ENG

PEDRO M. ARGUELLO, M.D.

Diplomates of American Board of Gastroenterology

PATIENT INFORMATION

NAME:____ DOB:____________________
Last First MI

ADDRESS:____ APT/SUITE #:________________

CITY:________________________ STATE:__________________ ZIPCODE:__________________

HOME PH# ( ) ______________________ CELL PH# ( ) ______________________________

E-MAIL:____

EMPLOYER:___________________________ WORK PH# ( )_________________________

SSN:__________________________________ GENDER: MALE: _________ FEMALE: _________

MARITAL STATUS: MARRIED SINGLE DIVORCED LEGALLY SEPARATED WIDOWED

WHO TO NOTIFY INCASE OF EMERGENCY: NAME: _________________________________

PHONE # ( ) ______________________________ RELATION: ___________________________

HOW WERE YOU REFERRED? SELF FRIEND FAMILY INTERNET PRIMARY PHYSICIAN

REFERRING PHYSICIAN NAME: ________________________ PH # ( ) ____________________

PHARMACY NAME AND ADDRESS: ____

PHARMACY PH#: ( ) _______________________________

PLEASE COMPLETE THE FOLLOWING IF YOU ARE NOT THE PRIMARY INSURANCE HOLDER OR IF YOU ARE UNDER 18 YEARS OLD

NAME OF RESPONSIBLE PARTY: ____

DOB: _______________________________________ SSN: ____________________________________

NAME OF HEALTH INSURANCE: ____

ID # ____________________________________ GROUP/PLAN#: ____________________________

SECONDARY INSURANCE: ______________________________ ID#:____________________________

INSURED'S OR AUTHORIZED PERSON: It is understood that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered to me. I authorize release of any medical or other information necessary to my medical insurance for payment of medical benefits to the undersigned physician Pedro M. Arguello, M.D., F.A.C.P. I have reviewed and signed a copy of "The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

_________________________________ _________________________

Signature of Patient (or parent if patient is a minor) Date

Pedro M. Arguello, M.D.P.A. Gastroenterology
9190 Katy Fwy Suite 102
Houston, TX 77055
Ph. 713-647-9300 Fax: 713-647-5582

NAME: ____ **DOB:** ___________________________

CHIEF COMPLAINT: ____

PAST MEDICAL HISTORY: (Please read carefully and complete all questions.)

Diabetes? ………………………………………………………………………………… YES ____ NO ____

Heart Disease? ……………………………………………………………………………… YES ____ NO ____

High Blood Pressure? ……………………………………………………………………… YES ____ NO ____

Crohn's Disease or Ulcerative Colitis? ……………………………………………… YES ____ NO ____

Lung Disease? ……………………………………………………………………………… YES ____ NO ____

Kidney Disease? …………………………………………………………………………… YES ____ NO ____

Cancer? If so, what kind? ________________________ Age: _____ YES ____ NO ____

Have you been tested for HIV?....... Positive _____ Negative ______ YES ____ NO ____

Screened for HEPATITIS?................ Positive _____ Negative ______ YES ____ NO ____

If positive, what type? Type A __ Type B __ Type C __

Mental Health? (ex: Anxiety, Depression, Bipolar, etc.) ____

VACCINE RECORD

Have you had Hepatitis A & B Vaccine? ………………………………………… YES ____ NO ____

Have you had Pneumonia Vaccine? ……………………………………………… YES ____ NO ____

Have you had Flu Vaccine? ………………………………………………………… YES ____ NO ____

Have you had COVID-19 Vaccine? If so, when: _________________

FEMALE PATIENTS ONLY:

Have you had a Mammogram? YES____ NO_____ If so, results? _____________________

When was the day of your last menstrual cycle? ________________

SOCIAL HISTORY:

What type of diet do you follow? ____

Do you exercise?....................... YES ____ NO ____ If so, how often: _____________________________

