PRESCRIPITON & MEDICAL HISTORY UPDATE FORM

Name: _____

Primary Care Physician: _____

Referring Physician: _____

Medical Surgeries/History Updates: _____

_____

_____

Medication Allergies: _____

_____

**** PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE TAKING ****

MEDICATION	STRENGTH	DOSE	PRESCRIBING PHYSICIAN

* IF YOU NEED ADDITIONAL SPACE, PLEASE USE OTHER SIDE*

CONROE WOODLANDS GASTROENTEROLOGY

DR. STEPHEN M. KELLY
1501 RIVER POINTE DR, STE 240 CONROE TX 77304
17198 ST. LUKES WAY, STE 620 THE WOODLANDS, TX 77384
Phone: (936) 760.1900 Fax: (936) 441.1907

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, the patient, hereby authorize Dr. Kelly to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, health care providers employed by Conroe Woodlands Gastroenterology, can refuse to treat me.

I have been informed that Conroe Woodlands Gastroenterology has prepared a notice which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing the consent.

I understand that I may revoke this consent at any time by notifying Conroe Woodlands Gastroenterology, in writing, but if I revoke my consent, such revocation will not affect any actions that Conroe Woodlands Gastroenterology, took before receiving my revocation.

I understand that Conroe Woodlands Gastroenterology, has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Conroe Woodlands Gastroenterology restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Conroe Woodlands Gastroenterology, does not have to agree to such restrictions, but that once such restrictions are agreed to Conroe Woodlands Gastroenterology, must adhere to such restrictions.

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**
- **Baylor Pathology – 713-798-7242**
- **Alliance (pathology) --888.427.4144**

STEPHEN M. KELLY, M.D.
PATIENT REGISTRATION

PATIENT INFO:

LAST NAME	FIRST NAME	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
BIRTHDATE	AGE	**M** OR **F**
PRIMARY PHONE	HOME OR CELL	
SECONDARY PHONE		
EMPLOYER		
SOCIAL SECURITY NUMBER		
EMAIL		

INSURED PARTY INFO IF DIFFERENT FROM PATIENT:

LAST NAME	FIRST NAME	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
BIRTHDATE	AGE	**M** OR **F**
PRIMARY PHONE	HOME OR CELL	
SECONDARY PHONE		
EMPLOYER		
SOCIAL SECURITY NUMBER		
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

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