

Gastrointestinal Care Consultants, P.A.

Madhukar Kaw M.D. Tojo Thomas M.D. Shashideep Singhal M.D. Prianka Singapura M.D

PLEASE PRINT

Name: _____ DOB: _____ Age: _____

Sex: _____ SSN#: _____ DL#: _____ State: _____

Address: _____

Street City State Zip

Phone # (Work) : _____ (Home): _____ Cell: _____ Personal Email: _____

Employer: _____ Family Email: _____

Name Street City Zip

Occupation: _____ Marital Status: Single Married Divorced Widowed

Spouse Name: _____ SSN# _____ DOB: _____

Phone#: (work) _____ Home: _____ Cell: _____

Emergency Contact: _____

Name Relationship Phone#

Referring/Primary: _____

Physician Address Phone#

Pharmacy Name & Phone Number: _____

Preferred Lab: LABCORP OR QUEST & Phone number: _____

RESPONSIBLE PARTY (Complete if someone other than the patient is responsible)

Name: _____ Relation: _____ Phone: _____

Address: _____

Street City State Zip

Employer Address: _____ Phone: _____

Name City State Zip

PAYMENT OF FEES, INSURANCE RELEASE AND AGREEMENT

I, the undersigned assign all benefits payable to Gastrointestinal Care Consultants, P.A. I understand that I am financially responsible for all charges whether or not paid by said insurance. I am also responsible for charges at any facility, laboratory or hospital outside the office. I understand that if any unpaid portion of my personal balance becomes sixty (60) days delinquent and further collection efforts are necessary, I agree to pay all costs and attorney's fees incurred by Gastrointestinal Care Consultants, P.A. in said collection efforts. I hereby authorize Gastrointestinal Care Consultants, P.A. to obtain or release all or any information necessary to process any claim or appeal on my behalf and secure the payment of benefits.

Patient or Responsible Party Signature: _____ Date: _____

As your physician, I believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I provide this notification; I hold an ownership interest at Sugar Land Surgery Center, LLP, doing business at Sugar Land Surgery Center and ask you to sign below indicating your receipt of this notification. By my signature below, I hereby acknowledge that I have received notification of Dr. Kaw's, Dr. Thomas, Dr. Singhal's, and Dr. Singapura ownership at Sugar Land Surgery Center, LLP, doing business as Sugar Land Surgery Center.

Patient or Responsible Party Signature: _____ Date: _____

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Allergies:

List: _____

Social History:

Married Single Divorced Widowed

Occupation: _____ Children/Ages: _____

PERSONAL HISTORY

Smoking (circle) Never, Former smoker, Current someday, Current every day smoker
 _____ Pack/day For _____ Years

Alcohol (circle) Never, Former drinker, Occasional, Regular drinker, Current every day drinker
 Beer/Hard Liquor Quantity _____

Illicit Drug Use: Yes No Details: _____

Recent Travel _____

Medications:

Name	Dose	Frequency	Date Started

Family History:

(Specify relationship: i.e. Mother/Father/Sister/Brother/Aunt/Uncle/Grandmother, Maternal/ paternal etc.)

	yes	No	Relative		yes	No	Relative	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyps	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Uterine Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Cirrhosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

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CHIEF COMPLAINT:

Your past Medical History: If Yes, Give details below, if Known

yes	no		yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	GERD/Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety_____ Depression_____
<input type="checkbox"/>	<input type="checkbox"/>	Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	COPD
<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer_____
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Stricture	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal LFTs	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Vascular stent past year
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A___ B___ C___	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism
<input type="checkbox"/>	<input type="checkbox"/>	Liver Mass	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	<input type="checkbox"/>	Liver Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Liver Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Uses Home Oxygen

Surgical History: if yes, give details below, if known

yes	no		yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Lung Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic surgery	<input type="checkbox"/>	<input type="checkbox"/>	Colon surgery
<input type="checkbox"/>	<input type="checkbox"/>	Stomach surgery	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder surgery
<input type="checkbox"/>	<input type="checkbox"/>	Head/Neck	<input type="checkbox"/>	<input type="checkbox"/>	Bowel surgery
<input type="checkbox"/>	<input type="checkbox"/>	Heart bypass	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy – partial/total
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____

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Patient Name: _____

Welcome and thank you for choosing GICCPA for your medical care.

