The Endoscopy Center of Texarkana
PATIENT QUESTIONNAIRE

COMPLETED BY: PATIENT / RELATIVE / FRIEND / STAFF MEMBER

PROCEDURE DATE: ________________ PHYSICIAN: COZART BALMAIN BOEHMKE SO

Who is your primary physician? ________________________________________________________________________

What phone number can the patient be reached at for post op phone interview? __________________________________

Who may we discuss your procedure with other than yourself? ______________________________________________

Who will be here to talk with the doctor and drive you home? ________________________________________________________________________________________

DO YOU HAVE OR HAVE YOU EVER HAD:

[ ] ☐ Airway/Breathing problems
[ ] ☐ Sedation/Anesthesia problems
[ ] ☐ Diabetic meds/Thyroid meds
[ ] ☐ Eye, Ear, Nose, Throat problems
[ ] ☐ Bleeding/Brusing problems
[ ] ☐ Radiation / Chemotherapy
[ ] ☐ Back/Neck problems
[ ] ☐ Tattoo / Body piercings; please remove
[ ] ☐ Contact lens / glasses / hearing aid
[ ] ☐ Artificial limbs, Braces
[ ] ☐ Eye prosthesis
[ ] ☐ Colostomy / ileostomy
[ ] ☐ Dentures / Caps / Braces
[ ] ☐ Take aspirin frequently
[ ] ☐ Birth control pills
[ ] ☐ Blood Thinners
[ ] ☐ Loose Teeth / Bridgework How many _____
[ ] ☐ Immunocompromised
[ ] ☐ Radiation / Chemotherapy
[ ] ☐ Back/Neck problems
[ ] ☐ Tattoo / Body piercings; please remove
[ ] ☐ Contact lens / glasses / hearing aid
[ ] ☐ Artificial limbs, Braces
[ ] ☐ Eye prosthesis
[ ] ☐ Colostomy / ileostomy
[ ] ☐ Dentures / Caps / Braces
[ ] ☐ Take aspirin frequently
[ ] ☐ Birth control pills
[ ] ☐ Blood Thinners
[ ] ☐ Loose Teeth / Bridgework How many _____
[ ] ☐ Immunocompromised

Any other medical problems not listed above that we should know about? _________________________________________

Any surgical operations? (Please give approximate year of surgery, kind of surgery) _______________________________
_______________________________________________________________________________________________________________
_______________________________________________________________________________________________________________

Has the patient or any member of the patients’ immediate family had any problems with anesthesia?

Yes _____ No _____ Explain _____________________________________________________________________________________

Has the patient ever been hospitalized for any reason other than surgery? Yes _____ No _____

EXPLAIN (Give approximate date, why, and where) _______________________________________________________________
_______________________________________________________________________________________________________________

WEIGHT ______________________ (approximate) HEIGHT: __________ ft. __________ in.

REVIEWED BY ____________________ DATE ____________________ TIME ____________________

I have reviewed the information provided and verify that it is correct or I have made the corrections.

AUTHORIZED SIGNATURE ____________________ DATE ____________________ TIME ____________________

Patient _____ Power of Attorney _____ Parent _____ Legal Guardian _____ Spouse
The Endoscopy Center of Texarkana

PATIENT REGISTRATION
(PLEASE PRINT LEGIBLY)

Patient Name: ___________________________ DOB: ___________________________

Last 4 digits of SSN: _____________________ Home Phone: _____________________ Age: _______________

Mailing Address: __________________________ City: ___________________________ State: ___________ Zip Code: ___________

Work or Cell Phone Number: __________________________

Please Circle: SEX:  M   F      MARITAL STATUS:      Single      Married       Divorced       Widowed

Primary Insurance: __________________________________________________________________________________

Policy # ___________________________ Group # _____________________ Eff: ___________

Secondary Insurance: __________________________________________________________________________________

Policy # ___________________________ Group # _____________________ Eff: ___________

Is your insurance through your spouse's employer? Yes ____  No ____

Spouse Name: ___________________________ Last 4 digits SSN: ___________

Spouse date of birth: _____________________

Emergency Contact Information (Someone other than spouse) List 2

Name ___________________________ Relation to Patient: ___________________________

Home Phone _____________________ Cell Phone ___________________________

Name ___________________________ Relation to Patient: ___________________________

Home Phone _____________________ Cell Phone ___________________________

Please list who is with you today: _____________________________________________________________

Patient Signature: ___________________________________________ Date: _______________

Copyright 2023

The Endoscopy Center of Texarkana

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRIVACY PRACTICE NOTIFICATION

I, __________________________, understand that as part of my health care, the Endoscopy Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

• A basis for planning my care and treatment
• A means of communication among the many health professionals who contribute to my care,
• A source of information for applying my diagnosis and surgical information to my bill,
• A means by which a third-party payer can verify that services billed were actually provided, and
• A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I hereby consent to the centers use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the centers Notice of Privacy Practices, which describes the obligations of the center regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the center reserves the right to change its notice and practices. If the center changes the notice, I can obtain a revised copy by asking the Clinic Director of the center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the center is not required to agree to the restrictions requested. If the center does agree to such restrictions, however, the center must comply with such restrictions.

