Northwest General & Colon-Rectal Surgery, P.A.
Khawaja Azimuddin, MD, FACS, FASCRS
Tal Raphaeli MD, FACS
Jean Knapps, MD

Personal Information

Name: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip Code

Home phone: _____ Cell phone: _____ SSN: _____

Email address: _____ Height:_____ Weight:_____

Sex: _____ DOB: _____ Race: _____ Ethnicity:_____

Pharmacy name:_____ Pharmacy Tel:_____

Pharmacy address:_____

Patient Employer: _____ Occupation: _____

Employer Address: _____ _____
Street City State Zip Code

In case of emergency who should be notified? _____ _____
Name Phone Work phone

Insurance Information

Insured's Name: _____ Insured's DOB:_____ Insured's SS#: _____

Primary Insurance Company : _____

Patient ID #: _____ Group #: _____

Secondary Insurance Company: _____

Patient ID #: _____ Group #: _____

Guarantor Information

Person responsible for account: _____ Relationship to Pt.: _____

Address: _____

Phone #: _____ SSN: _____ DOB: _____ Sex: _____

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to Dr. Azimuddin/ Dr. Raphaeli/Dr. Knapps all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.Printed Name of **Patient/Guardian**

_____ _____
Printed Name of Patient/Guardian **Signature of Patient/Guardian** **Date**

NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A

MEDICAL QUESTIONNAIRE (PART 1)

Your Name: _____

How did you hear about us? (circle one)
a. Internet Search
b. Friend or Relative
c. Insurance Company
d. Other (Please specify) _____

Who is your primary care doctor? _____

What is the reason for seeing the doctor today? _____

_____

Please check if you currently or have had any of these conditions:

- Anemia
- Anesthesia related problems
- Back or neck problems
- Bleeding or bruising tendency
- Blood thinners other than Aspirin
- Blood clots in legs
- Blood transfusion reaction
- Cancer
- Chest pain
- Chronic cough
- Chronic pain
- Diabetes
- Heart disease
- Heart surgery
- High blood pressure
- Jaundice or liver disease
- Kidney disease
- Lung disease (asthma or emphysema)
- Nervous breakdown
- Pacemaker
- Seizures

Do you have any of these problems? (Circle all that are applicable)

Rectal bleeding	Rectal pain
Change in bowel habits	Abdominal pain or cramps
Constipation	Diarrhea
Weight loss	Weakness or tiredness
Fever	Difficulty in breathing
Chest pain	Palpitation

NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A

MEDICAL QUESTIONNAIRE (PART 2)

Social history:

How much alcohol do you drink in a day? _____

Do you smoke? Yes Past Smoker Never

If you are over 65, have you had a pneumonia vaccine? (Circle) YES NO

Have you had an influenza shot since last September? (Circle) YES NO

Personal history: ***(For Colon & rectal patients only)***

Do you use any laxatives? (Circle) YES NO

Do you use any herbal or diet supplements? (Circle) YES NO

Does something protrude or stick out of the rectum? (Circle) YES NO

Do you have accidental leakage of gas, liquid or solid stools? (Circle) YES NO

Do you have any anal discharge or leakage staining your underwear? (Circle) YES NO

How many bowel movements do you have? _____ per day / week

Have you ever had a cancer of the colon or rectum? (Circle) YES NO

Have you ever had any operations on your colon or rectum? (Circle) YES NO

Have you ever had a colonoscopy? (Circle) YES NO If so, when was your last colonoscopy? _____

Family history:

- Colon cancer
- Colon Polyps
- Ulcerative colitis or Crohn's disease
- Breast, Ovarian or Uterine cancer

List any previous surgery or procedures:

_____

_____

_____

List your current medications: (or provide copy of medication list)

_____

_____

_____

Allergies:

_____

_____

Are you allergic to iodine or latex? (circle one) YES NO

NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A.

KHAWAJA AZIMUDDIN M.D.
TAL RAPHAELI M.D.
JEAN KNAPPS M.D.

Consent for examination and treatment: I consent to evaluation, examination and treatment by the doctors during my visits. This may include minor procedures necessary to evaluate and treat my medical condition.

