PRE-COLONOSCOPY PATIENT QUESTIONNAIRE

This form is intended for HEALTHY PATIENTSONLY,who arenot experiencing ANYGIsymptoms.Ifyou are experiencing GI symptoms or symptoms listed below, please call the office to schedule an appointment at 281-869-3009 option 1.

❑ Difficulty swallowing ❑ Abdominal Pain ❑ Diarrhea ❑ Heartburn/Acid Reflux ❑ Blood in Stool ❑ Ulcers ❑ Change in Bowel Movements and/or habits ❑ Hiatal Hernia ❑ Abnormal Weight Loss ❑ Black Stool ❑ Nausea/Vomiting ❑ Constipation

If you see any of the following physician(s), please stop filling out forms and call the office to schedule an appointment:

- Cardiologist *Pulmonologist *Neurologist *Nephrologist

Colonoscopy is a relatively short and safe procedure. However, as with any medical procedures, complications are possible (for details, please read the included brochure "COLONOSCOPY "). To minimize the risk of unexpected events or possible complications, please read carefully and complete the questionnaire below. It is important that you answer all questions as accurately as possible. Answers to questions 9 and 10 will be updated at colonoscopy by your physician. At that time, you will also be examined, and you will have the opportunity to discuss any important issues with your physician.

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** _____ **Age:** _____**Sex:** _____ **Ethnicity**: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Race:** _____

Preferred Language: _____ **Home Phone:** _____ **Cell Phone:** _____

E-mail address: _____

Emergency contact: _____ **Relationship:** _____ **Phone**:_____

First and Last Name of Referring physician: _____ ❑ Ido not have a referring physician

INSURANCE INFORMATION

❑ Check here if you DO NOT have health insurance and you will take full responsibility for medical expenses!

Name of **PRIMARY** insurance: _____**Policy/Member ID**: _____ **Group Number:** _____

Address of **PRIMARY** insurance: _____ Phone Number: _____

SECONDARY Insurance: _____ **Policy/Member ID:** _____ **Group Number**: _____

Address of **SECONDARY** insurance: _____Phone Number: _____

Responsible Party (if other than you): _____Relationship: _____ DOB: _____

PATIENT HEALTH INFORMATION		
Height: Ft:_____ In:_____ Weight:_____ lbs.		
GENERAL HISTORY		
(*Please circle the correct answer (YES or NO) and check all boxes with positive answers to the respective question)*		
1. Are you allergic to any medications?	YES NO	**If YES**, list all medications: _____
2. Do you currently smoke?	YES NO	If you smoked in the past, when did you quit: _____
3. Do you drink alcohol?	YES NO	**If YES**, for how many years: Number drinks/day ___
4. Have you ever been diagnosed with colorectal cancer?	YES NO	If YES, when was the diagnosis made (date)_____
4a. Did you have colonoscopy(s) performed after diagnosis of colorectal cancer?	YES NO	**If YES**, when was your last colonoscopy _____
5. Do you have a family history (first-degree relatives) of **colon cancer?**	YES NO	**If YES**, check all the relatives with polyps and/or cancer: ❑ Mother, at age_____ ❑ Father, at age___ ❑ Brother, at age____ ❑ Sister, at age___
5a.Do you have a family member(s) with **colon polyps** removed.	YES NO	❑ Child, at age_____ Explain: _____

PREVIOUS HISTORY OF COLONOSCOPIES AND ABDOMINAL DISEASES		
6. Have you ever had a **full colonoscopy** with sedation? **If YES**, how many colonoscopies? _____ **When did you have your last colonoscopy ____**	YES NO	**If YES**, did you have any complications including: ❑ abdominalpain❑ fever ❑ nausea/vomiting ❑ bowel perforation ❑ abdominal gas/bloating ❑ rectal bleeding after the procedure ❑ other (describe)
7. Have you ever had **polyps removed** during colonoscopy?	YES NO	**If YES**, how many times_____ ● Dateoflastcolonoscopyandlast provider performed by: _____ ● How many polyps removed at the last colonoscopy _____ Additional comments:
8. Have you ever been diagnosed and treated for **any cancer of an abdominal organ** (including prostate, ovary, uterus, liver, gallbladder, pancreas, small bowel, stomach, and abdominal lymphoma)?	YES NO	**IfYES**, which organ was involved: _____

9. Have you had any of the **abdominal surgeries** listed below? Please include month and year of surgery:

❑ Cholecystectomy (removal of the gallbladder) when_____ ❑ Appendectomy (removal of the appendix) when: _____

❑ Hysterectomy (removal of the uterus) when: _____ ❑ Hernia repair, when: _____

❑ C-section – How many and when: _____

❑ Other not listed (please describe briefly) _____

MEDICATIONS YOU CURRENTLY TAKE (Prescribed or Over the Counter) AND PAST MEDICAL HISTORY

10. List **all** medications you have been taking **within the last month** (including "as needed" basis, supplements and over the counter):

_____

11. Specifically, **within the 2 last weeks you have** at least taken any of the following blood thinners, diabetes or weight loss medication, if yes, please discontinue filling out forms and call the office to schedule an appointment.

