BRICK EDUARDO ALVA, MD, PA

GASTROENTEROLOGY & LIVER DISEASES

PATIENT REGISTRATION **ACCOUNT:**

PATIENT:
First Name: _____ Middle Initial: ____ Last Name: _____ SSN: ____-____-____

Date of Birth: ____/____/____ Sex: Male/Female Marital Status: Married/Single/Divorced/Widow

Address: _____City/State _____Zip Code: _____

Home Phone: (___) ____-_____ Cell-Phone (___) ____-_____ e-mail: _____

EMPLOYER:
Name: _____ Phone Number: (____) _____-_____
Address: _____

REFERRED BY:
Name: _____
Primary Care Physician: (if different from referring): _____

EMERGENCY CONTACT:
Name: _____ Relationship: _____
Address: _____
Home Phone: (___) ____-_____ Cell-Phone (___) ____-_____ Work Phone: (___) ____-_____

FIRST INSURANCE INFORMATION
Plan Name: _____
Policy Holder name: _____
Subscriber I.D. number: _____
DOB: _____
SSN of Policy Holder _____
Patient's relationship to subscriber: _____

SECOND INSURANCE INFORMATION
Plan Name: _____
Policy Holder Name: _____
I.D. number: _____
DOB: _____
SSN of Policy Holder _____
Patient's relationship to subscriber: _____

PHARMACY INFORMATION:
Name: _____ *Phone:* _____
Address: _____
*FAX*_____

The above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Brick Eduardo Alva, MD, PA. I acknowledge that I am financially responsible for any balance resulting after insurance pays my claims.

NOTICE OF PRIVACY PRACTICES ACKNOWLEGDEMENT

I acknowledge that BRICK EDUARDO ALVA, MD, PA provided me with written copy of his/her Notice of Privacy Practice.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Signature: _____ Date: _____/_____/_____ _____
Patient or Guardian/Representative Relation to Patient

11738 FM 1960 Rd W. Houston, TX 77065-3514 P: (281) 469-5252 F: (281) 469-5259
www.gastrorelief.com beamdpa@yahoo.com

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____ **Date of Birth:** ____/____/____
First Middle Last

Authorization for Disclosure of Information: I voluntarily authorize and direct my health care provider

_____

to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: BRICK EDUARDO ALVA, MD
11738 FM 1960 Rd W
Houston, TX 77065

Purpose: I understand that the specific purpose of this Authorization is:

__Continuing medical care __Insurance Review __Legal Review __Other:

Information to be disclosed:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Only the following records or types of health information:

_____

_____

Term: This Authorization will remain in effect for:

- ❑ 90 days after the date of my signature
- ❑ Other:

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

A photocopy of this consent shall be considered as effective as an original

_____ _____ _____
Signature Date Signature of Witness

If Patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness

BRICK EDUARDO ALVA, MD, PA

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FINANCIAL POLICY

Welcome to Brick Eduardo Alva, MD. PA. We appreciate your confidence and goodwill.
We are presenting to you our FINANCIAL POLICY as is required by law:

Self-Pay/Non-Contracted Plans:

• All charges are due and payable at time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Patients with insurance:

• It is your responsibility to make sure the physician(s) you will see is currently enrolled with your plan. All necessary referrals must be obtained prior to each visit. If a referral is not completed or obtained prior to your appointment, it may result in a delay or possibly rescheduled.

• We will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is *required to pay to our practice for a service that has been provided, you are only responsible for what* is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90days from the date of service, both the insurance and patient portions of your account then become your responsibility. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.

• Pre-existing clause: If the patient has a current pre-existing clause in the policy, the patient is required to pay the full charge for the service being rendered instead of patient's copay.

No-Show and Cancellation Policy:

• If the patient fails to cancel his/her procedure appointment at least 48 hours in advance, the patient is responsible for $50 fee which will not be applied to any copay, deductible or coinsurance.

Delinquent / Unpaid Account:

• Prior to providing services, payment of prior outstanding accounts will be requested and should be received.

Refunds:

• Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient's refunds will not be processed until all active or past due accounts are paid in full.

Third Party Litigation:

• Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.)

Insurance / Disability forms:

• There will be a $30 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms and disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

Returned Checks:

• Checks returned to the practice for insufficient funds, closed account, stopped payment, or for any other reason will be subject to $20.00 fee.

Medical Record:

• A fee of $10.00 for the first ten pages and $0.15 per page for every copy thereafter. Requests will be completed within 10 business days.

I, the patient/patient's legal representative, understand and agree to abide by the financial policy set forth.

