

Section I:

Patient Information

Today's Date _____

Name: _____
Address: _____ Apt or Lot: _____
City: _____ State: _____ Zip _____
Phone (_____) _____ Work Phone (_____) _____
Cell Phone (_____) _____ Email _____
Date of Birth: __/__/____ Social Security Number: ____-____-____
Employer Name: _____ FT PT Retired
Check Appropriate Box: Single Married Widowed Separated Divorced
If Student FT PT

Section II

Insurance Information

Primary Insurance Co Name _____
Network Name (if applicable) _____
ID# _____ Grp # _____ Employer _____
Name of Primary Insured _____ DOB __/__/____
Relationship to Insured _____ SSN#: ____-____-____

----- DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No

IF YES, COMPLETE THE FOLLOWING -----

Secondary Insurance Co Name _____
Network Name (if applicable) _____
ID# _____ Grp # _____ Employer _____
Name of Primary Insured _____ DOB __/__/____
Relationship to Insured _____ SSN#: ____-____-____

Tertiary Insurance Co Name _____
Network Name (if applicable) _____
ID# _____ Grp # _____ Employer _____
Name of Primary Insured _____ DOB __/__/____
Relationship to Insured _____ SSN#: ____-____-____



North Texas Gastrointestinal Associates, P.A.

2501 Scripture Street, Suite 201 • Denton, Texas 76201 • Ph: (940) 566-4720 • Fax: (940) 566-4727 • www.ntgi.com

Shawn William Panzer, M.D.

Name _____ Age _____ Date _____

REASON FOR THIS VISIT IS _____

Referring M.D. _____ Other M.D./OB GYN _____

PLEASE LIST ANY DRUG OR FOOD ALLERGIES: _____

DO YOU CURRENTLY HAVE ANY OF THESE PROBLEMS: (FILL OUT FRONT & BACK)

CONSTITUTIONAL SYMPTOMS

- Yes No
 Recent weight loss/gain
 Fever/chills

- Yes No
 Fatigue

HEMATOLOGIC/LYMPHATIC

- Yes No
 Bleeding or bruising
 Anemia

GASTROINTESTINAL

- Yes No
 Trouble swallowing
 Painful swallowing
 Gallbladder problems
 Yellow skin color/jaundice
 Abdominal pain
 Constipation
 Laxative use

- Yes No
 Poor appetite
 Hepatitis
 Hemorrhoids
 Pain with bowel movements
 Food/milk intolerance
 Hernia
 Vomiting blood

- Yes No
 Diarrhea
 Blood in bowel movement
 Acid reflux/Heartburn
 Indigestion
 Nausea/vomiting/regurg.
 Other _____

EYES

- Yes No
 Eye disease/Glaucoma
 Wear glasses/contact lens
 Blurred or double vision

EAR/NOSE/MOUTH/THROAT

- Yes No
 Nose or gum bleeds
 Mouth sores
 Bad breath or bad taste

CARDIOVASCULAR

- Yes No
 Chest pain or angina
 Palpitation
 Swelling of feet, ankles

RESPIRATORY

- Yes No
 Chronic or frequent cough
 Spitting up blood
 Shortness of breath
 Asthma or wheezing
 Sleep Apnea

GENITOURINARY

- Yes No
 Frequent urination
 Burning or painful urination
 Blood in urine
 Prostate problems
 Last menstrual period _____

MUSCULOSKELETAL

- Yes No
 Joint pain/stiffness
 Back pain
 Arthritis

INTEGUMENTARY (skin, breast)

- Yes No
 Rash or itching
 Change in hair
 Change in nails
 Unusual moles

NEUROLOGICAL

- Yes No
 Headaches/Dizziness
 Alzheimer's/Dementia
 Convulsions/Seizures
 Depression/Stress

ENDOCRINE

- Yes No
 Hormone problem
 Thyroid disease
 Excessive thirst

PAST SURGICAL HISTORY

Have you **ever had** any of the following types of surgery:

- Yes No
 Colon surgery/Colonoscopy
 Appendix
 Gallbladder
 Hysterectomy
 Tonsils
 Hiatal Hernia

- Yes No
 Hernia/Groin
 Bilateral Tubal Ligation
 Back surgery
 Prostate
 Breast surgery
 Joint replacement _____

- Yes No
 Laparoscopy
 Hemorrhoids
 Heart bypass/Stent
 Blood transfusion
 Other _____

CHRONIC DISEASE

Have you **ever had** any of these problems:

- Yes No
 Exposure to HIV/AIDS
 Ulcers
 Colon trouble
 Colitis
 Diverticulitis
 Pancreatitis

- Yes No
 Alcoholism
 Heart attack/Disease
 Stroke
 High blood pressure
 Diabetes
 Tuberculosis

- Yes No
 Emphysema
 Depression
 Arthritis
 Kidney trouble
 Prostate
 Cancer _____
 Type _____

No Show /Cancellation Policy Office Visit or Procedure

To our patients:

In the event you do not cancel/reschedule or no-show for your office visit or procedure, the following no-show/cancellation fee will be assessed:

A \$25 fee will be assessed for “no showing” or failure to give 24-hour notice of the need to cancel/reschedule all office visit appointments. Advance notice allows other patients, who may be waiting to see the doctor, to use the available appointment time.

A \$100 fee will be assessed for “no showing” or for failure to give 48-hour notice of the need to cancel/reschedule procedures.

