REGISTRATION FORM NORTH TEXAS GASTROINTESTINAL ASSOCIATES SHAWN W. PANZER M.D.

Section I:
Patient Information **Today's Date_____**

Name:_____
Address:_____ Apt or Lot:_____
City:_____ State:_____ Zip_____
Phone (_____)_____ Work Phone (_____) _____
Cell Phone (_____)_____
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		Yes	No	
☐	☐	Recent weight loss/gain	☐	☐	Fatigue
☐	☐	Fever/chills			

HEMATOLOGIC/LYMPHATIC

Yes	No	
☐	☐	Bleeding or bruising
☐	☐	Anemia

GASTROINTESTINAL

Yes	No		Yes	No		Yes	No	
☐	☐	Trouble swallowing	☐	☐	Poor appetite	☐	☐	Diarrhea
☐	☐	Painful swallowing	☐	☐	Hepatitis	☐	☐	Blood in bowel movement
☐	☐	Gallbladder problems	☐	☐	Hemorrhoids	☐	☐	Acid reflux/Heartburn
☐	☐	Yellow skin color/jaundice	☐	☐	Pain with bowel movements	☐	☐	Indigestion
☐	☐	Abdominal pain	☐	☐	Food/milk intolerance	☐	☐	Nausea/vomiting/regurg.
☐	☐	Constipation	☐	☐	Hernia	☐	☐	Other _____
☐	☐	Laxative use	☐	☐	Vomiting blood			

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		Yes	No		Yes	No	
☐	☐	Colon surgery/Colonoscopy	☐	☐	Hernia/Groin	☐	☐	Laparoscopy
☐	☐	Appendix	☐	☐	Bilateral Tubal Ligation	☐	☐	Hemorrhoids
☐	☐	Gallbladder	☐	☐	Back surgery	☐	☐	Heart bypass/Stent
☐	☐	Hysterectomy	☐	☐	Prostate	☐	☐	Blood transfusion
☐	☐	Tonsils	☐	☐	Breast surgery	☐	☐	Other _____
☐	☐	Hiatal Hernia	☐	☐	Joint replacement _____			

CHRONIC DISEASE

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

Yes	No		Yes	No		Yes	No	
☐	☐	Exposure to HIV/AIDS	☐	☐	Alcoholism	☐	☐	Emphysema
☐	☐	Ulcers	☐	☐	Heart attack/Disease	☐	☐	Depression
☐	☐	Colon trouble	☐	☐	Stroke	☐	☐	Arthritis
☐	☐	Colitis	☐	☐	High blood pressure	☐	☐	Kidney trouble
☐	☐	Diverticulitis	☐	☐	Diabetes	☐	☐	Prostate
☐	☐	Pancreatitis	☐	☐	Tuberculosis	☐	☐	Cancer _____
						☐	☐	Type _____

OFFICE USE ONLY

LOCATION, SEVERITY, TIMING, ASSOCIATED SIGNS/SX, QUALITY, DURATION, CONTEXT (WHERE/WHEN), MODIFYING FACTORS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

▶ *PATIENT INFORMATION continued…*

FAMILY HISTORY

Has any blood relative had any of these problems:

Yes	No		Yes	No		Yes	No	
☐	☐	Colon cancer	☐	☐	GYN cancer	☐	☐	Stroke
☐	☐	Colon polyps	☐	☐	Gallbladder disease	☐	☐	Sickle Cell disease
☐	☐	Cirrhosis	☐	☐	Ulcer disease	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Diabetes	☐	☐	Mental illness
☐	☐	Alcoholism	☐	☐	High blood pressure	☐	☐	Prostate cancer
☐	☐	Breast cancer	☐	☐	Heart attack	☐	☐	Other cancer _____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widow ☐ Divorced

Yes	No		Yes	No	
☐	☐	Do you smoke? Packs per day _____	☐	☐	Homosexual/bisexual?
☐	☐	Do you drink alcohol? How much? _____	☐	☐	More than one sex partner?_____
☐	☐	Do you drink coffee? Cups per day _____	☐	☐	Used IV drugs or cocaine _____
			☐	☐	Tattoos, body piercings

LIST THE NAME AND DOSAGE OF ALL MEDICINES YOU TAKE NOW

Yes	No		Yes	No	
☐	☐	High blood pressure_____	☐	☐	Antihistamines _____
☐	☐	Stomach medicines _____	☐	☐	Hormones/birth control _____
☐	☐	Laxatives _____	☐	☐	Diabetic medication-Insulin/oral_____
☐	☐	Sleeping pills _____	☐	☐	Asprin, Advil, Ibuprofen, pain pills, etc. _____
☐	☐	Tranquilizers _____	☐	☐	Arthritis medicines _____
☐	☐	Thyroids_____	☐	☐	Heart _____
☐	☐	Antibiotics _____	☐	☐	Other _____
☐	☐	Blood thinners (Coumadin, Lovenox, Plavix, Persantine (Dipyridamole) Ticlid _____			

Patient's Signature _____ Date_____

MD Signature_____ Date_____

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Shawn William Panzer, M.D.

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

NORTH TEXAS GASTROINTESTINAL ASSOCIATES, DR. SHAWN W. PANZER, M.D.
2501 SCRIPTURE, BLDG 6, STE 201, DENTON, TX 76201
PH: (940)566-4720 FAX: (940)566-4727

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. **The right to inspect and copy your information**
2. **The right to request corrections to your information.**
3. **The right to request that your information be restricted**
4. **The right to request confidential communications**
5. **The right to a report of disclosure of your information; and**
6. **The right to a paper copy of this notice.**

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective date of this notice	**January 1, 2011**
Phone Number	**940-566-4720**

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

X_____ X _____

SIGNATURE OF PATIENT **PRINTED NAME OF PATIENT**

_____

DATE

2501 SCRIPTURE, BLDG 6, STE 201 DENTON, TX 76201
PH: (940)566-4720 FAX: (940)566-4727

Financial Responsibility:

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. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Your insurance:

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.

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.

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.

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.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to NORTH TEXAS GI ASSOCIATES for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any, I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize NORTH TEXAS GI ASSOCIATES to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from NORTH TEXAS GI ASSOCIATES on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

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.

X _____ **X** _____ **DATE:** _____

SIGNATURE OF PATIENT **PRINTED NAME OF PATIENT**

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.
- 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

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 ae 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