Arlington Gastroenterology Services

Hamid Kamran, M.D. FACG

Office 817-417-4027 • www.agstexas.com • Fax 817-417-4043

PATIENT INFORMATION **(Please Print)** **Marital Status** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** **Sex** ☐ **Male** ☐ **Female**

Name _____ _____ _____
Last Name First Name Initial

Street Address: _____ (Apt#) _____ City: _____ State: ____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Mobile Phone: (___) _____

Date of Birth: ____/___/_____ Driver's License: (State & #) _____ Social Security #: _____
MM/DD/YYYY

E-Mail Address: _____ Employer's Name: _____

Spouse's Name: _____ _____ _____ Spouse's Work#: _____
Last Name First Name Initial

RESPONSIBLE PARTY INFORMATION **(If different than patient)**

Responsible Party: _____ Date of Birth: _____/_____/_____
MM/DD/YYY

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____ Social Security #: _____

Responsible Party's Home Phone: (___) _____ Work Phone: _____

Street Address: _____ (Apt#) _____ City: _____ State: ____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Mobile Phone: (___) _____

Employer's Name: _____ Phone Number: (___) _____

INSURANCE INFORMATION

PRIMARY Insurance Name: _____ Secondary Insurance Name: _____

Insurance Address: _____ Insurance Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Insurance ID#: _____ Grp#: _____ Insurance ID#: _____ Grp#: _____

Relationship to Insured ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** Relationship to Insured ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

PATIENT'S REFERRAL INFORMATION

Name of PCP: _____ and Referring Physician (if different) _____

EMERGENCY CONTACT **(not living with you)**

Emergency contact Name: _____ Relationship: _____ Contact Ph#: _____

PHARMACY PREFERENCE

Name: _____ Phone #: _____

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PATIENT MEDICAL INFORMATION

NAME: _____ **DATE:** _____

WEIGHT (LBS): _____ **HEIGHT:** _____**feet** _____**inches**

Do you have, or have you ever experienced the following? ***Check (Y) Yes or (N) No***

Y	N		Y	N		Y	N	
		Abnormal Bleeding			Diabetes			Jaundice (Yellow)
		Alcohol Abuse			Difficulty Breathing			Kidney Problems
		Artificial Valves			Drug Abuse			Liver Disease
		Artificial Bones/ Joints			Emphysema			Mitral Valve Prolapse
		Arthritis			Epilepsy			Pacemaker/ Defibrillator
		Asthma			Fainting Spells			Radiation Treatment
		Blood Pressure (High)			Glaucoma			Rheumatic Fever
		Blood Pressure (Low)			Headaches			Scarlet Fever
		Blood Transfusion			Heart Attack			Seizures
		Cancer			Heart Murmur			Sinus Problems
		Chemotherapy			Heart Surgery			Stroke
		Chest Pain after Exercise			Hepatitis			Thyroid Problems
		Colitis			HIV/ AIDS			Tuberculosis (TB)
		Congenital Heart Disease			Hospitalized			Ulcers/Stomach Disease

Please list any serious medical condition(s) you have experienced:

_____

_____

Please list name of medications you are currently taking:

_____

_____

Please list any drug allergies:

_____

_____

Are you taking any of the following? ***Check (Y) Yes or (N) No***

Y	N		Y	N		Y	N	
		Acetaminophen			Blood Pressure Meds			Nitroglycerin
		Antibiotics			Blood Thinners			Recreational Drugs
		Antidepressant			Cold Remedies			Steroids/ Cortisone
		Antihistamines			Digital/ Heart Medication			Thyroid Medicine
		Aspirin			Insulin/ Diabetes Medication			Tranquilizers

What problems or symptoms did you come to see the doctor about today?

_____

_____

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Please PRINT AND complete ALL sections below!

May we speak to anyone else regarding your medical condition? ☐ Yes ☐ No

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Health Insurance Portability & Accountability Act (HIPAA)

• I have been provided the opportunity to review the Notice of Privacy Practices, I, the undersigned, authorize Arlington Gastroenterology Services, to send/ receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R, Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories and other medical caregivers for the coordination of care for the patient listed below. I may revoke this authorization within five (5) days with a written notice to Arlington Gastroenterology Services.

Assignment of Benefits-Financial Agreement

• I hereby authorize payment of insurance benefits to be made directly to Arlington Gastroenterology Services any for services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance carrier. I also authorize Arlington Gastroenterology Service to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be considered valid just as the original.

NOTICE

• Time slots for office visit and procedures are allocated per patient agreement. As a courtesy, a three (3) business day notice (procedures) and two (2) business day notice (office visits) must be provided to our office in order to properly allocate those available time slots. In the event that a timely notification is not provided to the office, the patient will be responsible for any and all appropriate charges.

• Indicate where you can be reached during business hours: ☐ Home ☐ Work ☐ Cell

• May we leave a message? ☐ Yes ☐ No

Patient Name: _____

Authorized Signature: _____ **Date:** _____

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Please Initial Each Line

We are committed to providing you and your family with the best possible care. In order to achieve this, we want you to understand our financial policy. Below we have provided detailed information pertaining to this policy. ALL or only some of the policy may apply to you and your current situation and may also depend on what you are being seen for.

