FINE DIGESTIVE HEALTH
JEFFREY S. FINE, MD • GASTROENTEROLOGY
6750 N. MacArthur Blvd • Suite 300 • Irving TX 75039 • 1-972-253-4205 • www.drfoodsensitivity.com

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____ City: _____ State/Zip: _____
Home Telephone: _____Cell:_____Work:_____
Email Address: _____
Social Security: _____ Date of Birth: _____ Age: _____ Male/Female
Marital Status: Single Married Divorced Widowed
Race: American Indian or Alaska Native Asian African American Native Hawaiian or other Pacific Islander
White Hispanic Preferred Language_____

Employer: _____Phone:_____ Fax: _____
Address: _____ City: _____ State/Zip: _____
Occupation: _____

Insurance: _____Phone:_____
Member ID: _____ Group: _____
Referring Doctor: _____ Phone: _____ Fax: _____
Chief Complaint: _____

Emergency Contact
Name: _____Relationship: _____Phone:_____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS
I authorize Dr. Jeffery Fine, M.D., to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand that I am responsible for all medical fees incurred from my treatment with Dr. Jeffery Fine, M.D., not covered by my Insurance. If surgery is required, I assign all medical and/or surgical benefits to which I am entitled to Dr. Jeffery Fine, M.D. This assignment will remain in effect until revoked by me in writing.

A photocopy or assignment is to be considered as valid as an original.

BY SIGNING BELOW, I CERTIFY T HAT I HAVE READ THIS AGREEMENT AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS AND THAT I AM THE PATIENT OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I understand that I have the right to refuse to sign this authorization and in doing so, I will assume all costs involved for my medical care. I will be responsible for full payment at each time of service. I absolve my insurance company and or employer from any responsibility for my medical care expenses.
Patient Signature: _____ Date: _____

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Date: _____

PERSONAL HISTORY FORM

A thorough and complete medical and social history is very important for your doctors to understand and accurately diagnose any medical problems that you might have. This information is strictly confidential and will not be released to anyone without your consent. Please complete each section completely; it will help us to assist you.

Name: _____ Sex: ___ Age: ____ Date of birth: _____
Occupation: _____ Social Security #: _____
Primary Care Physician name and address: _____
_____
Referred by: _____
Present illness: _____
Please state briefly the main problem which prompted you to consult us, and the length of time you have had it:_____
_____

PAST MEDICAL HISTORY

Have you had any of the following listed (If yes please place a check next to it)

___German Measles	___Nervous Disorder	___Ruptured disc or Sciatica
___Mumps	___Heart Disease or Murmur	___Gout
___Rheumatic Fever	___High blood pressure	___Asthma
___Chicken Pox	___Vein Trouble	___Hay Fever
___Tuberculosis	___Blood disease or Anemia	___Skin Disorder
___Pneumonia or Pleurisy	___Bleeding Tendency	___Chronic Bronchial Tube
___Syphilis	___Kidney disease	___Peptic Ulcer
___Gonorrhea	___Kidney or bladder infection	___Jaundice or Hepatitis
___HIV or AIDS	___Kidney Stones	___Liver Problems
___Cancer, type:	___Prostate Trouble	___Gallbladder Disease
___Epilepsy or Seizures	___Arthritis or Joint Trouble	___Hemorrhoids
___Stroke or Paralysis	___Back Trouble	___Diabetes
___Goiter or Thyroid	___Other Glandular Trouble	

Any illness or disease not included above:
_____

What surgical operations have you had?	**DATES**
___Tonsils	_____
___Hysterectomy	_____
___Appendix	_____
___Gallbladder	_____
___Hemorrhoids	_____

Other Operations (please list): _____

PHARMACY ADDRESS AND PHONE NUMBER

_____

Have you ever had a serious accident or injury? (If so how and when)

_____

_____

Broken bones? (Which?)

_____

Concussion or Head injury?

_____

Medications

Medication	Dosage	How often	Date started

Please list any medications you are sensitive or allergic to or have caused a rash or other side effects

_____

_____

Have you ever had a blood transfusion? ___YES___NO If so when?_____

Have you ever received any form of penicillin?___YES___NO If so were there any unfavorable reactions?___YES___NO. If yes please describe:_____

_____

Marital History ___single ___married ___divorced

FAMILY HISTORY

	Living	Age or age at death	Present health or cause of death
Father			
Mother			
Brothers			
Sisters			

Have any of your **blood** relatives ever had: (If yes state relationship including aunt,uncle,grandparent etc)

Cancer _____ Allergy _____ Bleeding Tendency _____
Heart Trouble _____ Migraine _____ Nervous or mental disease _____
High Blood Pressure _____ Diabetes _____ Tuberculosis _____
Stroke _____ Kidney Disease _____ Thyroid _____
Glaucoma _____ Peptic Ulcer _____ Arthritis _____

SOCIAL HISTORY

Do you use tobacco now?_____In the past?_____For how long?_____Type and amount?_____
Do you use alcoholic beverages now?_____In the past?_____Type and amount daily/weekly_____
How many cups of coffee do you regularly drink per day?_____
What hobbies do you have?_____
How many hours per week do you work?_____How often do you take a vacation?_____
Do you get regular exercise?_____What kind?_____How often?_____
Any pets (or farm animals) at home?_____

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PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule give the individuals the right to request a restriction on uses and discloseures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communiction of PHI made by the alternative means, such as sending codependence to the individual's office instead of the individuals home. In our efforts according to your wishes when it comes to yor family, friends, and co-workers.

