Radha Tamerisa MD
25230 Kingsland Blvd Suite 102 Katy, Texas 77494
P: (281) 869-3009 F: (832) 437-5182

DEMOGRAPHICS FORM
PLEASE PRINT CLEARLY

Patient Name: _____DOB: _____ Gender_____

Social Security # _____-_____ -_____ Marital Status: _____

Address: _____

Cell Phone #: _____ Home/Work Phone #_____

Patient Email Address_____

Race: _____ Ethnicity: _____ Language: _____

Employer: _____

Pharmacy (Name, Address/Cross Street & Phone): _____

Primary Care Doctor Name & Phone #: _____ or circle: None

Referring Doctor Full Name & Phone #: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____Is this person an existing patient of ours? Yes No

Primary Insurance Company Name: _____ Policy #: _____

Primary Policy Holder Name: _____DOB: _____

Relationship to Patient: _____ Primary Policy Holder SS # ____-____-_____

Secondary Insurance Company Name: _____ Policy #: _____

Which is the best method to contact you? _____

May we contact you via text? Yes or No

Would you like to register for our patient portal? Yes or No

Print Patient Name: _____

Signature of Patient or Representative: _____ _____
Date

If Representative, Name and Relationship to patient: _____

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FOR KATY INTEGRATIVE ASTROENTEROLOGY

It is the patient's responsibility to provide us with the most current insurance and billing information. This includes but is not limited to new insurance policies, referrals from the patient's PCP (if required) insurance, insurance policy changes, new identification cards, etc. If the patient fails to provide accurate insurance information in a timely manner, the insurance company may deny the claim.

If claim has been denied, the patient will be financially responsible for the services rendered. We must emphasize that, as medical providers, our relationship is with the patient, and not the patient's insurance company. It is the patient's responsibility to know and understand the coverage for level of services under the patient's insurance plan. We encourage all patients to contact their insurance companies, Employers, or Benefits Coordinators before services have been rendered to understand proper coverage.

Payment for services is due in full at the time services are rendered. **Katy Integrative Gastroenterology** may accept assignment of insurance after verification of coverage. Please be aware that some or perhaps all of these services provided may not be covered in full by the patient's insurance company. It is the patient's responsibility to obtain referrals from their PCP if required by insurance. If referrals are invalid or expired, or if insurance policies are termed, inactive, or within a Grace Period, the appointment may result in cancellation or will be subject to Self Pay rates: $250 for Initial Consultations, and $150 for Follow Up visits.

Most procedures are considered to be outpatient surgeries and are therefore scheduled at outpatient surgery centers. If a procedure is scheduled at Zazen Surgery Center, our team will work diligently to ensure that patients scheduled at Zazen Surgery Center meet certain requirements in order to avoid financial hardships. Patients who do not meet the criteria, may be scheduled at a different facility. The providers are credentialed with multiple surgery centers which may be considered as " **in network** facility". Patients considered "high risk" may be scheduled in a hospital setting.

Payment for the professional components of the fees for all procedures are collected at the time of scheduling. Payments must be collected 48 hours prior to procedure or may result in cancellation. **Katy Integrative Gastroenterology** will bill the insurance companies ONLY for the professional component of the fees (Physician Fee) for procedures. In addition to the professional fee, the following components may apply and are billed separately:
i)**Pathology Fees**- if biopsies are taken
ii)**Anesthesia Fees**- if anesthesia services are rendered.
iii)**Hospital or Surgery Center Facility Fees**

Katy Integrative Gastroenterology utilizes the services **of Enhanced Revenue Solutions** for billing services. For questions pertaining to statements, claims, balances, and all other billing matters, please contact them directly at 281-943-2800.

CANCELLATION POLICY AND FEES

Katy Integrative Gastroenterology makes several attempts to remind patients of their appointments via phone calls, text, and email to confirm appointments and procedures in advance. As a result, in an effort to best serve our patients, there is a fee of $35.00 for **appointments** cancelled without 24-48 hours notice. If a patient cancels or reschedules 3 or more times in a row within a calendar year, a $35 fee will be collected prior to scheduling. Failure to notify us of a cancellation, or a **"No Show"**, will result in a $35 fee that must be collected before rescheduling. There is a fee of **$150.00 for procedures** cancelled without a 24 hours notice. If a patient cancels or reschedules 3 or more times in a row within a calendar year, a $150 fee will be collected prior to scheduling. Failure to notify us of a cancellation, or a "**No Show**", will result in a $150.00 fee that must be collected before rescheduling.

Please make every effort to notify this office within 24-48 hours of your appointment if you must cancel or reschedule to avoid penalties. I acknowledge that I have read and understand the financial policy for outpatient procedures.

