Mike Bismar, MD, FACG, FASGE
Gastroenterology & Endoscopy
11801 South Fwy • Suite 140 • Burleson, TX 76028
Phone (817) 551-6161
Fax (817) 551-6177
www.gastro.center

New Patient Welcome Packet

Dear Patient:

Thank you for trusting us with your healthcare. We know that medical forms can be tedious, but your thorough answers help us provide the personalized, high-quality care you deserve. Additionally, this paperwork is essential for protecting your patient rights and ensuring your health information is handled securely. We look forward to a positive partnership in your health.

Your appointment location:

Gastroenterology Center
Huguley Hospital
Medical Office Building 3
11801 South Freeway, Suite 140
Burleson, TX 76028

Please remember to bring your:

1. Health insurance card.
2. Driver's License or government-produced picture ID.
3. List of your medications along with dosages.

Patient Payment information: We strongly recommend that you contact your insurance company regarding charges prior to any service being rendered, as it is the responsibility of the patient to obtain coverage and benefit information from their insurance carrier. The insurance verification we provide is done as a courtesy.

Your financial liability can include your copay, deductible and coinsurance as determined solely by your insurance company and due at the time of service. If you do not have your payment, your visit may be rescheduled.

Medical Records: If you had previous upper endoscopy (EGD), colonoscopy, or any other procedure, related X-ray, CT-scan, test or lab works, please contact our office and ask for the Medical Assistant, as early as possible **before** your scheduled visit so we can obtain your medical records and findings ahead of time; this will minimize your wait time during your visit. Obtaining your records from other providers may take 1 to 2 hours and sometimes a day or two.

We understand how valuable your time is, but please be aware that even though you have an estimated scheduled time for your appointment, it might be delayed. Some procedures/patient visits could take much longer than expected and this is not something in our control, or that we can tell prior to the visit.

If you have any questions, please contact our office during business hours. Thank you and we look forward to seeing you at your appointment.

Business Hours:
Monday to Thursday ..... 8:30am – 12:00pm & 1:30pm – 5:30pm
Friday ..... 8:30am – 12:00pm

Sincerely,
Gastroenterology Center PA

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New Patient Registration

Last Name: _____ First: _____ MI: _____

Social No: _____ _____ _____ DOB: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ _____ Home: _____ _____

Email: _____
Required to view results on the Patient Portal

Emergency Contact: _____ _____ _____
full name phone relation

Preferred Pharmacy: _____ _____ _____
name phone location

Insurance Information:

Insurance: _____ 2ndary Insurance (if any): _____
company name

Insurance Policy Holder (if different from patient)**:** **Relation to Patient:** Spouse Parent Child

Last Name: _____ First: _____ DOB: _____
insured's

Social No: _____ _____ _____ Phone: _____

List doctors you have seen in the past so we may contact them to obtain your medical records:

	Primary Care Physician	Referring Physician	Gastroenterologist (previously seen)
Full Name			
Phone			

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Gastroenterology Center PA Office Policies

- "Notice of Patient Information Privacy Practices" can be downloaded from the website: www.gastro.center click on PATIENTS link at the top menu …….. **Initials: _____**

- Assignment of Benefits: I authorize my medical insurance benefits and/or government benefits to be paid directly to Mike Bismar, MD or Gastroenterology Center PA ..... **Initials: _____**

- I understand that I am financially responsible for any charges not covered by my insurance company ……. **Initials: _____**

- There will be a $25.00 bank fee for every returned check ……..… **Initials: _____**

- If you fail to meet your financial obligations, Gastroenterology Center PA, within 30 days, reserves the right to forward your account to a collection agency. I agree to pay all collection costs involved, including reasonable attorney fees and court costs. Additionally, the collection agency may report the patient's name and any unpaid balances to national credit bureaus …….. **Initials: _____**

- I authorize the Gastroenterology Center PA and my insurance company to release any information required to process my claims …… **Initials: _____**

- I authorize the Gastroenterology Center PA to obtain or release my Protected Healthcare Information from or to other entities. I understand that the information in my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse …….. **Initials: _____**

