LIVER ASSOCIATES OF TEXAS, P.A. Patient Registration

PATIENT INFORMATION

Patient Name (Last, First, MI): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____

Work Telephone: _____

Alternate Telephone: _____

DOB: _____/_____/_____ Social Security # _____

Marital Status: Single Married Other

Gender: Male Female

Employed: YES NO Retired

Employer: _____ Start Date: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Ethnicity: Caucasian African American Hispanic Asian Other _____

Email Address: _____

INSURANCE INFORMATION

It is important that the information below be completed in order to file with your insurance carrier

Primary Insurance Company: _____

Policy Holder Name: _____

ID/Member #:_____ Group # _____

Insurance Telephone: _____

Address to Mail Claims: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: ___Self ___Spouse ___Parent ___Legal Guardian

If other than Self, please fill out below:

Policy Holder Name: _____

DOB: _____/_____/_____ Social Security # _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____

Policy Holder Name: _____

ID/Member #:_____ Group # _____

Insurance Telephone: _____

Address to Mail Claims: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: ___Self ___Spouse ___Parent ___Legal Guardian

If other than Self, please fill out below:

Policy Holder Name: _____

DOB: _____/_____/_____ Social Security # _____

I attest that the above demographic and insurance coverage information is correct.
Signature _____ **Date** _____/_____/_____

Patient Information

DATE COMPLETED: _____

Patient: (last,first,MI): _____

Socal Security # _____

Date of Birth: _____

Liver Associates of Texas, P.A.

Primary Care Physician (i.e.Family Physician, Internist)

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Referring Physician (Physician who sent you to Liver Associates of Texas)

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Gastroenterologist

WITHIN PAST YEAR, HAVE YOU SEEN A GASTROENTEROLOGIST? YES NO

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Other Treating Physicians

WITHIN PAST YEAR, HAVE YOU SEEN ANY OTHER PHYSICIANS? YES NO

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Other Treating Physicians

ADDITIONAL PHYSICIANS SEEN WITHIN THE PAST YEAR

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Other Treating Physicians

ADDITIONAL PHYSICIANS SEEN WITHIN THE PAST YEAR

Name: _____ Specialty: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ ZipCode: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Liver Associates of Texas, P.A.

LIVER ASSOCIATES OF TEXAS, P.A.

Health Questionaire

NAME_____

DOB_____Date _____

DO YOU HAVE ANY ALLERGIES? Please List

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Include Dose and Frequency

HAVE YOU RECEIVED ANY HEPATITIS VACCINATIONS?

Hepatitis **A** Vaccination	NO	YES	If Yes, Date _____
Hepatitis **B** Vaccination	NO	YES	If Yes, Date _____
Others			

PAST MEDICAL HISTORY

	You X	Family (Relation)	Details/Complications
Headaches/ Migraines			
Vision Problems or Hearing Loss			
Glaucoma/Cataracts			
Heart Disease:MI/Angina			
Seizures			
Stroke (CVA/TIA)			
Thyroid Disease			
Heart Failure/Murmur/Arrhythmia			
Hypertension			
Cholesterol/Lipids			
Asthma/Copd			
Pneumonia/Bronchitis			
TB			
Anemia/Transfusions			
HIV			
Diabetes			
Pancreatitis			
Liver Disease/Hepatitis			
Esophageal Disease:reflux/heartburn			
GI Disease:Ulcers/Inflammatory bowel dx			
Gallbladder Disease			
Kidney Disease /Stones			
Incontinence (lost control of urine)			
Joint Problems/Arthritis/Gout			
Cancer			
Mental Illness/Depression/Bipolar/Anxiety			
Diverticular Disease			
Colon Polyps/Cancer			
Alcoholism			
Other:			

LIVER ASSOCIATES OF TEXAS, P.A.

FINANCIAL POLICY

The primary goal of our practice is to provide the finest specialty care services to the patients in our community. Since our practice also has obligations that must be met, we expect all patients to Pay in Full their appropriate co-pay, deductible, or % due on the day of their visit for all services rendered. The amount due at the time of service is dependent upon your coverage. For your convenience you may pay by cash, check, Master Card, VISA, or Discover. We will file a claim with your insurance company and obtain payment from them for their portion of the bill.

INSURANCE
You must bring your insurance card with you in order to prevent billing errors for both the patient and the office. Insurance plans vary and may cover anywhere from zero to 100% of your medical and surgical costs. You are responsible for any amount not covered by your plan.

Our policy for patients with Commercial Insurance is as follows for ***medical services***:

- Patients pay in full their appropriate co-pay/deductible or % charge due on the day of their visit for all office services provided.
- Our staff files claims for all patients and for all charges.
- If a Referral is required by your HMO insurance, it is your responsibility to obtain and maintain an up-to-date referral prior to your appointment.

Our agreement is with **YOU** and **NOT** your insurance company. Although we will assist you in submitting your claim to your insurance carrier, ***you are ultimately responsible for payment for the services you receive.*** Payment to our office is not contingent or dependent upon your insurance carrier. Any disagreements concerning an unpaid claim should be taken up with your insurance carrier since your insurance coverage is a contract between you and the insurance company.

MEDICARE
We are a participating provider with the federal Medicare program. If you carry only Medicare, you are responsible for 20% of all services and a $_____ annual deductible. This amount is expected to be paid on the day of your visit when services are rendered.

If you have a supplemental policy, we will file a claim as a convenience for you.

MEDICAID
You are expected to bring your current monthly Medicaid card with you on your visit showing you have coverage. If this card is not presented at the time of your visit, we will consider you a Self Pay patient and you will be responsible for payment of the visit.

ADDITIONAL FEES

- Returned Checks will be charged a $25.00 overdraft fee.