❑ Aspirin, Ibuprofen, Advil, Naprosyn, Voltaren, Aleve or similar anti-inflammatory medications ❑ Coumadin (Warfarin) ❑ Heparin ❑ Lovenox (Enoxaparin) ❑ Plavix (Clopidogrel) ❑ Ticlid (Ticlopidine) ❑ Pradaxa ❑ GLP-1 ❑ Mounjaro

❑ Wegovy ❑ Ozempic ❑ Saxenda ❑ Semaglutide

12. Do you have or ever been treated for any of the following disorders:

Asthma	YES NO	Loss of consciousness	YES NO
Diabetes	YES NO	Irregular heartbeat	YES NO
Insulin Dependent	YES NO	Abnormalities in blood clotting	YES NO
Stroke/TIA	YES NO	Crohn's disease or ulcerative colitis	YES NO
Heart attack	YES NO	Seizures	YES NO
Emphysema	YES NO	Hypertension or High Blood Pressure	YES NO
Sleep Apnea	YES NO	Chest Pain	YES NO
Anemia: When_____	YES NO	Shortness of Breath	YES NO

PAST HISTORY OF HEART DISEASES

13. Have you ever had heart or lung surgery? YES NO

14 Do you have a pacemaker? YES NO ------ Have you ever had an abnormal EKG? YES NO

15. Do you have an implanted defibrillator? YES NO

16. Do you have an artificial heart valve? YES NO

17. Have you ever had endocarditis? YES NO

18. Have you had coronary artery disease, arrhythmias, Congestive Heart Failure? YES NO

19. Do you have any loose/capped teeth or dentures? YES NO Have you ever been given antibiotics before dental or surgical procedures? YES NO

20. Do you have any bleeding disorders or anemia? Have you been diagnosed with Anemia within the past 12 months? YES: when: _____ NO

21. Do you have Thyroid disease? YES NO

22. Have you undergone chemotherapy or radiation? YES NO

23. Is there any chance you could be pregnant? YES NO Date Last menstrual period? _____

24. Have you or a family member ever had a problem with an anesthetic other than nausea? YES NO _____

25. Do you have a cold, cough or have any breathing difficulty? YES NO _____

26. Do you have any prosthetic devices? YES NO _____

27. Do you have back, neck, or jaw problems? YES NO _____

28: Do you have kidney disease? YES NO _____

29. Have you ever had Hepatitis or HIV? YES NO _____

30. Do you have any other medical conditions not listed above: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____ City: _____ State: _____ Zip Code: _____

Please, carefully review all your answers above. **If you are uncertain about some of the answers, leave the space blank or place a question mark. You will have the opportunity to clarify these issues later, during a short interview with a member of our staff.** *If you have any questions or additional information you would like to share with us at this time, please write them in the space below.*

PATIENT CONSENT AND ACKNOWLEDMENT

I have reviewed the above Pre-Colonoscopy Patient Questionnaire, and I have answered all the questions to the best of my knowledge. I understand that incomplete or false information may result in unexpected complications related to the colonoscopy procedure itself or to the conscious sedation. These complications, which may happen even with your excellent health, may include abdominal pain and bloating, bleeding, bowel perforation, and reaction to medications.

I also understand and accept the fact that my colonoscopy may not be completed due to inadequate preparation of the colon, my reactions to the medications used for conscious sedation, or excessive risk for complications as decided by the performing physician before or during the procedure. In such a case, I may choose to have another colonoscopy at different times, or to have barium enema – a radiological procedure (X-ray) during which a liquid contrast material is used to evaluate colon for presence of polyps and cancers. However, barium enema is generally less sensitive to detection of small polyps and masses than colonoscopy, may be uncomfortable, and does not allow removal of detected lesions.

Finally, I may choose not to have any follow-up screening procedure, and I understand the possible risks of such a decision.

