CONRNOE WOODLANDS GASTROENTEROLOGY

Dr. Stephen M. Kelly
Conroe Woodlands Gastroenterology
Financial Policies

We are dedicated in providing you with the best possible care and service, and regard your understanding of our financial policies as an essential part of your care and treatment. To assist you, we have the following financial policies.

Payment at time of Service

As a courtesy, we will bill your insurance for all office visits and procedures. We ask that you pay any portion not covered by your insurance due to deductibles, co insurance, or co-payments on the day of service, unless other arrangements have been made. For your convenience we accept, VISA, Discover, MasterCard and American Express

Appointment Policy

Should you have to cancel your office appointment please give 24 hour notice in consideration of other patients, failure to do so will result in a $25.00 cancellation fee. Should you have to cancel your procedure appointment please give 24 hour notice, failure to do so will result in a $50.00 cancellation fee.

Insurance Claims

We will submit your insurance claims to your insurance company. However, it is important to remember your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services after your insurance processes all claims.

Balances Due After Insurance Pays

Any remaining balance after your insurance carrier pays is due within 30 days. We attempt to collect these balances at your post procedure visit. You will receive a statement from our office regarding any remaining balance due.

Outstanding Balances

We encourage you to keep your account current. Outstanding balances will need to be cleared before appointments can be made. Account balances past due will be sent to an outside agency for collections. At this point the account is out of our hands. To make appointments after accounts have been sent to an outside agency, you will need to clear your account with the agency. You will be responsible for the full amount of your account balance and any charges incurred with the agency. It is your responsibility to contact our business office if there are special circumstances regarding your account before your account is turned over to an outside agency.

Additional Charges Associated with Your Procedure:

In order to provide a safe and comfortable experience your outpatient procedure requires a team of dedicated professionals. In addition to the professional fee charged by Dr. Kelly, you and/or your insurance carrier will incur charges from the facility, the anesthesia provider, and the pathology company. Please direct any questions regarding their fees for services to the appropriate office at the numbers below. They are not part of our billing services. Therefore, you will need to contact them to make sure they are part of your network and for any other questions regarding estimated amounts, etc.

We are required to inform you in advance that Dr. Kelly has a financial interest in River Oaks Endoscopy Center.

- **River Oaks Endoscopy Center (facility) – 936-494-3636**
- **USM Anesthesia – 936.494.3003**
- **Boston Scientific – 888-581-1201**
- **Alliance (pathology) --888.427.4144**

STEPHEN M. KELLY, M.D.
PATIENT REGISTRATION

PATIENT INFO:			**INSURED PARTY INFO IF DIFFERENT FROM PATIENT:**		
LAST NAME	FIRST NAME	MIDDLE	LAST NAME	FIRST NAME	MIDDLE
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
BIRTHDATE	AGE	**M** OR **F**	BIRTHDATE	AGE	**M** OR **F**
PRIMARY PHONE	HOME OR CELL		PRIMARY PHONE	HOME OR CELL	
SECONDARY PHONE			SECONDARY PHONE		
EMPLOYER			EMPLOYER		
SOCIAL SECURITY NUMBER			SOCIAL SECURITY NUMBER		
EMAIL			RELATIONSHIP TO INSURED PARTY		

REFERRED BY DR. ______________________________________ TELEPHONE # ____

ADDRESS ____ CITY ____________ STATE ________ ZIP ___________

IN CASE OF AN EMERGENCY CONTACT:

NAME ____ RELATIONSHIP _______________________________________

ADDRESS ____ PHONE # ____

PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST TO PHOTOCOPY.