Are you a tobacco smoker?........ YES ____ NO ____ NEVER A SMOKER ____

If so, how often:____________ If you quit, how long ago? _______________

Are you sexually active?............ YES ____ NO ____ If so, what is your sexual preference? ____________

Do you drink alcohol?................ YES ____ NO ____ If so, how often? _____________________

Do you sleep well at night? ________________ Do you snore or have sleep apnea? _________________

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MEDICATIONS LIST

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Are you taking any **BLOOD THINNERS/ ANTICOAGULANTS?** YES ____ NO ____

If so, which ones: ____

Do you presently use NSAIDs? (ex. Aspirin, Ibuprofen, Naproxen, etc.) YES ____ NO ____

If so, which ones: ____

DO YOU HAVE ANY ALLERGIES? (Ex: drugs, latex, seasonal, etc.) YES ____ NO ____

If so, which ones and what is the reaction? ____

____________________________ ____________________________ ____________________________

SURGICAL HISTORY:

Have you had a **COLONOSCOPY** in the past? YES ____ NO ____

If so, when? __________________________ What were the findings: ______________________

Have you had any **SURGERIES** performed? ______________________ YES ____ NO ____

Please circle and date if you have had any of these surgeries:

Cholecystectomy ____________ Appendectomy _______________Hysterectomy ______________________

Partial/Complete Colon Resection __________________________ Ovary Removal ______________________

Gastric Bypass/Sleeve/Band ___________ Heart Surgery _________Other Surgery: ______________________

Have you had ANY ANESTHESIA PROBLEMS in the past? YES ____ NO ____

If so, what? :____

FAMILY HISTORY

Diabetes mellitus.................................. YES____ NO ____ Heart disease........... YES ____ NO ____

Hypertension.. YES ____ NO ____

Have you or any of your family members had any of the following types of cancer?

Colon/Rectum: ___________________________ Family Member: ________________________ Age: ______

Uterine/Endometrial: ______________________ Family Member: ________________________ Age: ______

Ovaries: __________________________________ Family Member: _______________________ Age: ______

Stomach/Small Intestine: __________________ Family Member: _______________________ Age: ______

Bile duct, liver, pancreas: ___________________Family Member: _______________________ Age: ______

Other cancer: _____________________________ Family Member: _______________________ Age: ________

NAME: ____

SIGNATURE: ____ DATE: _________________________

PEDRO M. ARGUELLO, M.D.PA

PATIENT'S FINANCIAL RESPONSIBILITIES

We have developed financial polices to promote confidence and understanding between our patients and our practice. In addition to supplying quality medical care, we are committed to providing the best possible service, including but not limited to, a complete understanding of your financial responsibilities.

PATIENT'S NAME: ____ DATE: _____________________

RESPONSIBLE PARTY (NAME): __________________________________ DATE: _____________________

- ***I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service. Co-payments/deductibles are due at time of service.*** *In the event that my health plan determines a service to be* ***"not payable",*** *I will be responsible for the complete charge and agree to pay the costs of all services provided.*
- **HMO/Manage Care Patients**: It is the responsibility of the patient to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is responsible for any and all services rendered that are not part of the referral. If you did not get a referral for our services, you will be required to pay the full amount for all services.
- Please understand that your medical benefit is entirely up your insurance plan. Should you have any questions or concerns over your coverage, please call your respective insurance company.
- It is the responsibility of the patient to have their insurance information with them at the time of visit and to notify the practice of changes in insurance coverage.
- If your insurance cannot be verified at the time of the visit, the practice will be forced to collect full payment for the visit.
- **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS** I hereby authorize and direct payment of my medical benefits to Pedro M. Arguello, M.D.P.A. on my behalf for any services furnished to me by the provider.
- **AUTHORIZATION TO RELEASE RECORDS** I hereby authorize Pedro M. Arguello, M.D.P.A. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.
- **Missed Office Visit Appointments without notification (No shows) will be a $50.00 charge.**
- **Missed appointment for Procedures will be a $100.00 charge. Payment for procedures (if applied) must be made within 48 hours of appointment. No shows for procedures; in order to be rescheduled, a pre-payment will be required.**

