Pavani Muddasani, MD
508 S. Adams St, Suite 202
Fort Worth, Texas 76104
Phone #: (817) 877-3446 Fax #: (817) 377-6553

FILL OUT THESE FORMS IN ITS ENTIRETY

Name: _____ **Age**: _____ **DOB**: _____

Phone Number: _____ **Alt Number**_____

Email address:_____ OR **None**_____

Reason for visit?: _____

Primary Care Physician:_____**Phone**_____

Previous Gastroenterologist: _____**Phone**_____

Current Medications: (Including prescription, over the counter, herbals and vitamins)

Medication **Dose** **Schedule**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Please list all medications you are allergic to, including the reaction (for example, nausea vomiting, rash, headache, etc.) OR No Known Drug Allergies_____

_____

_____

What is your preferred pharmacy?_____**Phone**_____

Pharmacy Address:_____

Have you ever been diagnosed with the following?					
YES	**NO**		**YES**	**NO**	
		High blood pressure			Pancreatitis
		Heart Attack			Jaundice
		Stroke			Liver Disease Which type? Hepatitis ___
		Rheumatic Fever			Kidney disease
		Asthma			Gout
		COPD / Emphysema			Degenerative Joint Disease
		Tuberculosis or Exposure			Arthritis Type:
		Peptic ulcer disease			Epilepsy / Seizures
		GERD			Thyroid disease
		Hiatal Hernia			Anemia
		Crohn's Disease			Cancer Location?
		Ulcerative colitis			Depression
		Irritable bowel syndrome			Scarlet Fever
		High Cholesterol			Diabetes
		Congestive Heart Failure			Other:
		Irregular Heart Beat			Had Mammogram? Date: _____
_____	_____	Colon Polyps HIV/AIDS			Pneumonia Vaccine? Year:_____

Have you had any of the following surgeries?							
YES	**NO**	**DATE**		**YES**	**NO**	**DATE**	
			Appendectomy				Vasectomy
			Tonsillectomy				Hysterectomy
			Adenoidectomy				Removal of ovaries
			Gall Bladder removal				C-Section
			Heart Surgery				Colonoscopy
			Hernia Repair				Endoscopy
			Tubal ligation				Other:

Which Physician performed your Endoscopy / Colonoscopy? _____

Where were these procedures performed? _____

Other hospitalizations_____

Family History: **___ Unknown OR (Adopted) _____**

Parents:	Age	Living	Deceased	Health Problems
Mother				
Father				
Brothers:				
Sisters:				
Children:				

In your immediate family, is there a history of:

Colon Polyps? YES / NO Relationship: _____

Colon Cancer? YES / NO Relationship: _____

Liver Disease? YES / NO Relationship: _____

Social History: (Please circle)

Do you drink alcohol? YES / NO Beer___ Wine____liquor____

If yes, how many drinks? _____ **Drinks/Ounces/Beers** How often? **Daily/Weekly/Monthly**

If no, did you previously drink alcohol? YES / NO
If yes, when did you quit? _____

Do you drink caffeine? YES/NO **Coffee, Tea, Soda, Chocolate** **How Many A day_____?**

Have you ever used tobacco? YES / NO

If yes, what type Cigarettes / Cigars / Smokeless? How much? _____

If you smoked in the past, what age did you start?_____ stop? _____

Have you ever tried to quit? YES / NO When? ____ How long?_____Days / Weeks / Months
Why did you start smoking again? _____

Hepatitis Risk questions:

If you have ever experienced any of the following events or conditions please mark the "yes" box at the end of the list.

•I.V. Drug use (injection with needles, even one time)
•Nasal drug use, such as cocaine
•Body piercing
•Tattoo
•Receive blood or plasma by transfusion prior to 1992
•Work in emergency room, operating room, doctor's office or blood bank
•Sexually transmitted disease

□ Yes □ No □ Unsure

Do you <u>CURRENTLY</u> have any of the following symptoms?

YES	NO		YES	NO		YES	NO	
		Chills			Diarrhea			Headache
		Fever			Difficulty swallowing			Numbness
		Fatigue			Heartburn			Tremors
		Weight loss			Vomiting blood			Anxiety
		Double vision			Blood in stools			Depression
		Ear infections			Loss of appetite			Increased stress
		Eye pain			Black stools			Hives
		Nasal congestion			Nausea			Skin sores
		Sinus infection			Acid reflux			Rash
		Sore throat			Vomiting			Back pain
		Shortness of breath			Painful urination			Muscle pain
		Frequent cough			Blood in urine			Joint pain
		Painful breathing			Frequent urination			Easy bleeding
		Wheezing			Incontinence urination			Easy bruising
		Chest pain			Urinary retention			Lymph node disease
		Edema in legs			Cold intolerance			Asthma
		Palpitations			Excessive thirst			Food allergies
		Abdominal pain			Heat intolerance			Immunosuppression
		Constipation			Dizziness			Seasonal Allergies