● IS IT OK TO LEAVE A MESSAGE AT NUMBERS LISTED? ______

● I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I HAVE RECEIVED A COPY OF Dr. Kelly's FINANCIAL POLICY. ______

● I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE CLAIMS. I ALSO ASSIGN BENEFITS FOR THOSE CLAIMS THE DOCTOR FILES FOR ME. ______

In accordance with the Medical Privacy Act of Texas, the physician and/or staff of Conroe Woodlands Gastroenterology are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release information regarding your care to anyone other than yourself please complete the following information. **I hereby authorize the physicians and/or staff of Conroe Woodlands Gastroenterology to release information regarding my condition and care to the following individuals**

Name **Relationship**

Name **Relationship**

SIGNATURE OF PATIENT (GUARDIAN) DATE

PHARMACY: ______________________________________

CONROE WOODLANDS GASTRENTEROLOGY, P.A.
STEPHEN M. KELLY, M.D.

CANCELATION AND MISSED APPOINTMENT POLICY

Appointments are made in order to see our patients as efficiently as possible. *"No-Shows"* and *"Late Cancelations"* cause problems that go beyond a financial impact on our practice. When an appointment is missed, the available time is lost for another patient.

To "No-Show" means that one has missed a scheduled appointment or procedure.

A "Late Cancellation" means that one has failed to call and cancel, in advance, with the time frames shown below:

OFFICE VISITS

25.00 fee will be charged for each no-show or late cancelation, if notice is given in less than ***24 business hours.***

PROCEDURES

50.00 fee will be charged for each no-show or late cancelation, if notice is given in less than ***48 business hours.***

Business hours are Monday through Friday, between 8:30 am and 5:00 pm, except holidays. Insurance companies consider this charge to be entirely the patient's responsibility.

______________________________ ______________________________

Patient Signature Please print your name

____

Date

CONROE-WOODLANDS GASTROENTEROLOGY, P.A. **STEPHEN M. KELLY. M.D.**

REFERRING PHYSICIAN ______________________ PHONE NUMBER ______________________

HEALTH HISTORY QUESTIONNAIRE

NAME ______________________ DATE OF BIRTH ____________ AGE ____________

What is your principal reason for seeing the doctor? ______________________

____

How long have you had this problem? ______________________

What other problems are you having? ______________________

____

List all medicines ______________________

____

List all drug allergies and reactions ______________________

____

List all operations, if any	Date
1. ______________________	Yr. ( )
2. ______________________	Yr. ( )
3. ______________________	Yr. ( )
4. ______________________	Yr. ( )

List past illnesses and injuries	Date
1. ______________________	Yr. ( )
2. ______________________	Yr. ( )
3. ______________________	Yr. ( )
4. ______________________	Yr. ( )

Specifically, have you ever had:

Bronchial or Lung Trouble	Y	N
Heart Problems	Y	N
High Blood Pressure	Y	N
Diabetes	Y	N
Kidney or Bladder Problems	Y	N
Kidney Stones	Y	N
Stroke	Y	N
Gall Bladder Trouble	Y	N
Ulcer	Y	N
Jaundice	Y	N
Hepatitis	Y	N
Prostate Trouble	Y	N
HIV Positive	Y	N
Aids	Y	N
Blood Transfusion	Y	N
Tattoo	Y	N
Cancer	Y	N

If yes, what type ______________________

Or has any of your family had:

Heart Disease	Y	N
High Blood Pressure	Y	N
Stroke	Y	N
Diabetes	Y	N
Any Trouble Similar to Yours	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Chrohn's Disease	Y	N
Ulcerative Colitis	Y	N
Cancer	Y	N

If yes, what type ______________________

Do you smoke Y N How much per day ______________________

Do you drink caffeine Y N How much per day ______________________

Do you drink beer, wine, liquor Y N Amount per day ____________ Amount per week ____________

Have you ever had a drinking problem Y N ______________________

Are you following any diet Y N Type ______________________

REVIEW BY SYSTEMS (Just circle Yes or No – Doctor will inquire about details later)

GENERAL SYMPTOMS

Question		
Have you lost your appetite?	Yes	No
Have you lost or gained weight?	Yes	No
Lost Amount ________ Gained Amount ________		
Do you feel feverish? Or actually run fever?	Yes	No
Do you have hay fever, sinus allergy, asthma or skin allergy?	Yes	No
Have you noticed any swelling or knot anywhere about your neck, arms, armpits, breasts, skin or anywhere else about your body?	Yes	No
If so, where ________		
Do your feet or ankles swell?	Yes	No