I have read and understand all of the above information and financial responsibilities:

_______________________________ _________________________________ _____________

Signature Print Name Date

PEDRO M. ARGUELLO, M.D. PA

AUTHORIZATIONS

AUTHORIZATION TO DISCLOSED PRIVATE HEALTH INFORMATION

I authorize the release of any information including diagnosis and the records of any treatment of examination rendered to me or dependent to third party payers and/or other practitioners involved in my care.

Signature: ___________________________________ **Date**: ____________________

I give permission to the following relatives to have access to my protected health information and reserve the right to revoke this at any time by notifying the office in writing:

1.________________________ Relation: ___________________ Phone #: ________________________

2.________________________ Relation: ___________________ Phone #: ________________________

E-mail or Fax Privacy Waiver:

I understand that my medical records may be transmitted electronically by e-mail or fax and may be received in error by third parties. In the event that this should occur, I absolve Pedro M. Arguello M.D. and his staff. I reserve the right to revoke this at any time by notifying in writing.

Signature: __________________________

I give authorization to call me and leave me in detail, information regarding future appointments to:

Phone #: _______________________________ Preferred Language: ____________________________

Signature: ____ **Date**: ___________________________

Note: This authorization will remain in effect until revoked by patient or legal representative.

PEDRO M. ARGUELLO, M.D. PA

9190 KATY FREEWAY, SUITE 102
HOUSTON, TEXAS 77055
713-647-9300

RECTAL EXAM CONSENT
(Consentimiento de examen colorrectal)

Patient Name: ______________________________________ **Date:** _____________________
(Nombre de el Paciente) (Fecha)

English

Written consent of the patient or the patient's legal representative or guardian is required prior to a medical examination. Part of your evaluation may include but not limited to a colorectal exam.
The rectal exam includes examination which may include provider's gloved hand or instrumentation (Scope or Colonoscope).

The rectal exam performed by the Physician may include:
- A visual inspection,
- Digital rectal examination (gloved hand) and/ or use of diagnostic instruments such as anuscope, proctoscope or sigmoidoscope
- If needed stool or tissue sample may be collected

I understand and consent to a Medically indicated rectal exam. This will be performed by the physician.

Spanish

Se requiere el consentimiento por escrito del paciente o representante legal antes de un examen médico.
Parte de su evaluación puede incluir, entre otros, un examen rectal.

El examen rectal realizado por el médico puede incluir:
- Una inspección visual
- Tacto Rectal y/o uso de instrumentos diagnósticos como anuscopio, proctoscopio o sigmoidoscopio.
- Si fuera necesario una muestra de heces o tejido, podría obtenerse durante el examen.

Entiendo y doy mi consentimiento para un examen rectal si es médicamente indicado. Esto será realizado por el médico.

Patient Signature (Firma del Paciente): ___________________________________

Signature of Legal Representative (Firma de representate legal: ___________________________

Witness Signature (Testigo): _______________________________________

CONSENT FOR RELEASE OF INFORMATION

DATE: ____________________________

I hereby authorize ____ **to release the following information from the health record(s) of:**

Patient Name: ____

Address: ____

SSN: ____ **Date of Birth:** ____________________

Covering the periods of care from ______________________ **to** __________________

Information to be released:

_________ **Copy of complete health record(s)**

_________ **History & Physical.**

_________ **Excluding information related to HIV testing and/or results.**

_________ **Other:** ____

Information to be released to:
PEDRO M. ARGUELLO, M.D.
9190 KATY FREEWAY, SUITE #102
HOUSTON, TEXAS 77055
P: 713-647-9300
F: 713-647-5582

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Specification of the date, event, or condition upon which this consent expires:

The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: __________________________________ __________________________
Patient or Representative Relationship to patient

____ __________________________
Witness **Date**

ORIGINAL

PATIENT RIGHTS AND RESPONSIBILITIES

It is the policy of the practice of Pedro M. Arguello, M.D. PA to follow specific procedures to ensure the rights of patients. We have established Patient Rights and Responsibilities with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physicians, and practice. The rights and responsibilities of each patient are outlined in a statement titled Patient Rights and Responsibilities, which is posted in the lobby/waiting area.