We are committed to providing you quality care, our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other areas physician's charge. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Regarding Insurance

GICCPA will file claims directly with your insurance carrier for services, which are covered benefits where benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, copays, deductibles and fees for non-covered services, when applicable, are required at the time of service. Each time you make an appointment with a GICCPA physician, it is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referrals when needed.

Please note: Your insurance carrier requires us to collect your copay at each visit.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance company has not paid within this time, you are responsible for the entire balance without the further notice. We will not become involved with dispute between you and your insurance company regarding deductibles, non-covered services, co-insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Method of Payment

GICCPA will be happy to accept cash, Visa or Master Card for payment of your medical services. A convenience fee will be applied to any other method of payment.

Cancelled Policy

In an effort to best serve our patients; for office visits we will charge a fee of \$35.00 for the cancellation/failure to keep an appointment. The fee charged for the cancellation/failure to keep an appointment of a schedule procedure will be \$50.00. Please make an effort to notify this office within 72 hours of your office visit or scheduled procedure if you must cancel or reschedule. ***A fee of \$25.00 will also be applied if a procedure is cancelled and requires a refund for any advanced payments made by debit/credit card.***

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

Date

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Insurances, Self-Pay Policy, and Referral Policy

We accept **most** major insurance carriers. Individuals who have insurances we do not accept will be considered a Self-Pay patient. There are also certain insurances we will not take without an insurance referral from your primary care provider. For more information about being a self-pay patient, or about referrals, please see below. Please also be aware, there are insurances/insurance plans we accept that deem our services as Out-Of-Network. Out-Of-Network benefits may be subject to an Out-Of-Network deductible. If you elect to be seen as a self-pay patient at the time of service you cannot later opt to use your insurance. _____ **Initial here**

We encourage you to call our office, to confirm whether or not we can accept your insurance. We will be more than happy to try and answer any questions you may have.

Self-Pay Patients:

You will be considered a Self-Pay patient if one of the following applies:

- No health insurance or
- Inactive insurance coverage or
- Having an insurance plan that doesn't cover the services we provide or
- Not obtaining an insurance referral at or before the time of service
- Election by patient to be considered a Self-Pay patient

Charges are determined based on standard medical coding and billing practices and are dependent on a variety of factors; which include the type and nature of the visit, and other services or procedures performed during the visit. Therefore, an additional bill may follow depending on the services rendered.

Also, patients who require lab work, pathology or anesthesiology services necessitated by procedures required may receive additional charges.

Referrals:

Insurance referrals are predominantly required for any HMO plan. If you are not sure if your insurance requires a referral you can do the following:

- Look on the back of your insurance card (sometimes it will list it as a requirement)
- Call insurance member services (number usually on back of card) and inquire.
- Call us, at 832-379-8603 information to get the referral process started if one is required.

How to Get a Referral:

We are more than willing to help, but it is primarily the patient's responsibility to obtain a referral from the primary care provider (PCP). To do this, call your PCP and ask to speak to someone about an insurance referral. They will ask you for the date of service and for our National Provider Identifier Number, or NPI. Please contact us to obtain the correct NPI number for the specific provider you saw or will be seeing. Once the referral is completed, we request that your PCP's office fax us a copy at 832-379-1928.

By signing below, I acknowledge I have read and fully understand the self-pay patient financial policy set forth by GICC, P.A. I agree to all the terms in the above self-pay patient financial policy. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the responsible party.

Responsible Party

Signature

Date