_____	_____	_____
Patient Name	**Signature**	**Date**

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Name/Nombre:_____ DOB/Fecha de nacimiento _____/_____/_____

Referring Physician/Doctor que lo refirio: _____ Date/Fecha: _____/_____/_____

Please circle the reason for your visit/Porfavor circule la razon de la visita

Colonoscopy/Colonoscopia Pain/Dolor (where/donde)_____ Reflux/Agruras Bloating/Distencion

Difficulty Swallowing/Dificultad al tragar Constipation/Estrenimiento Diarrhea/Diarrea Bleeding/Sangrado

Hemorrhoids/Hemorroides Liver Disease/Enfermedad del Higado Nausea or Vomiting/Nauseas o Vomito

Follow up/Cita de seguimiento Other/otro:_____

PAST MEDICAL HISTORY/ HISTORIAL MEDICO

Prior Colonoscopy: Y/N If yes, when: _____ Where_____ Doctor_____

Ha tenido una Colonoscopia: S/N, Cuando_____ Donde _____ Doctor_____

Prior Upper Endoscopy: Y/N If yes, when: _____ Where_____ Doctor_____

Ha tenido una Endoscopia: S/N, Cuando_____ Donde_____ Doctor_____

History of Coronary Artery Disease: Y/N Have you ever had a bypass Y/N Have you ever had a stent Y/N

Historia de la Arteria Coronaria S/N Ha tenido una Derivacion S/N Ha tenido un Stent S/N

Check if *you* have a history of/ Marque si usted tiene histora de:

___ Cancer

___ Colon Polyps/Polipos de Colon

___ Diverticulosis/Diverticulos

___ Hemorrhoids/Hemorroides

___ Peptic Ulcer Disease/Ulcera del estomago (Duodenal/Stomach)

___ IBS (Irritable bowel syndrome)/Colon Irritable

___ Gastroesophageal Reflux Disease (GERD)/Reflujo

___ Hiatal Hernia

___ Barrett's Esophagus

___ Gallstones/Piedras en la vesicula

___ Pancreatitis

___ Liver Cirrhosis

___ Hepatitis A B C

___ Fatty Liver Disease/Higado Grasoso

___ High Blood Pressure (HTN)/Alta Presion

___ Diabetes (DM)/Diabetes

___ High Cholesterol

___ Asthma

___ COPD/Emphysema/Enfisema

___ CVA/Stroke/Accidente Crebro Vascular

___ Hypothyroidism/Tiroides

___ Dementia

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___ Ulcerative Colitis

___ Chron's Disease

___ Kidney Stones/Piedras en la vesicula

___ Parkinson

Other: _____

PAST SURGICAL HISTORY/ ANTECEDENTES QUIRUJICOS:

___ Appendectomy (appendix removed)/Apendice

___ Cholecystectomy (gallbladder removed)/Vesicula

___ Colon surgery/Cirugia de colon

___ Bariatric Surgery (Weight loss surgery)

- (Gastric Band/Sleeve/Bypass)

___ Hemorrhoidectomy/Hemorroides

___ C-Section/Cesarea

___ Hysterectomy

___ CABG (Coronary Artery Bypass Grafting) (Heart Stent)/

___ Cardiac Catheter/

___ Hernia Repair (Umbilical/Inguinal)

___ Tonsillectomy/Anjinas

ALLERGIES/ALERGIAS:

No known medication allergies/No alergia a medicamentes: _____

Type/Tipo: _____ Reaction: _____

Type/Tipo: _____ Reaction: _____

SOCIAL HISTORY/HISTORIA SOCIAL

Marital Status/Estado Civil: Married/Casado(a): ____ Single/Soltero(a): ____ Widowed/Viudo(a): ____ Divorced/Divorciado(a): ____

Lives with/Vive con quien?: _____ Occupation/Ocupacion: _____

Alcohol use/Usa Alcol: Daily/Diario: _____ Occasional/Ocasional: _____ Rarely/Raramente: _____ None/Nada: _____

Tobacco use/Usa Tabacco: Daily/Diario: _____ Occasional/Ocacional: _____ Rarely/Raramente: _____ None/Nada: _____

Drug use/Usa Drogas: Type/Tipo: _____ Daily/Diario: _____ Occasional/Ocasional: _____ Rarely/Raramente: _____ None/Nada: _____

FAMILY HISTORY/HISTORIAL FAMILIAR

History of Colon Cancer Y/N Who?/Historial de Cancer de Colon S/N, Quien?_____

History of colon polyps Y/N Who?/Historial de polipos en el colon S/N, Quien?_____

History of Heart attacks Y/N Who?/Historia de Ataques al Corazon S/N, Quien?_____

Other/Otro: _____ Who?/Quien?: _____

IF YOUR TAKING MEDICATIONS PLEASE PROVIDE A LIST /SI ESTA TOMANDO MEDICAMENTOS PORFAVOR PROPORCIONAR UNA LISTA

WT:_____ Ht:_____ T:_____ BP:_____ HR:_____ Age:_____

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