HOUSTON SURGICAL GROUP

Dr. Ayyar Dr. Leiva Dr. Ziad Amr

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please print. All information will be confidential
If you need help filling out paperwork, please let the staff know.

PATIENT INFORMATION

PATIENT NAME:_____ **BIRTHDATE**:_____ **AGE**: _____

TODAY'S DATE:_____ **MARITAL STATUS:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

RACE: ☐ American Indian/Alaska Native * ☐ Asian * ☐ Native Hawaiian/Pacific Islander * ☐ Black/African American * ☐ White * ☐ Hispanic
* ☐ Choose not to disclose * ☐ Other not listed _____

SS#_____ **HOME ADDRESS**: _____

E-MAIL:_____ **HOME PHONE** :_____ **CELLULAR :** _____

EMPLOYER :_____ **WORK PHONE** : _____

OCCUPATION: ☐ Retired ☐ Disabled ☐ Working, Current occupation _____

EMPLOYER ADDRESS: _____

REASON FOR TODAY'S VISIT: _____

WHOM MAY WE THANK FOR REFERRING YOU? :_____ **PHONE NUMBER**: _____

PRIMARY CARE DR:_____ **PHONE:**_____

EMERGENCY CONTACT NAME AND NUMBER: _____

PARENT IF PATIENT IS A MINOR:_____ **PHONE:**_____

***PHARMACY NAME**: _____ Phone# _____ Address: _____

Do you give HSG permission to obtain your medication history? YES * NO ☐ ☐

Primary Insurance _____ **ID#**_____ **Group#** _____ **Name on the Policy:**_____

IS THIS A WORK RELATED INJURY? _____ ***IF YES, PLEASE PROVIDE FOLLOWING INFORMATION:***

Claim Adjustor's Name:_____ **Phone**:_____ **Date of Injury**: _____

Claim Numb*er*:_____ **Contact at Employer& #:** _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and treating, obtaining clinical information and results from previous physicians and or healthcare facilities. As well as administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician
SIGNATURE:

_____ _____

PERSONAL SAFETY

DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU USE A CANE? ☐ YES ☐ NO

DO YOU HAVE FREQUENT FALLS? ☐ YES ☐ NO

DO YOU USE A WHEELCHAIR? DO ☐

YOU HAVE AN ADVANTAGE DIRECTIVE OR LIVING WILL? ☐ YES ☐ NO

*** If no, if you would like one to prepare, please notify staff.**

When was your last Colonoscopy? _____ **When was your last Breast Cancer Screening?** _____

When was your last Flu vaccine?_____ **When was your last Pneumonia Vaccine?** _____

CURRENT MEDICATION

Name of Medication / Nombre de Medicamento	Dosage / Dosis	Frequency / Cuantas veces al dia	Why do you take this Medication? / Razon de tomar esta medicina	MD Who Prescribed / Nombre del Medico	COMMENTS / Comentarios?

MEDICAL HISTORY

Please Circle C for Current Medical History / Circle P for Past Medical History

☐Angina	C / P ☐☐	☐Excessive Bleeding	C / P ☐☐	☐Leg Swelling	C / P ☐☐
☐Asthma	C / P ☐☐	☐Gallstones	C / P ☐☐	☐Liver Disease	C / P ☐☐
☐Arthritis	C / P ☐☐	☐Gout	C / P ☐☐	☐Lung Disease	C / P ☐☐
☐Acid Reflux	C / P ☐☐	☐Heart Disease	C / P ☐☐	☐PCOS	C / P ☐☐
☐Back Pain	C / P ☐☐	☐Heart Attacks	C / P ☐☐	☐Stomach Ulcers	C / P ☐☐
☐Cancer: _____	C / P ☐☐	☐High Blood Pressure	C / P ☐☐	☐Stroke	C / P ☐☐
☐Crohn's Disease	C / P ☐☐	☐High Cholesterol	C / P ☐☐	☐Thyroid Disease	C / P ☐☐
☐Diabetes	C / P ☐☐	☐Hepatitis	C / P ☐☐	☐Other: ☐	
☐Depression	C / P ☐☐	☐Irritable bowel syndrome	C / P ☐☐		
☐Diverticulosis	C / P ☐☐	☐Kidney Disease	C / P ☐☐		
☐Epilepsy/Seizures	C / P ☐☐	☐ HIV	C / P ☐☐		

ALLERGY AND PHARMACY INFORMATION

Are you allergic to any medication? List:_____ Reaction: _____

Do you take blood thinners?_____ ☐ Aspirin / ☐ Coumadin / ☐ Plavix / ☐ Pradaxa

What doctor prescribes you blood thinners? _____

SURGICAL HISTORY

SURGERY TYPE	DATE	SURGERY TYPE	DATE

FAMILY HISTORY

	AGE	HEALTH PROBLEM	AGE OF DEATH		AGE	HEALTH PROBLEM	AGE OF DEATH
FATHER				GRANDFATHER			
MOTHER				BROTHER			
GRANDMOTHER				SISTER			