- I understand that I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization …..…… **Initials: _____**

- Professional Fees: Gastroenterology Center PA will gladly submit claims to your insurance for our physician's services; however, please remember that all co-pays, deductibles, and coinsurance are due at the time of your visit. Should a colonoscopy or upper endoscopy procedure be required, any quoted physician fees are strictly estimates for the doctor's services only. Other parties involved in your care, such as the hospital or surgery center, anesthesia team, and pathology lab, will bill you separately for their own services. We strongly encourage you to contact both your insurance and the scheduled facility to determine your total out-of-pocket responsibility for these additional costs ……..…… **Initials: _____**

- Medical Records: Copies of your records are complimentary when sent directly to another physician. For all other requests, such as legal, a signed release and a $30 processing fee are required prior to delivery. All requests may take up to 14 business days to fulfill ……..……..…… **Initials: _____**

I acknowledge that I have received, read, and understand the Gastroenterology Center PA office policies and agree to comply with them.

Patient (or Legal Representative) Name	Signature	Date

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Release of Patient Protected Healthcare Information and Confidential Communication

This form indicates the means and communications that I prefer to be informed or reminded of my appointments, procedures, test results, medications, inquiries and visits.

● I consent to the release of any of my Protected Healthcare Information including notices, letters, procedures and test results, to the following persons:

Full Name _____ Relationship _____

Full Name _____ Relationship _____

● I wish to be contacted in the following manner (circle all that apply):

Home Phone:_____	I give permission to leave a message with detailed information.	Only Leave name / doctor with call back number.
Cell Phone: _____	I give permission to leave a message with detailed information.	Only Leave name / doctor with call back number.

● When unable to contact me by phone, or for future care or repeat treatments, a written communication may be sent to my address on file.

I acknowledge that I have received, read, and understand the Gastroenterology Center PA policies regarding the Release of Protected Health Information and Confidential Communications, and I agree to abide by these policies.

_____	_____	_____
Patient (or Legal Representative) Name	Signature	Date

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NEW PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

CURRENT PROBLEM OR CONCERN: _____

IN THE PAST, HAVE YOU HAD ANY COMPLICATIONS WITH ANESTHESIA OR CONSCIOUS SEDATION (CIRCLE ONE)?

No Yes If yes, explain: _____

ACCURATE PROCEDURES HISTORY (VERY IMPORTANT SO WE CAN REQUEST YOUR MEDICAL RECORDS AND PREVIOUS PROCEDURES FINDINGS)

PROCEDURE	DATE	REASON	FINDINGS	DOCTOR	LOCATION
EGD					
Colonoscopy					

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES (CIRCLE ALL THAT APPLIES)?

SURGERY	MM/YYYY
Angioplasty/ Heart Stent	
Heart Bypass / CABG	
Heart Valve Replacement	
Other:	

SURGERY	MM/YYYY
Appendectomy	
Bowel Obstruction	
Gallbladder Removal	

SURGERY	MM/YYYY
Hernia Repair -Type:	
Breast	
Hysterectomy	

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLIES)?

Colon Polyps	Liver Disease	Heart Disease	Arthritis	Thyroid Disease
Colon Cancer	Pancreatitis	Atrial Fibrillation/ Afib	Asthma	Anxiety
Ulcers, where:	Diabetes	Arrhythmia	Pneumonia	Depression
GERD	High Cholesterol	Heart Failure	Obstructive Sleep Apnea/CPAP	Anemia
Hepatitis: A B C D	High Blood Pressure (Hypertension)	Heart Attack / MI	COPD	
Other:				

FAMILY MEDICAL HISTORY	RELATIONSHIP	DISEASE/ TYPE OF CANCER/AGE OF CANCER DIAGNOSIS
GI or Liver Disease		
Cancer		

SOCIAL BEHAVIORS, ARE YOU CURRENTLY OR HAVE YOU EVER USED ANY OF THE FOLLOWING:

Tobacco	Packs per day?	Number of Years?	Date Stopped:
Alcohol	How many drinks?	Day Week Month (circle one)	Date Stopped:
Recreational Drugs	If yes, what kind?		Date Stopped:

