



Southwest Gastroenterology Clinic
Office of Dr. Mukhtar Anees, MD and Dr. Muhammad A. Memon, MD
 701 E. Rendon-Crowley Road Burleson, Texas 76028 (817) 293-9292 office (817) 551-0616 fax
 www.swgiclinic.com

*****New Patient Information*****

Today's date: _____ - _____ - _____ Who referred you to us? _____
 PCP/Internist: _____

Name: _____ birthdate _____ - _____ - _____ age: _____
 last first middle initial

SEX: M F email address: _____

Address: _____

City: _____ state: _____ zip code _____

Home phone: _____ work phone: _____ ext. _____

Best place & time to call you to confirm appointments: _____

Social Security # _____ marital status (circle one) single married divorced widow

Employer: _____ address: _____

Patient's occupation: _____

Name of spouse: _____ spouse SS# _____ birthdate _____ - _____ - _____

Spouses employer: _____ address: _____

Work phone: _____ spouses occupation: _____

In case of emergency contact: _____ phone: _____

Relationship: _____

Reason for office visit: _____

 Primary insurance: _____

Insured's name: _____ birthdate: _____ - _____ - _____

Claim form address: _____ city: _____ state: _____ zip: _____

Insured's ID # _____ group # _____ phone: _____

Secondary insurance: _____

Insured's name: _____ birthdate: _____ - _____ - _____

Address: _____ city: _____ state: _____ zip: _____

Insured's ID # _____ group # _____ phone: _____

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes that I am responsible for all physician charges. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to the SOUTHWEST GASTROENTEROLOGY CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I have received the Notice of Privacy Practices. Patient's signature: _____ Date: _____



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Dear Patient,

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

Payment Guidelines:

1. You must pay any co-payments, co-insurance and/or deductibles at the time of service, unless other arrangements have been made in advance with our office.
2. We accept cash, checks, money orders and credit cards (VISA, MasterCard, Discover, American Express).
3. The remainder of your bill will be sent your insurance company for payment to our office.
4. If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. Please do not send payment back to the insurance company.

When should you present your insurance card?

Please present your insurance card at **EACH VISIT**. Specifically bring to our attention any changes (new card, new group number, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

What if your insurance company denies payment?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

- this is a pre-existing illness or condition that they do not cover
- you have not met your fill calendar year deductible
- the type of medical service required is not covered
- the insurance was not in effect at the time of service
- you have other insurance which must be filed first
- you have exceeded your maximum dollar/visit amount
- you did not have a referral # for your visit/service

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at (817) 293-9292.

Sincerely,

Dr. Mukhtar Anees

Dr. Muhammad A. Memon

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Southwest Gastroenterology Clinic and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

Patient signature:

today's date:



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NOTICE TO PATIENTS

Due to multiple policy changes for the different insurance companies, this office is unable to keep up with the requirements for each patient's individual policy. There are multiple requirements stated in your policy, some of which are on the back of your insurance card and some which are not.

Some of the most common requirements are:

- *Pre-admission certification*
- *Pre-admission testing*
- *Second opinion*
- *A.M. admissions*

Our office checks on these particular requirements for our patients. But if you do not ask the insurance company about a particular requirement point blank, they do not volunteer any information to you. Our office will be happy to assist you in any matter in accomplishing this task, but you are responsible for informing us of your insurance company requirements.

IT IS THE RESPONSIBILITY OF THE PATIENT TO BE AWARE OF AND FULFILL ALL THE REQUIREMENTS OF THEIR INDIVIDUAL POLICY.

I understand that should the insurance information I have provided be incorrect and a claim is denied, I will be responsible for the bill.

Patient's signature _____ Today's date _____

******Please note: Follow-up appointments after procedures are very important. This allows our physician to monitor your medical progress as well as give you any test results. It is not our policy to give this kind of information over the telephone.***



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PATIENT AUTHORIZATION FOR CONTACT

Please print all information. Then sign and date form at bottom.

Type of authorization: telephone contact / facsimile contact

Patient name (please print):

Purpose of request: I authorize Southwest Endoscopy & Surgery Center to disclose my protected health information in the following manner:

Home telephone:

- leave detailed messages on my answering machine / voicemail
leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Work telephone:

- leave detailed messages on my answering machine / voicemail
leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Mobile telephone:

- leave detailed messages on my voicemail
leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voicemail

Facsimile number:

- fax my Protected Health Information to this number
specify Protected Health Information:

fax general information (non-Protected Health Information) to this number

Expiration or termination of authorization - This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate the authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Attention: Privacy Manager

Patient signature Today's date

LIST ALLERGIES TO MEDICATIONS:

	YES	NO
Are you allergic to eggs?		
Are you allergic to soy?		

HAVE YOU BEEN TREATED FOR OR BEEN TOLD YOU HAVE:	YES	NO
Diabetes		
Cancer		
Anemia		
Hypertension		
Any heart disease		
Breathing problems		
Do you smoke?		
How much per day?		
For how long?		
Do you drink alcohol?		
How much daily?		
How much weekly?		
Do you wear dentures?		

BRIEFLY DESCRIBE YOUR AVERAGE DAILY MEALS:

Breakfast:

Lunch:

Dinner:

LIST ANY MAJOR OPERATIONS YOU HAVE HAD & YEAR:

FAMILY HISTORY: Please check all appropriate boxes.

	Father	Mother	Grandparents:				Brother	Sister	Children
			Mothers side-mother	Mothers side-father	Fathers side-mother	Fathers side-father			
Diabetes									
High Blood Pressure									
Stroke									
Tuberculosis									
Heart trouble									
Similar problems									
Cancer									

Describe the type of cancer(s):
