, you may authorize us to release any information regarding your care to the following family members or significant others:

Name	Relationship
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Name	Relationship
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Name	Relationship
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PATIENT INFORMATION

DATE _____

NAME _____ DATE OF BIRTH _____

LAST FIRST M.I.

ADDRESS _____ AGE _____ M ___ F ___

CITY _____ STATE _____ ZIP _____

HOME (____)____-____ CELL (____)____-____ WORK (____)____-____

EMAIL _____ SS# _____ - _____ - _____ MARITAL STATUS _____

EMPLOYER/SCHOOL _____

OCCUPATION _____

IN CASE OF EMERGENCY, NOTIFY (NAME) _____ PHONE(____)____-____

POLICY HOLDER IS: PARENT ___ SPOUSE ___ GUARDIAN ___ SELF ___ (PLEASE CHECK ONE)

GROUP OR POLICY# _____ NAME OF POLICY HOLDER _____

POLICY HOLDER EMPLOYER _____ WORK PHONE (____)____-____

POLICY HOLDER SS# _____ - _____ - _____ NAME OF INSURANCE CO. _____

Policy Holder Date of Birth _____

I understand that I am responsible for any amounts not covered by my insurance.

DATE _____ SIGNATURE _____

PRIMARY PHYSICIAN (Family Practitioner, Internists and-or Gynecologist)

How were you referred to this office? _____

What symptoms are you having? _____

FAMILY HISTORY- has any parent, brother and-or sister had any of the following problems? (Circle YES or NO)

Bleeding Disorder	Yes	No	Peptic Ulcers	Yes	No
Colon Cancer	Yes	No	Colon Polyps	Yes	No
Other Cancer	Yes	No	Gallbladder Disease	Yes	No
Colitis	Yes	No	Crohn's Disease/ileitis	Yes	No
Diverticulosis	Yes	No	Liver Disease	Yes	No
Irritable Bowel/Spastic Colon	Yes	No	Swallowing Difficulty	Yes	No
Heart Disease	Yes	No	Diabetes	Yes	No
Tuberculosis	Yes	No	Other Serious Disease	Yes	No

Spouse's Health _____ No Of Children/Health _____

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Health Status Questionnaire

Have coughing episodes at night or early in the morning..... **Please Circle Yes or No**

YES NO

Frequently wheeze or have asthma..... YES NO

Have sleep apnea or other airway problem. YES NO

If Yes, do you use CPAP at night..... YES NO

Smoke..... YES NO

If Yes, did you smoke today..... YES NO

Drink Alcoholic beverages every day..... YES NO

If Yes, how many drinks per day..... _____

Have a heart problem or murmur..... YES NO

Have stents or filters in any blood vessels.... YES NO

Have any artificial joints..... YES NO

Need to take antibiotics before procedures. YES NO

Have anemia..... YES NO

Bruise easily..... YES NO

Bleed easily or continue bleeding for awhile. YES NO

Have a diagnosed bleeding disorder..... YES NO

Have a history of seizures, convulsions or blackout spells..... YES NO

Have diabetes..... YES NO

If Yes, do you take insulin..... YES NO

Have episodes of low blood sugar..... YES NO

Take pain medications regularly..... YES NO

Have an implanted pain medication pump..... YES NO

Use "street" drugs..... YES NO

Have a history of cancer..... YES NO

If Yes to above, please list type(s) _____

Have you had a previous colorectal cancer screening procedure..... YES NO

If Yes, what were the results of the latest colonoscopy or Sigmoidoscopy procedure(s)? Year _____ Results _____

Gynecological History

Are you Pregnant..... YES NO

Date of Last Period..... _____

Last Exam..... _____

Pre-Men

Post Men

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PROCEDURE EXPERIENCE

(Circle Yes or No)

During a procedure of any kind, have you ever had any problems with the following: YES NO

Pre-procedure prep..... Yes No

Procedure Medications (Anesthesia)..... Yes No

Procedure/Post-procedure complications..... Yes No

If Yes, Please describe the problem(s) _____

GASTROINTESTINAL SYMPTOM REVIEW

ARE YOU

Experiencing unexplained weight loss..... Yes No

Having fever or chills..... Yes No

Having Nausea..... Yes No

Vomiting regularly..... Yes No

Vomiting Blood..... Yes No

Having Heartburn Symptoms..... Yes No

Having difficulty swallowing..... Yes No

Bothered by abdominal bloating or swelling... Yes No

Having abdominal pain or discomfort..... Yes No

Constipated..... Yes No

If Yes, how many bowel movements per week _____

Having diarrhea..... Yes No

If Yes, how many bowel movements per week _____

If Yes, do you have diarrhea at night..... Yes No

Having any black, tarry stools..... Yes No

Seeing any red blood during bowel movements Yes No

Having hemorrhoid symptoms..... Yes No

Have you ever had ulcers..... Yes No

Have you had an inflammatory disease of the small bowel or colon..... Yes No

Have you had gallstones..... Yes No

Have you had pancreatic problems..... Yes No

Have you had hepatitis or other liver problems Yes No

If Yes, is your liver function currently normal. Yes No

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security#: _____

I request and authorize _____ (Name of Clinic) to release the medical records of the patient named above to:

**Barry D. Winston, M.D.
1140 Cypress Station Dr. Suite 306
Houston, Texas 77090**

This request and authorization applies to:

_____ Health Care Information relating to the following treatment, condition or dates of Treatment: _____.

_____ All health care information

_____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of Patient
(or Patient's Authorized Representative)

Date Signed

Relationship or status if signed by anyone other than patient (Parent, legal guardian, personal Representative, etc.)

Date Signed

North Houston Gastroenterology Clinic, PA
1140 Cypress Station, Suite 306
Houston, Texas 77090
www.gi-clinic.com
Main: 281-440-3618 Fax: 281-440-6573