The Endoscopy Center of Texarkana is authorized by this form to disclose or discuss my protected health information with the following named people:

Name(s) and Relationship(s) ___________________________ ___________________________

Is any insurance through your spouse’s employer? __________________________

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the center is not required to agree to the restrictions requested. If the center does agree to such restrictions, however, the center must comply with such restrictions.

I hereby authorize the release of medical information in the possession of THE ENDOSCOPY CENTER OF TEXARKANA, concerning my illness, treatment, or recommendations to insurance companies, or medical facilities, requesting such information. I understand my medical records MAY contain copies of information received from other healthcare facilities or doctors, and I authorize the release of this information.

I further understand my medical records MAY contain reference to, or results of, HIV antibody (AIDS) testing, testing for communicable diseases, and treatment of drug or alcohol use, or abuse, and I authorize the release of this information.
The Endoscopy Center of Texarkana

Financial Responsibility and Release Form

FINANCIAL RESPONSIBILITY

Charges for services provided by The Endoscopy Center of Texarkana, LP (the “Center”) cover the following components: use of the procedure room, equipment and recovery room; all supplies and medications used during your stay; and any lab tests performed at the Center. We require payment of your copay or deductible amount, if applicable, on the date of your procedure.

Fees for physician services, procedural assistants, Anesthesiologist/Anesthesiologists, pathologists, laboratory work performed outside the Center and implants are separate from the Center’s fees and your responsibility for payment for these fees is between you and the provider of service.

We will submit to your insurance carrier within 48 hours of your procedure(s). You will be notified when final action (payment, denial, etc.) by your insurance carrier has been received. If any additional funds are owed, payment will be expected within 10 days of receipt of that notice. In the event that such amount is placed with our collection agency, you will be responsible for the collection fees, reasonable attorneys’ fees and court costs. A $250.00 service charge will be added to your account for checks returned due to insufficient funds.

We file your insurance claim for you as a courtesy to you; however, our relationship is with you, not your insurance company. It is your responsibility to be knowledgeable regarding your insurance coverage and benefits. We will expect your assistance in obtaining payment from your insurance company if difficulties arise. After 90 days, with certain exception, the balance will become payable in full by you.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to The Endoscopy Center of Texarkana, LP of any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Center, not to exceed the Center’s regular charges. This assignment of benefits is valid for all insurance companies and programs including Medicare, private and group insurance, workers’ compensation or other health plan payments.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Center to release medical information concerning the procedure(s) performed at the Center to the extent necessary to determine liability for payment and to obtain reimbursement. The Center may disclose portions of the medical record to any person, corporation or other entity who or which is or may be liable for any of the Center’s charges. This includes, but is not limited to, insurance companies, health care service plans, and worker’s compensation carriers.

CONSENT FOR OBSERVERS

I consent to the admittance of observers to the procedure room during my procedure for the purpose of advancing medical education.

CONSENT TO PHOTOGRAPH

I consent to the photographing or videotaping of my procedures as deemed necessary by my physician, for scientific or education purposes provided my identity is not revealed by the images or descriptive text accompanying them. I understand that these photographs and/or videotapes are the exclusive property of my physician.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS EXCEPT AS CROSSED OFF AND INITIALED. A photocopy of this authorization shall be considered as valid as the original.

PATIENT’S OR GUARDIAN’S SIGNATURE

DATE

ACKNOWLEDGED BY

DATE
The Endoscopy Center of Texarkana

DISCLOSURE OF PHYSICIAN AND OTHER OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Each of the physicians listed directly below has an ownership interest in The Endoscopy Center of Texarkana, LP.

   John C. Cozart, M.D. – NPI# 195230262
   Laura C. Balmain, M.D. – NPI# 1386642692
   James J. Boehmke, D.O. – NPI# 1154309375
   Brian So, M.D. – NPI# 1841499100

   The mailing address for all physicians above is 1920 Moores Lane, Texarkana, TX 75503.

2. Arkansas Integrated Community Health Network, Inc. is also an owner of The Endoscopy Center of Texarkana, LP. Their mailing address is 2600 St. Michaels Drive, Texarkana, TX 75503.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than The Endoscopy Center of Texarkana, LP.

4. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than The Endoscopy Center of Texarkana, LP.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of The Endoscopy Center of Texarkana, LP. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in The Endoscopy Center of Texarkana, LP.

