

**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 and for imaging studies, Northwest Diagnostics Imaging. If biopsies are necessary during your procedure, the specimens are sent to North Houston Pathology Associates 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 a 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 you 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

Date

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

Name Relationship

Name Relationship

CURRENT MEDICAL CONDITIONS

CURRENT MEDICATIONS (Please include all prescription and non-prescription medications, vitamins and herbal supplements such as birth control pills, hormones, antihistamines, aspirin, ibuprofen, vitamin E, fish oil, etc.)

DRUG ALLERGIES (Please include a description of the type of reaction: rash, breathing difficulty, etc.)

PAST HOSPITALIZATIONS, SURGERIES (Please include approximate dates, if known.)

Date

Date

Date

Date

Date

Date

Date

Date

HEALTH STATUS QUESTIONNAIRE

Do you

	Yes	No
Have coughing episodes at night or early in the morning.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently wheeze or have asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Have sleep apnea or other airway problem.	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, do you use CPAP at night.....	<input type="checkbox"/>	<input type="checkbox"/>
Smoke.....	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, did you smoke today.....	<input type="checkbox"/>	<input type="checkbox"/>
Drink Alcoholic beverages every day.....	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, how many drinks per day.....	_____	
Have a heart problem or murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Have stents or filters in any blood vessels..	<input type="checkbox"/>	<input type="checkbox"/>
Have any artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>
Need to take antibiotics before procedures.	<input type="checkbox"/>	<input type="checkbox"/>
Have anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily.....	<input type="checkbox"/>	<input type="checkbox"/>
Bleed easily or continue bleeding for awhile.	<input type="checkbox"/>	<input type="checkbox"/>
Have a diagnosed bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Have a history of seizures, convulsions or blackout spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, do you take insulin.....	<input type="checkbox"/>	<input type="checkbox"/>
Have episodes of low blood sugar.....	<input type="checkbox"/>	<input type="checkbox"/>
Take pain medications regularly.....	<input type="checkbox"/>	<input type="checkbox"/>
Have an implanted pain medication pump....	<input type="checkbox"/>	<input type="checkbox"/>
Use "street" drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Have a history of cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
If Yes to above, please list type(s)_____		

	Yes	No
Have you had a previous colorectal cancer screening procedure.....	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, what were the results of the latest colonoscopy or sigmoidoscopy procedure(s)?

<u>Year</u>	<u>Results</u>
_____	_____
_____	_____
_____	_____

Have you had abnormal results on any recent labs, tests or imaging studies.....

If Yes, what were the results _____

PROCEDURE EXPERIENCE

During a procedure of any kind, have you ever had any problems with the following:

	Yes	No
Pre-procedure prep.....	<input type="checkbox"/>	<input type="checkbox"/>
Procedure medications (Anesthesia).....	<input type="checkbox"/>	<input type="checkbox"/>
Procedure/Post-procedure complications..	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, please describe the problem(s) _____

GASTROINTESTINAL SYMPTOM REVIEW

Are you

Experiencing unexplained weight loss...	<input type="checkbox"/>	<input type="checkbox"/>
Having fever or chills.....	<input type="checkbox"/>	<input type="checkbox"/>
Having nausea.....	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting regularly.....	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood.....	<input type="checkbox"/>	<input type="checkbox"/>
Having heartburn symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>
Having difficulty swallowing.....	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by abdominal bloating or swelling.....	<input type="checkbox"/>	<input type="checkbox"/>
Having abdominal pain or discomfort....	<input type="checkbox"/>	<input type="checkbox"/>
Constipated.....	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, how many bowel movements per week..... _____

Having diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
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If Yes, how many bowel Movements per day..... _____

If Yes, do you have diarrhea at night.....	<input type="checkbox"/>	<input type="checkbox"/>
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Having any black, tarry stools.....	<input type="checkbox"/>	<input type="checkbox"/>
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Seeing any red blood during bowel movements.....	<input type="checkbox"/>	<input type="checkbox"/>
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Having hemorrhoidal symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>
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Did you ever have ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
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Do you have an inflammatory disease of the small bowel or colon.....	<input type="checkbox"/>	<input type="checkbox"/>
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Have you had gallstones.....	<input type="checkbox"/>	<input type="checkbox"/>
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Have you had pancreatic problems....	<input type="checkbox"/>	<input type="checkbox"/>
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Have you had hepatitis or other liver problems.....	<input type="checkbox"/>	<input type="checkbox"/>
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If Yes, is your liver function currently normal.....	<input type="checkbox"/>	<input type="checkbox"/>
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North Houston
GASTROENTEROLOGY CLINIC, PA
HOUSTON COLON CANCER SCREENING CENTER
Setting the standards for exceptional digestive care

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