Patient Signature _____ Date _____

Print Name _____ DOB _____

I have seen Dr. Radha Tamerisa in the past and she has performed my colonoscopy (circle one): ❑ YES ❑ NO

Once you have completed the following PRE-COLONOSCOPY PATIENT QUESTIONNAIRE, PLEASE EMAIL FORMS TO:

PROCEDURE@DRTGASTRO.COM

PLEASE ATTACH A COPY OF YOUR PICTURE ID AND A COPY OF YOUR INSURANCE CARD

We will contact you once our office has received and reviewed your Questionnaire (please allow 10 days). At that time, we will discuss with you the preparation needed for the procedure, date and possible time of the procedure as well as the location of the endoscopy suite. **If you have any questions, please call the office at 281-869-3009, option 3 for procedure scheduling.**

Consent Form

Consent to Treat: I hereby authorize Katy Integrative Gastroenterology a Division of American Gastro Health to examine me, the patient, and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate by today's standards. I authorize and give my consent to Katy IntegrativeGastroenterologyaDivisionofAmericanGastroHealthtosubmitspecimens(blood,urine,tissue,etc.)tothelaboratory(ies)of choice for analysis and study to include submission for payment to the insurance carrier for the named patient. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

Assignment of Benefits: I hereby allow Katy Integrative Gastroenterology a Division of American Gastro Health to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

Release of Information

I authorizereleaseanddisclosureofalloranypartofmymedicalrecordtoanypersonorentity(orrepresentativethereof)whichmaybe responsible for paying for any portion of the charge incurred, including but not limited to any private insurer, government program, workers compensation payer, employer, or family member. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care.

I alsoallowKatyIntegrativeGastroenterologyaDivisionofAmericanGastroHealthtoobtainmedicalrecordsfromothersourcesifneededfor my medicalcare.Aphotocopyofthisreleaseshallbeconsideredvalid.Nopersonorentityshallbeliablefordisclosingrecordsinthegoodfaith belief thatdisclosureisauthorizedbythisrelease. Thisreleasemaynot berevokedasto anyrecordsrelatingto servicesprovidedduringthis course of treatment.

Advance Beneficiary Notice

Many insurance companies will ONLY pay for services that it determines to be "reasonable and necessary". Therefore, certain procedures are excluded from their program. I accept personal responsibility for payment of charges for services rendered to me by Katy Integrative Gastroenterology a Division of American Gastro Health.

I understandasacourtesyKatyIntegrativeGastroenterologyaDivisionofAmericanGastroHealthdoesfileinsuranceclaimsforhospitalcharges and specialprocedures.However,thisdoesnotalleviatemyobligationtosettletheaccountinfullintheeventmyinsurancecompanydelaysor denies the charges. Statement of Ownership Disclosure, in order to allow you to make a fully informed decision about your health care, the physicians of Katy Integrative Gastroenterology a Division of American Gastro Health would advise you, the patient, that he/she may have a financial interestorownershipin oneor moreofthefollowinghealthcareproviders:Memorial HermannKingslandSurgeryCenter, MD Gastroenterology Anesthesia, Curbside Infusion, and Mangini-Lakhia & Associates. These providers may or may not be in-network with your health plan.Youhave therightto choosetheprovider ofyour healthcareservices. At somepoint duringyourcare, medical services, laboratory, pathology, anesthesiaorother treatmentmaybeperformedbyoneormoreoftheproviderspreviouslylisted.

Therefore, youhave theoptionto usea healthcareprovider other thanthoselistedabove. Youwill not betreateddifferentlybyyour physicianif you choosetoobtainhealthcareserviceswithanotherprovider/facility.

I understandthataspartofmycare,thisclinicmayrecommendtheuseofdietary supplements,includingbutnotlimitedtovitamins,minerals, herbal preparations, and other nutraceuticals, as well as functional medicine approaches aimed at supporting overall health and addressing underlying causes of illness. We may recommend sources of high-quality supplements, but you are welcome to purchase them anywhere. I acknowledge that the use of dietary supplements is considered complementary and is not intended to replace conventional medical treatments. Supplements may have potential side effects, interact with medications, or are not suitable for everyone. Functional medicine recommendationsareindividualizedandmay include lifestylechanges, nutritionplans, mind-body interventions, andlabtestingthat may not be recognized by or coveredbyinsuranceproviders.