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

Home telephone: _____

__ ok to leave message with detailed information

__ leave message with call back number only

Work telephone: _____

__ ok to leave message with detailed information

__ leave message with call back number only

Written communication: _____

__ ok to mail to my home address

__ ok to fax to this number

__ ok to mail to my worl/office address

Provide us with the name(s) and phone numbers that we may speak to regarding your treatments and or test results:

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Please list healthcare providers authorized to receive health information pertaining to you

Name of provider	Specialty	Phone #

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Financial Policies and Procedures

Thank you for choosing us as your Gastroenterology Specialist. We are committed to your treatment being successful. The following is a statement of our financial policies and office procedures, which we require you to read and sign.

APPOINTMENTS
Please arrive 15 minutes prior to your appointment time to update paperwork more than six months old or to review paperwork for accuracy.

CO-PAYMENTS, DEDUCTIBLES AND FEES
Co-payment, insurance deductibles and fees for service not covered by your policy are collected at the time service is rendered. We accept cash, checks, and credit cards. If you have surgery we do expect you to pay any deductible not met or co-insurance you are responsible for. Bills for surgery will not include charges for anesthesia, hospitalization or laboratory tests. These are billed separately from the facility where they are performed.

REGARDING INSURANCE
We will file insurance for you as a courtesy provided we are supplied with the proper information. If you do have health insurance please remember that professional services are rendered and charged to you and not to the insurance company. We will automatically file on insurance plans that we are contracted providers for.

MINOR PATIENTS
A minor has to be accompanied by an adult in order for services to be rendered and is responsible for payment of the minor patients account regardless of who the insurance policy holder is.

MISSED APPOINTMENTS AND CANCELATIONS
Our policy is to charge for missed appointments or appointments cancelled with less than 24 hours' notice at a rate $50.00 per appointment. We will only give one chance and will waive the fee, but after that you will be responsible for the $50.00 charge.

MEDICATION REFILLS
You will need to call your pharmacy and request a refill through them. They will fax a request to our office and refills will be done at the end of the day. You will have to be seen within 3 months in order to receive refills.

COMPLETION OF FMLA FORMS
A fee of $50.00 per form will be charged for first form for each patients. It is the patient's responsibility for completion of forms and must be paid in advance by cash, check, or credit card. We have 7-10 business days to complete forms. We do not accept forms by fax.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS, THIS NEEDS TO BE BROUGHT TO OUR ATTENTION PRIOR TO BEING EXAMINED.

I UNDERSTAND AND AGREE TO THIS POLICY.

_____ _____
Signature of Patient or Guardian Date

FINE DIGESTIVE HEALTH
JEFFREY S. FINE, MD • GASTROENTEROLOGY

Authorization to Release Medical Records

Patient Name_____ Date of Birth _____

Social Security Number_____-_____-_____ Day Time Phone# _____

RECORDS RELEASED FROM: I authorize the use or disclosure of the above-named individual's health Information as described below,
The following individual(s) or organization(s) are authorized to release information:

_____
Doctor's name or facility requesting records and phone number.

_____
Complete address of doctor or Facility City, State, Zip.

SEND RECORDS TO: The information Identified above may be used by or disclosed (released) to the following individual s) or organization(s):
Fine Digestive Health – Dr. Jeffrey S. Fine, MD_____
Doctor's name or facility requesting records and phone number.

6750 N. MacArthur Blvd Ste 300 Irving Tx, 75039 Ph: 972-253-4205 Fax: 469-317-7022_____
Complete address of doctor or Facility City, State, Zip.

The type of information to be used or disclosed is as follows (check appropriate):

_____ Problem List, _____ Medication List, _____ Allergies List, _____ Immunization Records, _____ Entire Records.

_____ Lab Results (Dates and type of test), _____

_____ X-Ray & imaging reports (Describe date and type) _____

_____ Other _____
This information for which I'm authorizing disclosure will be used for the following purpose:
_____ My personal records, _____ sharing with other health care providers, _____ Or other (please describe)
_____

Important Information and Disclosures
I understand that the Information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV), It may also Include Information about behavioral or mental health services, and treatment for alcohol and drug abuse,

I understand that I have a right to revoke this authorization at any time, I understand that if I revoke this authorization, I must do so in writing and send my written revocation to
Fine Digestive Health, 6750 N. MacArthur Blvd., Suite 300, Irving, TX. 76039.
I understand that the revocation will not apply to information that has already been released in response to this authorization, I understand that revocation will not apply to my insurance company when the laws provide my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the Information may not be protected by federal privacy laws or regulations. I also understand authorizing the use or disclosure of the Information Identified above is voluntary, I need not sign this form to ensure healthcare treatment,

Fees
Copies of medical records are subject to a minimum charge of $25.00 and prepayment is required before records are copied. Mail Payment to **Fine Digestive Health, 6750 N. MacArthur Blvd., Suite 300, Irving, TX. 75039.**

Contact Information / Fax Number
If you have any questions you may contact the Fine Digestive Health (**972) 253·4205**, we will accept this request in person, or mall to the above address or by faxing it to (**469-317-7022**. However, we will not accept this authorization by e-mail.

Signature of patient or legal representative _____ / Date _____

This authorization will expire (insert date or event). _____. If I fall to specify an expiration date or event, this authorization will expire in six months from the date on which it was signed.