OCCUPATION:	

DRUG ALLERGIES:	NONE YES, LIST ALL:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:					
MEDICATION NAME	DOSAGE	FREQUENCY	MEDICATION NAME	DOSAGE	FREQUENCY
1)			4)		
2)			5)		
3)			6)		

REVIEW OF SYSTEMS: CIRCLE ALL THAT APPLIES OR CIRCLE *NO COMPLAINTS*

GASTROINTESTINAL	HOW LONG	GASTROINTESTINAL	HOW LONG
Difficulty /Pain with Swallowing: Liquids / Solids		Diarrhea: Loose /Watery with Blood /without Blood	
Nausea /Vomiting: Food Particles / Blood / Other		Constipation Thin Stool	
Indigestion		Blood in Stool	
Heartburn Food Regurgitation		Other:	
Abdominal Pain		Other:	

CONSTITUTIONAL	NO COMPLAINTS			
Loss of Appetite	Weight Loss: Lbs. Over: Weeks / Months Intentional Unintentional			
Night Sweats	Fever	Chills	Fatigue	Other:

EYES	NO COMPLAINTS	Double Vision	Blurred Vision	Pain	Other:

EARS / MOUTH / THROAT	NO COMPLAINTS	Sinus Pressure	Decrease in Hearing	Nose Bleed	Clearing Throat
	Ear Pain	Ulcers in Mouth	Sore Throat	Other:	

CARDIOVASCULAR	NO COMPLAINTS	Chest pain	Edema	Shortness of Breath on Exertion
	Shortness of Breath While Lying Flat		Palpitation	Other:

RESPIRATORY	NO COMPLAINTS	Cough	Wheezing	Shortness of Breath	Coughing Blood

GU / GYNECOLOGY	NO COMPLAINTS	Pain with urination	Urgency	Spotting / Bleeding	Discharge
	Cramps	Pregnant Weeks	Possible Pregnancy	Other:	

MUSCULOSKELETAL	NO COMPLAINTS	Joint Swelling	Stiffness	Painful joint (s) location:
	Painful muscle:		Other:	

NEUROLOGICAL	NO COMPLAINTS	Headache	Seizures	Dizziness	Fainting Episodes
	Numbness, where:		Syncope	Other:	

ENDOCRINE	NO COMPLAINTS	Excessive Thirst	Temp Intolerance to Heat / Cold	Increase Frequency of Urination	Other:

SKIN	NO COMPLAINTS	Rash	Itching	Bruises	Hair Loss

HEM / LYMPHATIC	NO COMPLAINTS	Easy bruising	Bleeding	Blood Transfusions	Lymph Nodes

PSYCHIATRIC	NO COMPLAINTS	Depressed mood	Anxiety	Other:

ALLERGY / IMMUNOLOGIC	NO COMPLAINTS	Allergy Symptoms/Reactions	Immune Problems	Other:

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE

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No-Shows and Cancellation Policy

A minimum of **two (2) business days**' notice is required to cancel or reschedule any appointment.

Missed appointments or failure to provide at least two (2) business days' notice will be considered a **No-show** and will incur a **$25 fee.** This fee is the patient's responsibility and is not covered by insurance. Weekends and holidays do not count toward the notice period. After two no-shows or three reschedules for your appointment, our practice may decide to terminate its relationship with you.

Why do we have this policy:
Before your arrival, our staff prepares and updates your medical records, and your provider reviews your chart and history to ensure a productive visit. No-shows or late cancellations result in lost clinical resources and prevent other patients from receiving care. No-shows significantly impact the practice and limit our ability to provide timely care to others.

Acknowledgement:
I understand that my provider and staff perform clinical prep work in advance in anticipation of my visit. I agree to the terms above and accept financial responsibility for the $25 fee if I fail to provide the required notice.