Signature of patient: _____ Date: _____

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MEDICATION LIST AND SURGICAL HISTORY

Name:	
Phone:	
DOB:	

Allergic to any medications?	**Describe Reaction:**

LIST ALL THE MEDICINES YOU ARE CURENTLY TAKING: Prescribe or over-the-counter medication (example: aspirin, antiacids) and herbals (example: ginseng, gingko).

DATE	NAME OF MEDICATION & DOSE	DIRECTIONS:	Reason for taking	Date Stopped

LIST OF ALL SURGERIES:

DATE	TYPE OF SURGERY	PROVIDER'S NAME

PHARMACY NAME: _____**PHONE:** _____

Print Name: _____

Signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize the following practice:

Name of Hospital/Provider: _____

Phone Number: _____ Fax Number: _____

To release or obtain the patient's medical records requested below to:

Katy Integrative Gastroenterology
Dr. Radha Tamerisa
Chelsea Beiser, PA; Lissette Diaz, PA
25230 Kingsland Blvd, Ste 102
Katy, TX 77494
Phone: 281-869-3009 Fax: 832-437-5182

This request and authorization applies to the release of records indicated below. **If more than 20 pgs. please mail.**

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.

For Office Use Only **□ Request to Obtain Records** **□ Release Records**

□ Consult Notes	**□ Operative Notes**	**□ ER Records**	**□ Colonoscopy Report**	**□ EGD Report**	**□ Pathology Results**
□ Labs	**□ CT Results**	**□ Ultrasound Results**	**□ MRI Results**	**□ Pill Cam**	**□ All Records** Continuation of Care
☐ Other:					
Note to office:					

Print Patient Name: _____

Signature of Patient or Representative: _____Date _____

If Representative, Name and Relationship to patient: _____

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Acknowledgement of Review of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy Regarding my protected health information. The information obtained by **Katy Integrative Gastroenterology** can and will be used to:

●Conduct, plan and direct treatment - (in person, virtual, or over the phone)

- Please be advised -Audio calls 5 minutes or longer will be billed to your insurance carrier (copay or deductible may apply)

●Obtain payment from third party payers

●Conduct normal healthcare operations such as quality assurance

I have had the opportunity to read and understand the **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I also understand **Katy Integrative Gastroenterology** has the right to amend this notice and that I am entitled to an updated copy of this notice if requested.

I understand that I may request in writing that **Katy Integrative Gastroenterology** restrict how my health information is used or disclosed to carry out treatment and healthcare operations. However, I understand that the facility may not accept these requested restrictions, but if accepted must abide by treatment. I understand that I have the right to review and copy my health information and request a change to any information that I believe is not a complete list of each disclosure of my protected health information.

Ok to leave a message on my primary number? ___ Yes ____ No, If yes, preferred phone #: _____

Ok to email me: ___ Yes ___ No, If yes, Email address:_____

I authorize my records to be discussed with or picked by:

- Patient ONLY
- Other

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

I understand that I may revoke or terminate this authorization at any time by submitting a written request to Katy Integrative Gastroenterology.

Print Patient Name: _____

Signature of Patient or Representative: _____Date _____

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Have you experienced any of the following symptoms within the last 2 weeks?

General:	❑Fever/Chills ❑Fatigue ❑Headaches ❑Appetite change ❑None		**Musculoskeletal:**	❑Joint pain ❑Back pain ❑Joint swelling ❑Muscle swelling ❑Muscle weakness ❑None
ENT:	❑Sinus congestion ❑Sore throat ❑Nose bleeds ❑Hearing loss ❑Mouth sores ❑Trouble Swallowing ❑Dental problems ❑Hoarseness ❑None		**Skin:**	❑Color change ❑Wound ❑Rash ❑Itching ❑None
Respiratory:	❑Chest tightness ❑Wheezing ❑Shortness of breath ❑Cough ❑None		**Neurologic:**	❑Dizziness ❑Light-headedness ❑Numbness ❑Seizures ❑Speech difficulty ❑Fainting ❑Weakness ❑Confusion ❑None
Cardiovascular:	❑Chest pain ❑Leg swelling ❑Palpitations ❑None		**Hematologic (Blood):**	❑Swollen lymph nodes ❑Bleeds/bruises easily ❑Anemia ❑None
Genitourinary:	❑Difficulty urinating ❑Kidney stones ❑Flank pain ❑Blood in urine ❑Urinary incontinence ❑Dysuria (painful urination) ❑None		**Behavioral/ Psychological:**	❑Agitation ❑Behavior problem ❑Self-injury ❑Nervous/Anxious ❑Decreased concentration ❑Difficulty sleeping ❑None

Print Patient Name: _____

Signature of Patient or Representative: _____Date _____

If Representative, Name and Relationship to patient: _____