SOCIAL HISTORY

ALCOHOL: ☐ YES / ☐ NO If yes, how many glasses a week? _____ What type of alcohol? _____

TOBACCO: ☐YES ☐NO ☐NEVER ☐QUIT, WHAT YEAR? _____

IF YES, check all that apply ☐ Cigarettes: # a day _____ ☐ Chew ____ ☐ Pipe/Times a day _____ ☐ Cigars a day_____

CAFFEINE: ☐ YES ☐ NO Cups a day # _____ Type of Caffeine: _____ How Long? _____

Respiratory Disease

Sleep Apnea: ____ Apnea symptoms but negative study ____ C-PAP USE _____ BI-PAP ____ Hypoxemia
____ Pulmonary Hypertension _____ Obesity Hypoventilation _____ History of Pneumonia
_____ History of Tuberculosis ***** If you use a c-pap/Bi-pap indicate settings:_____

Sleep Evaluation

S. Manny Ayyar, M.D. **Jorge I. Leiva, M.D.** **Ziad Amr, M.D.**

Name:	
Height:	
Weight:	

Do you snore?	□ YES	□ NO
Do you gasp or pause in your Breathing during the night?	□ YES	□ NO
Frequent movement at night or Restless legs?	□ YES	□ NO
Do you still feel exhausted after 8 hours of sleep?	□ YES	□ NO
Do you have excessive daytime Sleepiness?	□ YES	□ NO
Do you fall asleep while driving or Stopped at light?	□ YES	□ NO
Do you awaken with headaches or Dry mouth?	□ YES	□ NO
Do you have high blood pressure?	□ YES	□ NO
Do you feel fatigue during the day?	□ YES	□ NO
Do you sweat excessively at night?	□ YES	□ NO
Do you often have trouble staying asleep throughout the night?	□ YES	□ NO
Does it often take you an hour or more before you fall asleep?	□ YES	□ NO
Do you feel paralyzed when you am waking up or falling asleep?	□ YES	□ NO

Patient HIPAA Acknowledgment and Consent Form

HOUSTON SURGICAL GROUP			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

_____(**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOMI give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at anytime. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: *This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment.
  Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- _____ ***I do want*** _____(Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- _____ ***I do not want*** _____(Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

PLEASE PRINT NAME ON TOP AND SIGNATURE AT THE BOTTOM ONLY

HOUSTON SURGICAL GROUP - AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**

I allow the Release of records to Houston Surgical Group	**Provider's Name:**	
ADDRESS:	**21216 Northwest Freeway Suite# 250 Cypress, TX 77429**	
	Recipient's Phone: 713-426-2400	**Fax # 713-426-3204**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available** *(e.g.,* **USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided *(e.g.* , paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks *(e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ If Yes, then this is the only item you may request on this authorization. You must submit another Authorization for other items below. ☐ If No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physicianorders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Operative information ☐ Cathlab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Itemized Bill: ☐ UB-04: ☐ OTHER:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if! ask for it.
6. I get a copy of this form after I sign it.

Section B: Is **the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?** ☐ Yes ☐ No
If yes, the health planor health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

PLEASE PRINT NAME ON TOP AND SIGNATURE AT THE BOTTOM ONLY

BARIATRIC AND PANNICULECTOMY PATIENTS

PHOTOGRAPHY RELEASE CONSENT

I,_____authorize Houston Surgical Group, representatives and their employees the right to take photographs of me and my property.
I authorize Houston Surgical Group, its assigns and transferees to copyright, use and publish the same in print and/or electronically.
I agree that Houston Surgical Group may use such photographs of me with or without my name and for any lawful purpose, including publicity, illustrations, advertising, and Web content.
I have read and understand the above:

Signature:_____
Printed Name: _____
Address: _____

If you wish to decline please check below and initial.

☐ **I decline to release my photography for any publicity, advertising or web content. I understand that any photograph taken in the office will be for my file only.**

Initials: _____

Houston Surgical Group

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intent that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risk and benefits of any test order for you. If you have any concerns regarding any test or treatment recommended by your health provider, we encourage you to ask questions. I voluntary request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deem necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statement and consent fully and voluntary to its contest.

Signature of Patient or personal representative:_____Date: _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Financial Agreement
I acknowledge, that as a courtesy, **HOUSTON SURGICAL GROUP** may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co- insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks.

Third Party Collection. I acknowledge **HOUSTON SURGICAL GROUP** may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to **HOUSTON SURGICAL GROUP** any insurance or other third-party benefits available for health care services provided to me. I understand **HOUSTON SURGICAL GROUP** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **NORTHWEST HOUSTON SURGICAL ASSOCIATION**, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **HOUSTON SURGICAL GROUP** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for **HOUSTON SURGICAL GROUP** or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **HOUSTON SURGICAL GROUP** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **HOUSTON SURGICAL GROUP** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature:_____ Date: _____