Patient (or Legal Representative) Name	Signature	Date

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Patient Informed Consent for AI Dictations

I, the undersigned patient, give my consent for the use of Artificial Intelligence (AI) scribe dictation technology to assist in documenting my medical records at the Gastroenterology Center PA throughout my visits and treatments. This form outlines how AI technology is used, its intended purpose, and the security measures implemented to protect my privacy.

PURPOSE OF AI DICTATION: AI scribe dictation technology is used to convert spoken words into text format, enabling efficient and accurate documentation of medical information. The AI system may be employed in the transcription of medical notes, reports, and other relevant documents.

HOW AI DICTATION WORKS: During your medical appointments, any verbal information provided by you or your healthcare provider may be recorded using AI scribe dictation. The AI system processes and transcribes spoken words into text, contributing to the creation of your medical records**. The AI scribe (dictation) will not be used to make any decisions about your care. Your healthcare provider will review all of the information in your medical record, including the AI-scribed notes, before making any decisions about your care.**

SECURITY MEASURES: This medical practice employs robust security measures to safeguard the confidentiality and integrity of the information processed through AI dictation systems. Measures include access controls and regular security audits to prevent unauthorized access and protect against data breaches.

PATIENT RIGHTS: Access to Information: I have the right to request access to my medical records and transcripts generated through AI dictation. Amendment of Information: I have the right to request corrections or amendments to any inaccuracies in my medical records. Withdrawal of Consent: I have the right to withdraw my consent for the use of AI dictation on future visits, by sending a signed letter to the Gastroenterology Center PA at 11801 South Fwy Ste 140, Burleson, TX 76028; this process may take up to 30 days.

PATIENT CONSENT:
I have read and fully understand the information provided in this consent form. I have had the chance to ask questions, and any concerns have been addressed to my satisfaction. By signing below, I voluntarily consent to the use of AI dictation technology in the creation of my medical records at the Gastroenterology Center PA.

_____	_____	_____
Patient (or Legal Representative) Name	Signature	Date

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Acknowledgment of Results Notification Policy

During your first visit, or following a procedure such as a colonoscopy or upper endoscopy (EGD), your provider may request additional diagnostic tests such as lab, x-ray, CT scan or pathology. Due to the variety and complexity of these evaluations, the turnaround time for results may differ. A follow-up visit with your provider (in person or via Telehealth) will be scheduled to review, professionally interpret the findings and to establish an appropriate plan of care moving forward.

If a colonoscopy or upper endoscopy (EGD) is performed, our office will NOT contact the patient with the procedure results. It is the patient's responsibility to ensure they schedule a follow-up appointment to review and discuss the findings with the provider. Due to anesthesia and the time required to receive pathology results, only preliminary findings will be reviewed immediately after the procedure. Final results, recommendations and plan of care will be discussed at the patient's next follow-up visit.

If required test(s) are performed at Huguley Hospital Labs, the results will be transmitted directly to the Patient Portal, typically within seven (7) business days. Some results may take longer to process. Patients may access the Patient Portal to review their results, provided a valid email address was supplied at check-in. An automated email from the Electronic Health Records (EHR) system will be sent to the patient with a link, user ID, and temporary password.

If a test result cannot be accessed within 10 business days, the patient is responsible for contacting our Medical Assistant to determine the reason. **If the patient is unable to attend the follow-up appointment, it is also their responsibility to call our office to review the results by phone.**

If the patient has testing performed at a facility other than Huguley Hospital, it is the **patient's responsibility** to have the results sent to us. Please contact our Medical Assistant before your follow-up visit to make sure that we received your results. Facilities like LabCorp and Quest Diagnostics do not automatically send us your results.

If the provider refers the patient to another facility or specialist and they have not contacted the patient, it is the patient's responsibility to contact that facility or the specialist to obtain an appointment.

Disclaimer – The Gastroenterology Center PA is not affiliated with any, pharmacy, laboratory or imaging service. Patient has the option to select any service that is preferred by them or their insurance plan. The patient should expect a separate bill from these services and is strongly encouraged to check with them about their fees in advance.

I acknowledge that I have received, read, and understand the above office policies about procedures and test results and agree to comply with them.

_____	_____	_____
Patient (or Legal Representative) Name	Signature	Date