All no-show/cancellation charges will need to be paid before another procedure or appointment is scheduled.

These fees are non-refundable.

I have read and understand the no show/cancellation policy of the practice and agree to be bound by the terms as stated.

Patient Signature

Date

Health Insurance Portability and Accountability Act - Administrative Simplification (HIPAA-AS) Notice of Privacy Practices

Our Legal Duty

As your health plan, we are required by applicable federal and state laws to maintain the privacy of your protected health information (PHI). This notice describes our privacy practices, our legal duties, and your rights concerning your PHI. We will follow the privacy practices that are described in this notice while it is in effect. This notice took effect **April 14, 2003**, and will remain in effect until a revised notice is issued.

We reserve the right to change our privacy practices and the terms of this notice at any time and to make the terms of our notice effective for all PHI that we maintain.

Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you.

How we can use or disclose PHI without a specific authorization

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice.

For Treatment: For example, we may disclose PHI in an electronic health record we create from claims information, to a doctor or hospital at their request, in order for them to provide treatment to you. Additionally we may disclose PHI to a doctor, dentist or a hospital at their request for their treatment purposes.

For Payment: For example, we may use and disclose PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may also disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.

For Health Care Operations: For example, we may use or disclose PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits and services or treatment alternatives that may be of interest to you. We may also disclose PHI to a health care provider or another health plan subject to federal privacy laws, as long as the provider or plan has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider or plan. We may also disclose PHI to other entities with which we have contracted to perform or provide certain services on our behalf (i.e. business associates).

For Public Health and Safety: We may use or disclose PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.

As Required by Law: We may use or disclose PHI when we are required to do so by law.

For Process and Proceedings: We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

For Law Enforcement: We may disclose PHI to a law enforcement official with regard to crime victims and criminal activities.

Special Government Functions: We may disclose the PHI of military personnel or inmates or other persons in lawful custody under certain circumstances. We may disclose PHI to authorized federal officials for lawful national security activities.

To Plan Sponsors, if applicable (including employers who act as Plan Sponsors): We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either:

- Obtain premium bids; or

- Decide whether to amend, modify or terminate your group health plan

For Research, Death, and Organ Donation: We may use or disclose PHI in certain circumstances related to research, death or organ donation.

For Workers' Compensation: We may disclose PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

To Family and Friends: While the law permits us in certain circumstances to disclose your PHI to family, friends and others, we will do so only with your authorization. In the event you are unable to authorize such disclosure, but emergency or similar circumstances indicate that disclosure would be in your best interest, we may disclose your PHI to family, friends or others to the extent necessary to help with your health care coverage arrangements.

Individual Rights

To exercise any of these rights, please call the customer service number on your ID card.

Access: With limited exceptions, you have the right to review in person, or obtain copies of, your PHI. We may charge you a reasonable fee as allowed by law.

Amendment: With limited exceptions, you have the right to request that we amend your PHI.

Disclosure Accounting: You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as allowed by law to respond to any additional request.

Use/Disclosure Restriction: You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are not required to agree to a requested restriction. We will agree to restrict use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a PHI address.

Note: If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.

Privacy Notice: You have the right to request and receive a copy of this notice at any time. For more information or if you have questions about this notice, please contact us using the information listed at the end of this notice.

Organizations Covered by this Notice

This Notice applies to the privacy practices of the organizations listed below:

NORTH TEXAS GASTROINTESTINAL ASSOCIATES

SHAWN W. PANZER, M.D.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:

Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Practice Contact Information:

North Texas Gastrointestinal Associates
HIPAA Compliance Officer: Kris Davis
2501 Scripture, Ste 201
Denton, TX 76201
940-566-4720

Patient Financial Policy Sheet
North Texas Gastrointestinal Associates
Dr. Shawn W. Panzer

To reduce confusion and any misunderstanding between our patients and this practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, we require full payment at the time of service. For your convenience we accept Visa, Mastercard, Discover, and American Express cards, cash or local check.

Your insurance

- It is your responsibility to know your healthcare benefits and coverage limitations.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or coinsurance that you may owe at the time of service.
- We have contracts with many major insurance carriers to accept an assignment of benefits. This means that we bill those plans for which we have an agreement and will require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. Co-payments are a contractual obligation with your insurance company.
- If you have insurance coverage with an insurance plan for which we do not have a contract with, we will send a claim for you on an unassigned basis. Consequently, you will have a higher than usual out of pocket expense and the charges for your care are due at the time of service.
- In the event your health plan determines a service as "non-covered" you will be responsible for the complete charge. Payment is due upon receipt of statement from our office. 90 days past due accounts will have a 6% finance charge applied.
- We will bill your health plan for all services provided in the hospital, whether done inpatient or outpatient. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- If you undergo a procedure, in addition to a bill from your physician, you will also receive a bill from the surgery center or hospital where the procedure is performed as well as anesthesia.
- For scheduled appointments, prior balances must be paid prior to the visit.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy for North Texas GI Associates, the office of Dr. Shawn Panzer, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms periodically.

Signature of patient or responsible party

Date

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION
TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to discuss your condition with members of your family or other individuals that you designate, we must obtain your written authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

___ I **do not** authorize North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to release any or all information concerning my medical care to any individual except as set forth above.

___ I **authorize** North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to verbally release any or all information concerning my medical care to the following individuals.

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Patient Name Date of Authorization

Print Patient Name Date of Birth Social Security Number

Witness Signature Date