While functional medicinemayofferbenefitsforchronicconditionsandgeneralwellness,itsefficacymayvary,andnotalltreatmentsare supported by conventionalmedicalconsensus.IunderstandthatIamundernoobligationtofollowanyspecificrecommendationandmaydiscuss any concerns or alternativeoptionswithmyprovider.Igivemyinformedconsenttoparticipateincarethatmayincludetheuse of supplements and functional medicine strategies, and I agree to inform the provider of any changes in my health status or medication use.

AI SCRIBE:

We want to assureyou thatyourprivacyisourutmostpriority.TheAItooladheresstrictlytoHealthInsurancePortabilityandAccountabilityAct (HIPPA) complianceguidelinestoensureyourdataissecuredandprotected.Onythehealthcareprofessionalsinvolvedinyourcarewillhave access to these notes.

CONSENT:

I acknowledge that I have discussed or have had the opportunity to discuss with my provider(s) the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for any future consultations or visits required.

PRIMARY CARE PHYSICIAN

Please note that **we are not your primary care physicians**. We recommend that you have a primary care physician. Please do not stop your prescription medications without consulting with your prescribing physician.

I have read the consent form and the above information, and I accept theconditions.

Print Patient Name: _____ Signature: _____ Date _____

Katy Integrative Gastroenterology aDivision of American Gastro Health
Acknowledgement of Reviewof Notice of Privacy Practices

Notice of Privacy Practices (HIPAA)

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

- Conduct, plan, and direct treatment (in person, virtual or over the phone). Please be advised that audio calls of 5 minutes or longer will be billed to your insurance carrier (*copays or deductible may apply).*
- Obtain payment from third-party payers
- Carry out healthcare operations, including quality assurance. Katy Integrative Gastroenterology a Division of American Gastro Health has the right to amend this notice and that I am entitled to an updated copy of this notice if requested.

I acknowledge that I have had the opportunity to read and understand the Notice of Privacy Practices, which describes in detail how my health information may be used and disclosed.
I understand that:

- I may request restrictions on how my PHI is used or disclosed, though the practice is not required to agree.
- I may review and obtain copies of my PHI.
- I may request amendments to my health information if I believe it is inaccurate or incomplete.
- I may request a list of certain disclosures of my PHI.

Administrative Policy & Fees

- Medical records may be faxed to another physician's office at no charge with a valid signed release.
- Hard copies of medical records are subject to a $25 administrative fee for first 20 pages and $0.50 for each additional page. If you choose email delivery, there will be no charge.
- Administrative forms (MLA, Disability Forms, etc.) completed by the physician are subject to a $25 administrative fee.

Third-Party Billing

- Providers may order diagnostic tests (labs, imaging, specialty testing) from outside facilities.
- It is the patient's responsibility to verify in-network coverage and benefits.
- Katy Integrative Gastroenterology a Division of American Gastro Health does not obtain insurance verification or submit claims for third-party services.
- If insurance denies the claim, the patient is financially responsible.

Procedures & Surgery Center Policies

- Most procedures are considered outpatient surgeries and scheduled at affiliated surgery centers.
- We utilize Memorial Hermann Kingsland Surgery Center for most patients and alternatively Memorial Hermann Katy Hospital, based on clinical necessity.
- Professional fees are collected at scheduling and must be paid at least 48 hours prior to the procedure.
- In addition to physician fees, separate charges may apply for:
  - Pathology (biopsy) fees
  - Anesthesia services
  - Hospital or surgery center facility fees

For billing questions, contact the office at 281-869-3009.

Cancellation Policy & Fees

We make every effort to remind patients of appointments and procedures via phone, text, or email.

- Office Visits:
  - $50 fee for cancellations without 24 hours' notice or No-show visits
  - Repeated cancellations (3 or more per year) require prepayment of the fee before rescheduling
- Procedures:
  - **$150 fee for rescheduling or cancellations without 5 business days' notice.**
  - **Repeated cancellations (3 or more per year) require prepayment of the fee before rescheduling.**

Please notify us at least 5 business days in advance to avoid penalties.

Patient Acknowledgement
I acknowledge that I have read and understand the Notice of Privacy Practices and the Financial Policy of Katy Integrative Gastroenterology a Division of American Gastro Health. I understand that these terms may be updated or amended by the practice without prior written notice. This form also gives us written consent for any virtual appointments with our providers.

I understand that I may request in writing that Katy Integrative Gastroenterology restricts 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: _____
Iauthorize my records to be discussed with or picked by:

oPatient ONLY **o Other**

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Do you have a living will or Medical Power of Attorney? Living Will_____ OR Power of Attorney _____

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

Print Patient Name: _____ Date _____