_____I understand that it is my responsibility to ensure that AGS has my current billing and insurance information. I will also inform the office of any changes.

_____I understand that Dr. Kamran has a contractual agreement with my health plan to collect any and all monies at the time of service. We are required to report any non-payment to your insurance company.

_____I understand that AGS is a provider for many managed care plans. We will file claims to those plans that we participate in and will require you to pay your copay/deductible/coinsurance at the time of the visit. Please be advised, if we have not heard from your insurance company within 60 days, the balance will become the patient's responsibility.

_____I understand that AGS will make every effort to help you with your referral from your primary care physician (if one is required) however it is the patient/guardian's responsibility to confirm that we have a current and valid referral. Physicians are permitted to treat ONLY the conditions listed on the referral.

_____I understand that AGS will file Medicare and a secondary/supplemental policy. You will receive a bill for any services approved by Medicare, but not paid by your secondary or supplemental plan. This is true also with other primary and secondary insurances.

_____I understand that full payments for services are due at the time of services are rendered for all self-paying patients. (Patients with either no insurance, or we are out of network with insurance. We accept cash, check, or credit cards)

_____I understand that AGS is **NOT** providers for Medicaid or any Medicaid Private Insurance Plans. AGS will only accept Medicaid patients as self-pay and all money will be collected at time of service. AGS will NOT file any claims to Medicaid as primary or secondary insurance.

PATIENT NAME: _____ DATE: _____

_____I understand that there is a $35.00 return check fee for NSF checks returned unpaid from your financial institution. Payment for a return check will be due by cash or money order. Failure to respond to return check will be turned over to the District Attorney's office for collections.

_____I understand that there is a $50.00 fee for AGS to complete any Disability, FMLA forms or any other work/school forms. For copies of medical records, there is a $25.00 fee for the first 20 pages and then $0.50 for each additional page. Fee is payable prior to completion of forms.

_____I understand that my balance over 90 days aging will be sent to a collection agency and I will be responsible for all collection fees, interest and legal expenses associated with any collection efforts.

_____I understand that there will be a $50.00 charge applied to all appointments not cancelled or rescheduled at least 24 hours before the appointment.

Procedures:

_____I understand that if my physician has sent me to AGS for a Screening Colonoscopy and during the course of the procedure, the doctor finds a medical condition that requires treatment, my diagnosis will change. This means that the Screening Colonoscopy may now become a Diagnostic Colonoscopy and will be billed as such.

_____I understand that a Screening Colonoscopy may be covered at 100% only if the patient is at least 45 years of age, has no current gastrointestinal diseases or symptoms, has no personal or family history of colon polyps and/or cancer and has been at least 10 years since last colonoscopy.

_____I understand that if I am scheduled for an outpatient procedure, that the deposit for my procedure is an estimate of what I owe and NOT A GUARENTEE of my full financial obligation to AGS. If a refund is due to you (the patient) one will be given to the responsible party.

_____I understand that I must give 72 hour notice (3 business days) notification to Cancel or Reschedule my procedure. Failure to do so will result in a $100.00 late fee. Only one reschedule will be permitted before you are required to schedule an appointment with AGS for re-evaluation.

NOTE:

In an effort to keep patients informed, please be aware that you may receive a separate bill from the following facilities:

1. Surgical Facility
2. Anesthesia
3. Pathology Labs

PATIENT NAME: _____ DATE: _____

Phone Calls:

If you are experiencing a medical emergency call 911 or go the nearest emergency room.

Please be sure to leave a number where you can easily be reached when you leave a message. We make every attempt to return each call on the same day. At times, however, our call volume can get so high that your call may not be returned until the next day.

Phone calls after 3:00 pm will be returned the following day.

_____I understand the due to costs involved with managing after hours call, it has become necessary to institute a nominal charge of $30.00 for these non-emergent, after hours phone calls per patient assessment, per call. This fee will not be charged to insurance, but will be posted to your account at the office. This charge will not apply to calls due to errors on our part, such as prescription that did not transmit to the pharmacy.

Prescription Refills:

We encourage our patients to be pro-active in their health care and seek needed refills on a timely basis. Because prescription refills require authorization by your provider, we ask that you allow 72 hours to obtain refills. The following information will be needed:

1. Patient's Name and Date of Birth
2. Patient's phone number
3. Name and dose of medication
4. The frequency the medicine is taken
5. Pharmacy name, location and phone number

Please also note the following with regard to prescription refills:

1. Patient are encouraged to call their pharmacy to verify their prescription is ready
2. Due to limited staffing, routine prescription requests will not be processed after hours or over the weekends
3. Medication will not be called in for individuals who are not active patients
4. If it has been 6 month since you were last seen by a Physician, you must schedule an appointment before a prescription will be refilled

_____I understand the prescription notice and that I need 72 hours for prescriptions to be refilled

PATIENT NAME: _____ DATE: _____