We must bill for these services due to the cost of the supplies, and the time and effort it takes our staff to copy these records for you.

- Copies of your lab results are $5.00 unless they are given to you during your office visit.
- Copies of your Medical Records will cost $25.00 unless you would like for us to fax it to another doctor's office.
- Completion of Disability Forms cost $10.00.

My signature on this form is evidence of the fact that I have read the entire form, understand, and have obtained a satisfactory answer to any question which I may have about my financial responsibilities under this policy.

_____ _____
Patient/Responsible Party Signature **Date**

ID#_____

LIVER ASSOCIATES OF TEXAS, P.A.

Consent for Use and Disclosure of Health Information for Treatment, Payment and Operations

By signing below, I consent to the use and disclosure of my protected health information by Liver Associates of Texas, PA, its staff and business associates for the purposes of treatment, payment and health care operations. My protected health information includes any information that reasonably identifies me and relates (1) to the provision of healthcare to me, (2) to any of my past, present of future health conditions, or (3) to the past, present or future payment for any provision of healthcare to me. The information that is protected includes information related to my physical or mental health.

I understand that I have a right to request that Liver Associates of Texas, PA restrict its use and disclosures of my protected health information that Liver Associates of Texas, PA is otherwise permitted to make for treatment, payment and health care operations. Liver Associates of Texas, PA however, is not required to agree to these restrictions. Nevertheless, if Liver Associates of Texas, PA agrees to any restrictions, those restrictions are binding on it. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that Liver Associates of Texas, PA has acted in reliance on it.

Date	Patient Signature (or legal guardian)	Print Full Name	Witness Signature

Assignment of Benefits to Liver Associates of Texas, PA

I certify that the information I have given Liver Associates of Texas, PA is true and correct to the best of my knowledge. I promise to pay Liver Associates of Texas, PA all charges and expenses for services provided to me by The Liver Associates of Texas, PA in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance or by another payment source such as Medicare or Medicaid. I request that payment of authorized benefits under any private or government insurance program that covers me, including the Medicare program, be made on my behalf to Liver Associates of Texas, PA for any services furnished to me by Liver Associates of Texas, PA. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine my Medicare benefits, if any, for services furnished by Liver Associates of Texas, PA. Liver Associates of Texas, PA may pursue collection of these benefits in my name or in the name of Liver Associates of Texas, PA. I also authorize the use of a copy of this authorization in place of the original. I understand that possession of medical insurance does not relieve me of financial responsibility to Liver Associates of Texas, PA. I will personally be responsible for all charges for services that are not covered by my health insurance provider.

Date	Patient Signature (or legal guardian)	Print Full Name	Witness Signature

Record usage by Liver Associates of Texas, PA

I give my consent for Liver Associates of Texas, PA to use my medical records for data gathering and research purposes. I understand that ALL identifying information in my record will be coded for confidentiality. I understand that all patient/medical provider communication will be held in the strictest confidence.

Date	Patient Signature (or legal guardian)	Print Full Name	Witness Signature

Acknowledgement of Notice of Privacy Practices

Liver Associates of Texas, PA can discuss my medical condition with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I acknowledge receipt of Liver Associates of Texas, P.A. Notice of Privacy Practices

Date	Patient Signature (or legal guardian)	Print Full Name	Witness Signature

****This Consent must be signed by the patient, by a parent of a minor, or by a guardian if the patient is incapacitated.**

Name:_____

DOB:_____

LIVER ASSOCIATES OF TEXAS, PA

Healthcare Questionnaire

REVIEW OF SYSTEMS

In the past six months have you had problems with the following?

(Please circle any problems that you have been treated for or presently suffer from)

Fever
Chills
Sweats
Anorexia
Enlarged lymph nodes
Fatigue
Weakness
Malaise
Weight Loss
Sleep disorder
Blurring
Diplopia
Irritation
Discharge
Vision Loss
Scotoma
Eye Pain
Photophobia
Earache
Ear discharge
Tinnitus
Nasal congestion
Loss of Smell
Nose Bleeds
Sore throat
Hoarseness
Difficulty swallowing
Chest Pains
Angina
Palpitations
Syncope
Dyspnea on exertion
Orthopnea
PND
Claudication
Dyspnea at rest
Lower back pain
Dyspnea with exercise
Bruising

Cough
Sputum
Wheezing
Coughing up blood
Sneezing
Pleurisy
Difficulty swallowing
Pain on swallowing
Nausea
Indigestion
Vomiting
Vomiting blood
Abdominal pain
Jaundice
Gas/Bloating
Diarrhea
Constipation
Change in bowel habits
Bloody bowel movements
Fecal incontinence
Urinary burning
Urinary frequency
Urinary hesitancy
Nocturnal urination
Urinary incontinence
Penile discharge
Genital sores
Decreased libido
Erectile dysfunction
Joint pain/LOM
Joint swelling
Joint stiffness
Joint deformity
Muscle weakness
Muscle cramps
Muscle atrophy
Leg pain at night
Leg pain with exertion
Bleeding

Shoulder pain/LOM/hand/wrist
Rash
Itching
Dry skin
Hay fever
Hives
Moles
Warts
Unhealing ulcers
Weakness
Paralysis
Abnormal sensation
Seizures
Syncope
Tremors
Vertigo
Transient blindness
Frequent falls
Frequent headaches
Difficulty walking
Sciatica
Radiculopathy other:
Restless legs
Depression
Anxiety
Memory loss
Suicidal ideation
Hallucination
Paranoia
Phobia
Confusion
Cold intolerance
Heat intolerance
Polydipsia
Polyphagia
Polyuria
Unusual weight change
Hirutism
Pagophagia