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:

Y	N		Y	N	
☐	☐	Airway/Breathing problems	☐	☐	Sedation/Anesthesia problems
☐	☐	Diabetic meds/Thyroid meds	☐	☐	Eye, Ear, Nose, Throat problems
☐	☐	Bleeding/Bruising 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

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.

ALLERGIC REACTIONS TO ANY MEDICATIONS? Yes ____ No ____ (if yes, give medications and type of reaction)______________________________

ALLERGIC REACTION TO LATEX: Yes ___ No ___

ALLERGIC REACTION TO IODINE: Yes ___ No ___

ALLERGIC REACTION TO EGGS: Yes ___ No ___

Current Medications:

Name	Dose	How taken

Vitamins, herbs, over the counter medication: ______________________________

____

Laxatives, street drugs, etc.: ______________________________

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? Yes ____ No ____

DO YOU HAVE A LIVING WILL? Yes ____ No _____

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

______________________________ ______________ ______________
AUTHORIZED SIGNATURE DATE TIME

______ Patient _____ Power of Attorney ______ Parent ______ Legal Guardian ______ Spouse

______________________________ ______________ ______________
REVIEWED BY DATE TIME

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The Endoscopy Center of Texarkana

PATIENT REGISTRATION

(PLEASE PRINT LEGIBLY)

PatientName:____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

Patients' Employer:____

PrimaryInsurance:____

Policy#_____________________________________Group#_________________Eff:_____________

SecondaryInsurance:____

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:*____

PatientSignature:____Date:______________

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)

____ ☐ Medical Information ☐ Appt./Testing

____ ☐ Medical Information ☐ Appt./Testing

I understand that I have the right to revoke anyone listed on the authorization and I must fill out the form before the revocation can be completed. All revocations must be sent to the center address to the attention of the ***Privacy Officer,*** and are not effective until received by such.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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.

____

PATIENT'S PRINTED NAME DATE

____

PATIENT'S SIGNATURE

____

ACKNOWLEDGED BY

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/Anesthetics, pathologists, laboratory work performed outside the Center and implants are separate from the Center's fee 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 nay such amount is placed with our collection agency, you will be responsible for the collection fees, reasonable attorneys' fees and court costs. A $25.00 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 tome 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

PATIENT'S RIGHTS AND RESPONSIBILITIES

- A patient has the right to quality health care, regardless of race, color, creed, age, sex, sexual preference, religion, disability, national origin, ability to pay, or recommendations of their party payers.
- A patient who does not speak English, or who is hearing impaired, has the right to have access to an interpreter.
- A patient has the right to considerate, respectful care given by competent personnel who adhere to high professional standards.
- A patient has the right to be informed in advance of the center furnishing or discontinuing patient care whenever possible.
- A patient has the right to a full explanation of the medical center bill, professional bills for care, and the availability of known financial resources for his/her health care.
- A patient has the right to a full explanation regarding all continuing health care needs, such as return visits and required medications that will be needed by the patient after discharge.
- A patient has the right to prompt resolution of a complaint/grievance and knowledge of whom to contact to file such a complaint/grievance.
- A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.
- A patient cannot be denied the right of access to an individual or agency that is authorized to act on his behalf to assert or protect the rights set out in this section.

Exercise of Rights

The patient or his/her representative have the right to:

- Make informed decisions regarding his/her care.
- Knowledge of the name of the physicians, nurses, therapists and other health care professionals participating in the patient's care.
- Be informed of his/her health status, and receive information about the illness, course of treatment and prospects for recovery in terms the patient can understand.
- Be involved in care planning and treatment, and actively participate in decisions regarding medical care, including decisions to withhold or withdraw treatment if the patient has a terminal condition.
- Participate in the development and implementation of his/her plan of care.
- Expect emergency procedures and implementation of his/her plan of care.
- Be able to request or refuse any and all drugs, treatment or procedures and be informed of the medical consequences of refusal.

Privacy and Safety

The patient has the right:

- to personal privacy
- to receive care in a safe setting
- to be free from all forms of abuse or harassment.

Confidentiality and Patient Records

The patient has the right:

- to the confidentiality of all communication, case discussion, consultation, examination, treatment and his/her clinical records, except as otherwise provided by law or third party contractual arrangements.
- to access information contained in his/her clinical record within a reasonable time frame while a patient in the center, or following discharge by placing a request with the Medical Records Department.

The center will actively seek to meet the requests of individuals who wish to gain access to their own medical records, and process such requests as quickly as the medical record keeping system permits.

Restraints in Acute Medical and Surgical Care

- The patient has the right to be free from any form of restraints (physical restraint or drug being used as a restraint) that is not medically necessary or is used as a means of coercion, discipline, convenience, or retaliation by staff.