1). We [honor] advance directives, as per state and local laws. This information is conveyed to the patient with the informed consent.

2). We provide certain translation services for those patients who have limited English proficiency.

- The need for translation services is determined prior to the procedure.
- In accordance with Title VI of the Civil Rights Act, the practice will provide a translator for non-English speaking patients. Translation services are provided to the patient free of charge.
- In accordance with the Americans with Disabilities Act, the practice furnishes appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. The practice does not provide a qualified interpreter for every deaf patient, as the need for an interpreter depends on the complexity of the medical matter.
- If needed, a sufficiently qualified interpreter, able to interpret "effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary," will be provided.

- The practice reserves the right to choose which oral language assistance option is best suited to meet the needs of patients with limited English proficiency, such as hiring a bilingual staff or staff interpreters, using contracted interpreters or community volunteers to provide interpretation services, and a telephone line for interpretation services.
- Whenever the services of an interpreter are used, the practice ensures that the interpreter is trained and competent and that the patient's right to privacy is protected.
- The translator's name is recorded in the medical record.

3). We encourage patients and/or visitors to voice their concerns or complaints and to have a procedure in place to address them.

- If a patient or visitor expresses a complaint or concern, it will be reported to [insert staff title, e.g., practice administrator, patient representative, privacy officer].
- When a complaint is received, it will be documented using an Incident Report Form.
- Voicing of a complaint or grievance does not and will not have any adverse effect on the care rendered to the patient unless the nature of the complaint renders the ongoing doctor-patient relationship untenable. In this situation, the patient will be referred to another equally qualified provider.
- Filing a grievance does not in and of itself compromise a patient's future access to care.

4). We inform patients about treatment, services, and outcomes, including unforeseen outcomes. The treating physician will be responsible for informing the patient and, when appropriate, the family members of any unforeseen outcomes.

Pedro M. Arguello, M.D. PA

9190 Katy Freeway, Suite 102

Houston, TX 77055

713-647-9300

This notice describes the privacy practices of PEDRO M. ARGUELLO, M.D. PA and the employers who assist in providing services to patients at this facility.

Patient Health information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

- **Treatment:** we will use and disclose your health information to provide you with medical treatment or services. For example, physicians, nurses, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
- **Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
- **Health Care Operations:** We will use and disclose your health information to conduct our standard internal

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this

information. **PLEASE REVIEW IT CAREFULLY.** operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

HIPPA FORM Pedro M. Arguello, M.D. PA

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosures That Can Be Made Without Your Authorization, there are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

- **Required by Law**: we may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- **Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities

- **Health oversight:** we may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Judicial and administrative proceedings:** we may disclose information in response to an appropriate subpoena or court order.
- **Law enforcement purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.
- **Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- **Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- **Research:** We may use or disclose information for approved medical research.
- **Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Special Uses, in any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights:

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

- **Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
- **Confidential Communications:** you may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
- **Inspect and obtain copies:** In most cases, you have the right to look at or get a copy of your health information; HIPAA permits us to charge a reasonable cost-based fee.
- **Amend Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
- **Accounting or Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty, we are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Change in Privacy Practices, we may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, use the contact information below.

Complaints, if you are concerned that we have violated your privacy rights, of if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complain to the U.S. Department of Health and Human Services. The office listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Office, if you have any questions, requests, or complaints please contact:

Pedro M. Arguello or office staff

9190 Old Katy Rd, Suite 102

Houston, TX 77055

713-647-9300

Reviewed 10/31/2024