

Central Texas Colon and Rectal Surgeons

Patient Registration and History Form

Are you a(n):						
New Patient	If you are a new patient, plea	se fill out all the sections on this fo	rm.			
Established Patient	If it has been one (1) year sin	ce your last visit, please fill out all	sections on this form			
Who is your appointment with today?	 Robert W. Cline, M.D. David Fleeger, M.D. April W. Fox, M.D. 	 Ernest D. Graves, III, M.D. Thiru V. Lakshman, M.D. John S. Mangione, M.D. 		I. Miller, M.D. Shah, M.D. . Solis, M.D.		
Please describe why	you are seeking treatment	today:				
Demographic Informat						
Name						
	Mr. Miss Ms. Mrs. Dr.	Other: Sex: M F				
First: Address:	Niddle ii City:	nitial: Last:	State 7	p Code		
	Ony: / Age:	Social Security #:		-		
Employor		Occupation				
Employer Preferred Language:	Ethnicity: Not His	spanic or Latino Hispanic or La				
Race (circle one): White	Black or African American Asi	ian Hawaiian or Pacific Islander	Native American or A			
Preferred Pharmacy and	Location:	Preferred Lab:				
		Primary Care Physician:				
Insurance Information						
		5				
Primary Insurance Secondary Insurance		Policyholder Policyholder				
•	ID					
Contact Information						
Phone Home: () -	Cell: ()	- Work: ()	- Preferred:			
Email Address:	Cen	Emergency Contact:	<u> </u>) -		
Do we have permission		3 ,	•	,		
Do we have permission			Yes	No		
Leave a message on y	your home answering machine?					
Leave a message on your work voicemail?						
Send a text message to your cell phone (i.e. appointment reminders; announcements)?						
Register you for our patient portal? (You will receive an email invitation). □ □ □						
2						
lf you answered yes, µ Nam		with and their relationship to you below ationship Phone Nu				
Allergies						
No Known Allergies	□ Yes (Please list any: for	od, drug, latex, and any other allergy w	e should know about b	elow)		
Medications						
Are you currently taking any n	nedications? Yes	□ No				
If your answer is yes, please I Medications	list all of the medications you are taki Dosage How Ofte	-	Dosage	How Often		
1		6				
2 3	<u> </u>	8				
4		9				
5		10				
Vaccines						
Immunizations						
Flu Shot: Pneumonia Vaccination:		ast Flu Shot: ast Pneumonia Vaccination:				
	□ Yes □ No Date of La	ast i neumonia vaccination.				

Check all that apply Cloon Polyps High Blood Pressure Uterine Cancer Breast Cancer Crohn's Disease Kidney Disease Other: Colon Cancer: Diabetes Ovarian Cancer Please list if "Other" checked: Mother Mother Ulcerative Colitis Please list if "Other" checked: Mother Yes No No Person Yes No Do you have children? Yes No No Yes No Yes No Do you sme alcohol? Yes No If yes, how many children do you have? Yes No Yes No Surgical History Yes No If yes, how many times a week? Yes No Yes No Yes No None Gallbladder Removal Pacemaker Defibrillator Knee Type? Pecemaker Defibrillator Appendectomy Heart I Type ? Rectal Surgery Type ? Pacemaker Defibrillator Tonsillectomy Breast Hip abscess plionidal cyst Thyroidectomy Tubal Ligation Colon Scopy Ovaries Removed hemorthoid Pacemaker Defibrillator Scoses Past Medical History Stocke/ CVA hemorthoid Sleep apnea	Family History				
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Central Texas Colon and Rectal Surgeons

For your visit, please be prepared to:

- Provide photo ID, insurance card, referral information, and to complete and sign all patient forms.
- Pay your copay. Payment is required at time of service.
- Have your referring physician provide any prior test results and office visit notes relating to your appointment.

PAYMENT/BILLING INFORMATION

Procedures and diagnostic exams done in the office may be categorized under your surgical benefits which can result in charges being applied to your annual deductible and not covered under your office visit co-pay.

The office will file insurance claims for services rendered to health plans we are contracted with, but patients are not relieved of responsibility for payment because of insurance coverage. Insurance Companies offer numerous plans and it is extremely difficult to determine prior to filing the claim how your benefits will be applied. We recommend reviewing your benefit plan and/or contacting your Insurance Company.

MEDICARE PATIENTS additional information

The doctors accept assignment. Medicare pays 80% of covered charges after your annual deductible is met. The patient is responsible for the other 20%. We will file a claim for secondary insurance if the information is provided at the time your visit.

In addition, the initial consult/visit is not covered for screening and history of diagnosis. Please consult Medicare if you have any questions about your coverage for well-visits with no symptoms.

PRIVATE PAY

Payment arrangements can be made prior to your appointment. This office offers a prompt pay discount when charges are paid at the time of service; no claim filing is required and this is not in violation of contractual agreements with insurance carriers.

INSURED PATIENTS

The following are examples of services and codes which may be helpful when contacting your insurance company to determine if services will be covered under annual deductible or office visit co-payment:

- <u>In Office</u>: Anoscopy (diagnostic rectal exam) CPT code 46600; Sigmoidoscopy (diagnostic colon exam) CPT code 45330; Hemorrhoid excision (office procedure/surgery) CPT code 46221.
- Screening Colonoscopy for colon cancer, Diagnosis code Z12.11, is used when there are no symptoms present or found. A different diagnosis code must be used if there is a personal history, symptomatic diagnosis (i.e. blood in the stool) or any other diagnosis is found (i.e.polyp). These may have different insurance benefits. A modifier is added to the procedure code to let the insurance company know this was a "screening" colonoscopy.
 Diagnostic Colonoscopy CPT code 45378: This procedure code is used for reporting both screening and symptomatic colonoscopies. If polyps are removed or biopsies taken other coding is used, an example would be 45380 (colonoscopy with biopsy, single or multiple).
- Colonoscopies are performed in an outpatient setting, (Hospital or Surgery Center), not in our office. You will be billed separately by the facility.

For additional information on payment or billing, please contact our Billing Office at 512-418-1979, option 6.

I have read and understand the above information.					
Patient/Responsible Party Signature	Date				
l have received the Notice of Privacy Practices and u	understand that I may receive a copy of this information upon request.				
	Data				

Patient/Responsible Party Signature _____ Date _____