HEAD, EYES, EARS, NOSE, THROAT

Question		
Do you have "sinus trouble," or trouble with your nose?	Yes	No
Have you been hoarse lately?	Yes	No

BONES, JOINTS, MUSCLES

Question		
Do you have rheumatism, arthritis, or pain in arms, legs or joints?	Yes	No
Does strength in some of your muscles seem reduced?	Yes	No
Are any of your joints swollen or stiff?	Yes	No
Have you ever been treated for arthritis?	Yes	No

RESPIRATORY SYSTEM

Question		
Do you have to cough very often?	Yes	No
If so, do you cough up any phlegm?	Yes	No
Have you ever coughed up any blood?	Yes	No
Do you prefer to sleep on more than one pillow?	Yes	No
Do you wheeze when you breathe or have asthma?	Yes	No
Does exertion bring on chest pain?	Yes	No
Has any doctor diagnosed you as having heart trouble?	Yes	No

DIGESTIVE SYSTEM

Question		
When you swallow does food or liquid ever stop in your throat or esophagus?	Yes	No
Do you have much "gas"?	Yes	No
Does your stomach often swell or bloat?	Yes	No
Do you belch often?	Yes	No
Does acid come up and burn in your chest or throat?	Yes	No
Do you ever feel "sick at your stomach" or nauseated?	Yes	No
Do you ever vomit, or spit up food?	Yes	No
Do you get any actual pain in your abdomen?	Yes	No
Has the pain become progressively worse?	Yes	No
Does the pain ever spread to another place in your body?	Yes	No
Does the pain wake you up at night?	Yes	No
Do you have "soreness", "heaviness", "aching", "gnawing", Or other type of discomfort in your abdomen?	Yes	No
If you have any other stomach discomfort, is it made worse by eating?	Yes	No
Or, made better by eating?	Yes	No
Is it made better by Alkalies such as Alka-Seltzer, Rolaids, Tums, etc.?	Yes	No
Are you often constipated?	Yes	No
Do you take laxatives or enemas?	Yes	No
Do you have loose bowels or diarrhea?	Yes	No
Do you wake up at night with diarrhea?	Yes	No
Do you have rectal pain, soreness, or hemorrhoids?	Yes	No
Do you ever pass blood from the rectum?	Yes	No
Do you ever pass black or "tarry" movements?	Yes	No
Do you have a rupture or hernia?	Yes	No

GENITO-URINARY SYSTEM

Do you have to urinate too often? .... Yes No
Do you have burning or pain on urinating? .... Yes No
Have you ever had infection, blood or pus in the urine? .... Yes No
Does your urinary flow seem slow? .... Yes No
Have you any trouble stopping the urine flow or leakage? .... Yes No
Do you have to wake up at night to urinate? .... Yes No

NERVOUS SYSTEM

Are you nervous, tense or easily upset? .... Yes No
Do you worry too much? .... Yes No
Are you worried about your health? .... Yes No
Do you have difficulty sleeping? .... Yes No

FAMILY HISTORY

Father: Living? ______ Age? ______ Health? ______
Deceased? ______ Age? ______ Cause of Death? ______

Mother: Living? ______ Age? ______ Health? ______
Deceased? ______ Age? ______ Cause of Death? ______

Brothers: No. Living? ______ Health? ______
No. Deceased? ______ Cause of Death? ______

Sisters: No. Living? ______ Health? ______
No. Deceased? ______ Cause of Death? ______

Are you currently married? Yes No If so, how many years? ______
Age of husband? ( ) wife? ( )
Is (wife) or (husband) in good health? Yes No
Children? ______ Number? ______ Ages? ______ Health? ______
Any deceased? ______ Cause of death? ______

Women: MENSTRUAL HISTORY

When was your last menstrual period? ______
Are your menstrual periods irregular? .... Yes No
Menstruations occur every ______ days, and last ______ days.