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ❍ OK to leave a message with detailed information
  - ❍ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ❍ OK to leave message with detailed information
  - ❍ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

Release of Information
Request

Texas Health Care

Patient's Name_____ Maiden/Former Name:_____

Patient's Address:_____

City, State, Zip:_____

Birth Date:_____ Social Security #:_____

Home Phone:_____ Other Phone:_____

I, Authorize:

_____

_____

_____

To Release to:

_____

_____

_____

The following information may be released:

- ☐ Entire Medical Record
- ☐ Specific Record From_____to_____
- ☐ Immunizations
- ☐ Billing Record
- ☐ Only_____

Purpose of Disclosure:

- ☐ Medical Care
- ☐ Insurance
- ☐ Attorney
- ☐ Other_____

I consent to the release of the indicated sensitive, legally protected records (patient to initial).

Mental Health Records……._____

HIV or AIDS ……..._____

Chemical Dependency……._____

Genetic Testing……._____

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____

Signature of Patient or Representative: Date:

_____ _____

Printed Name: Relationship to Patient:

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected. *09/2012*

Texas Health Care
Privia Medical Group North Texas

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Gastroenterology

Scheduling & Cancellation Policies

- **Office Appointments**:

Office hours are Monday – Thursday from 8:30-4:30 & Friday from 8:30–2:00

Late Policy: We request that you call our office if you feel you may be late to your scheduled appointment.

No Show Policy: Patient who schedule appointments but fail to show up will be documented as "No Show". We understand circumstances may arise that may prevent you from coming in, however, we request that you contact us within **24 hours.** This will allow us to schedule other patients that may need urgent medical care.

Failure to contact us **within 24 hours** will incur a patient **fee of $20.00.**

- **Procedure Appointments**:

We request that you carefully consider your procedure date prior to scheduling. Our office works diligently to provide instructions & insurance authorization if needed. This requires a significant amount of time & expense to coordinate with the facility & physician schedule. If you need to cancel or reschedule it must be at least **48 hours** prior to the day of your procedure.

Failure to contact us **within 48 hours** of your procedure will incur a patient **fee of $100.00.**

Due to increase in no shows & late cancellations we are forced to establish these policies. This will enable us to better care for all of our patients.

Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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FINANCIAL DISCLOSURE

Dear Patient,

We would like to take this opportunity to welcome you and let you know that we are committed to providing you with the best possible care. Please take a few minutes to read this important information regarding our financial policies. We will gladly discuss your proposed treatment and answer any questions you have related to your charges.

For billing purposes, there are separate service components for which you will be billed separately.

- Physician Professional Charge: We will bill Dr. Muddasani's charge to your insurance company on your behalf. This billing will be for the physician's professional services that are provided during your procedure. If you are a new patient to our office, there will be a separate consultation fee.

*Depending on your insurance benefits, we may require a deposit which is expected one week prior to the procedure. Also note that most insurance require you to meet a deductible as well. It is recommended that contact your insurance company in advance, to get an idea as to the amount you may be required to pay.

- Facility Charge: There will also be a facility bill for the use of the facility in which your procedure is being performed. The facility will bill these charges separately to your insurance company.
- Laboratory & Pathology Charge: If you have a biopsy taken, you may receive a bill from the laboratory that processes your biopsy.
- Anesthesia Charge: This professional charge will be billed separately to you for the services that are provided during your procedures.

PAYMENTS MADE TO THE FACILITY ON THE DAY OF SERVICE ARE CREDITED TOWARDS THE FACILITY CHARGE ONLY

Payment for physician services are due 48 hours prior to your procedure.

Patient Signature: _____ **DOB:** _____ **Date:**_____

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Consent for Treatment

By signing this consent, I am authorizing my physician and/or another person to perform all exams, tests, procedures, injections, phlebotomy and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Muddasani, with Privia Medical Group North Texas unless revoke by me in writing.

Print Name: _____ Date of birth: _____

Patient signature: _____ Date: _____

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: Dr. Pavani Muddasani (BEING SEEN TODAY)

LOCATION: 108 DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: _____ or School

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ (NAME) _____ (RELATIONSHIP) (___) _____ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ___ Other _____ (SPECIFY) Resp. Party SS #: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: _____ or School

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____ (___) _____ (WORK PHONE) (___) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ (DATE OF BIRTH) Spouse's Work Phone: (___) _____ (___) (EXT) Occupation: _____

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (STREET or P.O. BOX) (___) _____ (PHONE)

Co-Pay Amount: (if applicable) _____ _____ (CITY) _____ (ST) _____ (ZIP)

Primary Care Physician: _____

Policy Holder: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS #)

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____ (SPECIFY)

Employer's Name: _____ _____ (INSUREDS ID) _____ (GROUP NAME AND/OR NUMBER)

Address:

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: N/A Adj. N/A

Address: N/A City: N/A State N/A Zip N/A Phone N/A

Claim #: N/A DOI N/A

What Employer: N/A

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes _X_No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident N/A Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: N/A

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

SIGN HERE _____ _____ _____ _____