I acknowledge that I am responsible for following my physician's recommendations and to do what is necessary to control and treat my condition. I understand that the sole responsibility of my health and wellbeing is in my hands in view of the above and that I cannot reasonably hold my physician responsible if I do not adhere to his recommendations and/or not take medications as I am instructed to do so.

Declaration of financial responsibility: I am responsible for payment. If for any reason my insurance company does not pay the charges at Northwest General & Colon-Rectal Surgery, P.A. I will be liable for all unpaid balances. I understand that in an effort to expedite my care and to provide me with better service, the doctors may choose to perform my operation in a facility where they may have ownership interests. This in no form or shape will affect the medical care provided to me. I also understand that I have the option to choose an alternative location for my medical care, if I so choose to.

Signature: _____

Date: _____

Houston Colon & Rectal Surgery
Office Visit
24 Hour Cancellation/Rescheduling Policy

Houston Colon & Rectal Surgery has a 24 hour cancellation/rescheduling policy for office visits. If an office visit is missed, cancelled or changed with less than 24 hours notice, there will be a $50 charge. This amount will be the patient's responsibility so the insurance company will not be billed.

The clinic realizes there are many things that come up in the daily lives of patients. While truly sympathetic, the clinic cannot absorb the financial responsibility of last minute cancellations. In fairness to all patients, this policy is in effect regardless of the reason for the cancellation.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for **Houston Colon & Rectal Surgery** as described above.

Thank you for your understanding and cooperation.

_____

Patient's Name

_____

Date

Office Copy

Houston Colon & Rectal Surgery
Office Visit
24 Hour Cancellation/Rescheduling Policy

Houston Colon & Rectal Surgery has a 24 hour cancellation/rescheduling policy for office visits. If an office visit is missed, cancelled or changed with less than 24 hours notice, there will be a $50 charge. This amount will be the patient's responsibility so the insurance company will not be billed.

The clinic realizes that there are many things that come up in people's day to day lives. While truly sympathetic, the clinic cannot absorb the financial responsibility
of last minute cancellations. In fairness to all patients, this policy is in effect regardless of the reason for the cancellation.

By signing below, you acknowledge that you have read and understand the
Cancellation Policy for **Houston Colon & Rectal Surgery** as described above.

Thank you for your understanding and cooperation.

_____

Patient's Name

_____

Date

Patient Copy

NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A

HIPAA NOTICE OF PRIVACY PRACTICES

I am aware of the HIPAA Notice of Privacy practices for Northwest General & Colon Rectal Surgery and the copies of the notice are available for me to take upon request.

0Authorization to release protected health information to designated persons:

I give my authorization to release medical/surgical information to the following designated representatives:

- My Spouse (Name): _____
- My Children (Names): _____
- Other (Name): _____
- May not be given to anyone other than myself

I hereby authorize medical information to be relayed to me via phone / email:

Acknowledgment of receipt of privacy practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

HOUSTON COLON AND RECTAL SURGERY, P.A.

1125 Cypress Station Dr., Suite G3 Houston, TX. 77090
Phone: (281) 583-1300 Fax: (281) 583-1303

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE K. AZIMUDDIN, MD OR T. RAPHAELI, MD OR J.KNAPPS, MD
to _____release to: _____receive from:

_____
Person or Organization Address

_____
Phone Fax (if applicable)

INFORMATION/COPIES FROM THE MEDICAL RECORDS ON:

_____
Patient Date of Birth Social Security#

_____
Date(s) of Services

INFORMATION TO BE RELEASED:

__Emergency Room	__Radiology Reports	__Lab Work	__Radiology Films
__History and Physical	__Pathology Reports	__Billing Records	__Consultations
__Operative Reports	__Discharge Summary	__Other: _____	

THIS INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE:

__Continued Care __Attorney/Litigation __Insurance __Disability Services
__Other: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____
Signature of Patient or Legally Authorized Representative **Date**

_____
Printed Name of Legally Authorized Representative **Relationship to Patient**

_____
Witness - Printed Name/Signature **Driver's License/ID#**