__________________________________  _____________________________________
SIGNATURE OF PATIENT      SIGNATURE OF PARENT OR GUARDIAN (IF APPLICABLE)

__________________________________  _____________________________________
TYPE OR PRINT NAME OF PATIENT     TYPE OR PRINT NAME OF PARENT OR GUARDIAN (IF APPLICABLE)

Dated: _________________________________

The Endoscopy Center of Texarkana

ADVANCED DIRECTIVES

The Patient Self Determination Act requires healthcare facilities to inform their patients about advanced directives prior to scheduled procedures.

Under this law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for rights and personal wishes to be respected even if one is too sick to make decisions for themselves.

Everyone has a right, under certain conditions, to decide whether to accept or reject medical treatment. This includes whether to continue medical treatment and other procedures that would prolong life artificially.

These rights may be written out by each individual in a living will, containing his/her personal directions about life-prolonging treatment in the case of serious illness that could cause death.

Each patient may also designate another person, or surrogate, who may make decisions for them if they become mentally or physically unable to do so. This surrogate may function in one’s behalf for brief times or longer. For life-threatening or non-life-threatening situations, limits of the power of the surrogate to make decisions for the individual should be clearly expressed.

It is the policy of THE ENDOSCOPY CENTER OF TEXARKANA that any and all emergency conditions that arise during treatment will be treated regardless of Advanced Directive Status and patients will be transferred to a higher level of care.

By signing this document, you acknowledge that you have received and reviewed this document prior to your scheduled procedure.

___________________________________________________  ____________________
SIGNATURE          DATE
Patient Interview Form

Patient Information

First Name: ___________________________ Last Name: ___________________________

MRN: ___________________________ Date of Birth: ___________________________

Age: ___________________________ Notes: ___________________________

Preferred Language:
☐ English  ☐ Spanish  ☐ Other: _________________________________________

Contact Preference:
☐ Cell phone  ☐ Home Phone  ☐ Other: _________________________________________

Allergies

☐ Patient has no known allergies  ☐ Patient has no known drug allergies

☐ Latex  ☐ Iodine containing drugs  ☐ Codeine  ☐ Morphine  ☐ Demerol

☐ Other: ________________________________________  ☐ Sulfur (Sulfonamides)  ☐ Penicillin

Current Medications

☐ None

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How Taken?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reorder 903-832-7166 Netex #122509

Reorder 903-832-7166 Netex #122509
Past or Present Medical Conditions

- Anemia
- Asthma
- Atrial Fibrillation
- Alzheimer/Dementia
- Cancer
- Cirrhosis
- Crohn's Disease
- Depression
- Diabetes Mellitus
- Diverticulitis
- Heart Murmurs
- Hialt hernia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Migraines
- Osteoarthritis
- Osteoporosis
- High blood pressure
- Lupus
- Malignancies
- Rheumatic Arthritis
- Rheumatoid Arthritis
- Emphysema
- Parkinson's
- Tuberculosis
- Kidney Disease
- Kidney Failure
- Heart Murmurs
- Hiatal Hernia
- Colon Cancer
- Colon Prolapse
- Colon Prolapse
- Colon Resection
- Colonoscopy
- EGD/Upper Endoscopy
- ERCP
- Gallbladder removed
- Kidney
- Kidney Disease
- Kidney Failure
- Heart Attack
- TB
- TB exposure
- Irregular heartbeat
- Reflux
- TTN
- Difficulty swallowing
- Blood clots
- Radiation Therapy
- Chemotherapy

Previous Procedures

- Appendectomy
- Back Surgery
- C-Section
- Cardiac Bypass
- Cardiac catheterization
- Colon Resection
- Colonoscopy
- EGD/Upper Endoscopy
- ERCP
- Gallbladder removed
- Groin surgery
- Hemorrhoids
- Hiatal Hernia
- Joint Replacement
- Kidney
- Liver Biopsy
- Neck surgery
- Obesity Surgery
- Ovary surgery
- Stomach
- Thyroid
- Tonsil
- Tubal Iigation
- Uterus
- Dialysis
- Heart Valve Replacement

Family Medical History

- No knowledge of family history.

No family history of
- Colon cancer
- Polyps

Diagnoses
- Polyps
- Colon Cancer

Social History

Occupation: ____________________________ Number of Children: ____________________________

Alcohol:
- None

<table>
<thead>
<tr>
<th>Type</th>
<th>Quantity</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Tobacco:
- Current every day smoker
- Current some day smoker
- Former Smoker
- Smoker, current status unknown
- Unknown if ever smoked
- Never smoker

<table>
<thead>
<tr>
<th>Type</th>
<th>Started</th>
<th>Quit</th>
<th>Quantity</th>
<th>Frequency</th>
</tr>
</thead>
</table>

Drug Use:
- None

<table>
<thead>
<tr>
<th>Type</th>
<th>Quantity</th>
<th>Frequency</th>
</tr>
</thead>
</table>

Pharmacy

Name: ____________________________

Reviewed with

- Patient
- Parent
- Guardian
- Not Present