Seclusion and Restraint for Behavior Management

- The patient has the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline convenience, or retaliation by staff.
- Seclusion or restraint may be used in emergency situations, if needed, to ensure the patients' physical safety and less restrictive interventions have been determined to be ineffective.

All rights are applicable and extended to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.

Patient Responsibilities

- to provide to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies, and other matters relating to the patient's health.
- to report unexpected changes in their conditions to the responsible practitioner.
- to make informed decisions regarding their health care including communicating that he/she understands the course of treatment.
- to follow the treatment plan recommended by the practitioner responsible for their care, including the instruction of nurses and other health card personnel as they carry out the coordinated plan of care.
- to keep follow-up appointments, and when unable to do so for any reason, notify the practitioner.
- to accept the consequences if they refuse treatment or do not follow the practitioner's instructions.
- to ensure that the financial obligations of their health care are fulfilled as promptly as possible.
- for abiding by the rules and regulations affecting their health care and conduct.
- to be considerate of the rights of other patients and center personnel and for assisting in the control of noise, smoking, and the number of visitors.
- to respect the property of other persons and of the center.

Special Needs

The center will not deny medically-necessary services to patients on the basis of ability to pay, race, creed, color, national origin, age, sex or actual or perceived disability.
The center is accessible to and usable by disabled persons, including the person with impaired hearing and vision. Access features include:

- Accessible handicapped parking
- Ground-level entrances and ramps
- Level access into the facility
- Wheelchair accessibility.
- Wide corridors
- Wheelchair accessible bathrooms.

Auxiliary and communication aids are available to disabled persons with impaired hearing, vision or speech and include:

- Wheelchair assistance or transportation in center
- Braille signage for bathrooms and offices
- Language Line services.

The above has been reviewed with me, and I have been given a copy.

Patient signature: ______________________ Date: ____________

If Signed by Other than Patient, relationship: ______________________

If further assistance is needed contact:

Department of State Health Service
P.O. Box 149347
Austin, TX 78714-9347
1-888-973-0022

Office of the Medicare Beneficiary Ombudsman
1-800-MEDICARE www.Medicare.gov

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

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The Endoscopy Center of Texarkana

1920 Moores Lane • Suite B • Texarkana, Texas 75503 • Phone: 903-791-8657 Fax: 903-791-8650

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: ______________________ ☐ Sulfa (Sulfonamides) ☐ Penicillin

Current Medications

☐ None

Name	Dose	How Taken?

The Endoscopy Center of Texarkana

1920 Moores Lane • Suite B • Texarkana, Texas 75503 • Phone: 903-791-8657 Fax: 903-791-8650

Patient Interview Form

Patient Information

First Name: ______________________ Last Name: ______________________

MRN: ______________________ Date of Birth: ______________________

Age: ______________________ Notes: ______________________

Preferred Language:

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

☐ Other: ______________________ ☐ Sulfa (Sulfonamides) ☐ Penicillin

Current Medications

☐ None

Name Dose How Taken?

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Past or Present Medical Conditions

- [ ] None

☐ Anemia	☐ Asthma	☐ Atrial Fibrillation	☐ Alzheimer/Dementia	
☐ Cancer	☐ Cirrhosis	☐ Colitis	☐ Colon Cancer	☐ Colon Prolapse
☐ Crohn's Disease	☐ Depression	☐ Diabetes Mellitus	☐ Diverticulitis	☐ Emphysema
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Heart Murmurs	☐ Hiatal hernia
☐ High blood pressure	☐ Lupus	☐ Migraines	☐ Osteoarthritis	☐ Osteoporosis
☐ Parkinsons	☐ Pneumonia	☐ Rheumatic Fever	☐ Rheumatoid arthritis	☐ Seizures
☐ Skin Cancer	☐ Sleep Apnea	☐ TB exposure	☐ Thyroid disorder	☐ Duodenal Ulcer
☐ Fatty liver	☐ HIV/AIDS	☐ Irregular heartbeat	☐ Kidney disease	☐ Kidney failure
☐ Pancreatitis	☐ Paralysis	☐ Reflux	☐ Heart attack	☐ TB
☐ Ulcerative colitis	☐ Arthritis	☐ TMJ	☐ Difficulty swallowing	☐ Blood clots
☐ Radiation Therapy	☐ Chemotherapy			

Previous Procedures

- [ ] None

☐ 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 ligation	☐ Uterus	☐ Dialysis
☐ Heart valve replacement				

Family Medical History

- [ ] No knowledge of family history.

No family history of ☐ Colon cancer ☐ Polyps

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Polyps	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○

Social History

Occupation: ______________________ Number of Children: ______________

Alcohol:

- [ ] None

Type	Quantity	Frequency

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐ Never smoker

Type	Started	Quit	Quantity	Frequency

Drug Use

- [ ] None

Type	Quantity	Frequency

Pharmacy

Name: ______________________________

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

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