

Northwest Houston Surgical Association. LLP

**NHSA****Northwest Houston Surgical Association****Dr. Raman, Dr. Ayyar, Dr. Leiva, Dr. Russo-Going****Dr. Ziad Amr***Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential***PATIENT INFORMATION**

**Patient Name/Nombre de Paciente** \_\_\_\_\_

**Birthdate/Fecha de Nacimiento** \_\_\_\_\_ **Age/Edad** \_\_\_\_\_ **Gender /Sexo M/F** \_\_\_\_\_

**Marital Status/Estado marital** \_\_\_\_\_ **SS#/Seguro Social** \_\_\_\_\_

**Address/Domicilio** \_\_\_\_\_ **Zip Code/Codigo Postal** \_\_\_\_\_

**E-Mail/Correo Electronico** \_\_\_\_\_

**Home Phone/Telefono de Domicilio** \_\_\_\_\_ **Cellular/Celular** \_\_\_\_\_

**Employer/ Lugar de empleo** \_\_\_\_\_ **Work Phone/Telefono del Trabajo** \_\_\_\_\_

**Employer Address/ Direccion de Empleo:** \_\_\_\_\_

**Reason for today's visit/Razon por su visita** \_\_\_\_\_

**Whom may we thank for referring you? /A quien le agradecemos por referirlo?** \_\_\_\_\_

**Dr.'s Phone #/Telefono** \_\_\_\_\_

**Primary Care Physician ?/Doctor General?** \_\_\_\_\_

**PCP Phone# /Numero del doctor general**

\_\_\_\_\_

**In Case Of Emergency, Notify/En caso de emergencia Notificar A ?** \_\_\_\_\_

**Phone# / Telefono** \_\_\_\_\_

**Parent name if patient is a Minor? /Persona responsable si el paciente es menor de edad.**

\_\_\_\_\_

**General Medical Information/Informacion Medica**

**Are you allergic to any medication/Es alergico a Medicinas? (Y) (N) List/Lista:** \_\_\_\_\_

**List of Current Medications/Lista de medicinas (Please include any blood thinners, dietary and/or herbal supplements)**

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL QUESTIONNAIRE / QUESTIONARIO MEDICO

<b><u>PATIENT MEDICAL HISTORY</u></b>		<b><u>FAMILY MEDICAL HISTORY</u></b>
<b>DIABETES / DIABETES</b> (Y) (N) INSULIN OR NON-INSULIN	<b>ASTHMA/ ASMA</b> (Y) (N)  <b>SKIN DISORDERS</b> (Y) (N) <i>PROBLEMA- PIEL</i>	<b>DIABETES / DIABETES</b> NON-INSULIN (Y) (N) MOTHER OR FATHER MADRE /PADRE
<b>ALLERGIES / ALERGIAS</b> (Y) (N)	<b>PSYCHRIATRIC DISORDERS</b> (Y) (N) <i>PROBLEMA-PSIQUIATRICO</i>	<b>ALLERGIES / ALERGIAS</b> (Y) (N) MOTHER OR FATHER
<b>HEART DISEASE</b> (Y) (N)  <i>PROBLEMA DEL CORAZON</i> □ <i>N</i>	<b>THYROID TROUBLE</b> (Y) (N) <i>PROBLEMA- THYROIDE</i>	<b>HEART DISEASE</b> (Y) (N) <i>PROBLEMA DEL CORAZON</i> MOTHER OR FATHER MADRE /PADRE
<b>HIGH BLOOD PRESSURE</b> (Y) (N)  <i>PRESION ALTA</i>	<b>HIV / SIDA</b> (Y) (N)	<b>HIGH BLOOD PRESSURE</b> (Y) (N) <i>PRESION ALTA</i> MOTHER OR FATHER MADRE /PADRE
<b>STROKE / EPILEPSY / CONVULSIONS</b> (Y) (N)  <i>EMBOLIA / EPILEPSIA / CONVULSIONES</i>	<b>OTHER / NONE</b>	<b>STROKES/EPILEPSY/CONVULSIONS</b> (Y) (N) <i>EMBOLIA / EPILEPSIA / CONVULSIONES</i> MOTHER OR FATHER MADRE /PADRE
<b>CANCER / TUMORS / GROWTH</b> (Y) (N) <i>CANCER / TUMORES</i> <i>TYPE/TIPO</i>	<b>HEIGHT/ ALTURA</b>	<b>CANCER / TUMORS / GROWTH</b> (Y) (N) <i>CANCER / TUMORES</i> MOTHER OR FATHER MADRE /PADRE
<b>TUBERCULOSIS</b> (Y) (N)	<b>WEIGHT/ PESO</b>	<b>TUBERCULOSIS</b> (Y) (N)
<b>ULCERS/STOMACH PROBLEMS</b> (Y) (N) <i>ULCERA/PROBLEMA-ESTOMACAL</i>	<b>SMOKE/ FUMA</b> (Y) (N) <b>HOW MUCH/CANTIDAD</b> <b>HOW LONG/CUANTO TIEMPO</b>	<b>ULCERS/STOMACH PROBLEMS</b> (Y) (N) <i>ULCERA/PROBLEMA-ESTOMACAL</i> MOTHER OR FATHER MADRE /PADRE
<b>MAJOR BODY INJURY</b> (Y) (N) <i>FUERTE LESION DEL CUERPO</i>	<b>CAFFEINE/ CAFEINA</b> (Y) (N) <b>HOW MUCH/CANTIDAD</b> <b>HOW LONG/CUANTO TIEMPO</b>	<b>THYROID TROUBLE</b> (Y) (N) <i>PROBLEMA- THYROIDE</i>
<b>HEPATITIS / LIVER DISEASE</b> (Y) (N) <i>HEPATITIS / PROBLEMA-HIGADO</i>	<b>ALCOHOL / ALCOL</b> (Y) (N) <b>HOW MUCH/CANTIDAD</b> <b>HOW LONG/CUANTO TIEMPO</b>	<b>HEPATITIS / LIVER DISEASE</b> (Y) (N) <i>HEPATITIS / PROBLEMA-HIGADO</i> MOTHER OR FATHER MADRE /PADRE
<b>KIDNEY/BLADDER INFECTIONS</b> (Y) (N) <i>PROBLEMA-RIN</i> □ <i>ON / VEJIGA</i>	<b>ARE YOU PREGNANT?</b> (Y) (N)  <i>ESTA EMBARAZADA?</i>	<b>KIDNEY/BLADDER INFECTIONS</b> (Y) (N) <i>PROBLEMA-RIN</i> □ <i>ON / VEJIGA</i> MOTHER OR FATHER MADRE /PADRE
<b>TENDENCY TO EASILY BLEED</b> (Y) (N) <i>SANGRA FACILMENTE?</i>		<b>HIV / SIDA</b> (Y) (N)

**List any previous surgeries or hospitalizations/Lista de cirugias:**

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_ Year \_\_\_\_\_ Year \_\_\_\_\_

**Preferred Pharmacy Name/Farmacia** \_\_\_\_\_

**Phone/Telefono** \_\_\_\_\_

**Fax** \_\_\_\_\_

**INSURANCE INFORMATION/ SEGURO MEDICO**

**\*\*\*\*If the patient has a HMO insurance, a referral from the PCP is required to allow the patient to be seen by our group. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self-pay basis.**

**Primary Insurance:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Subscriber's Name** \_\_\_\_\_ **Subscriber SS#** \_\_\_/\_\_\_/\_\_\_ **Subscriber Date Of Birth** \_\_\_/\_\_\_/\_\_\_  
**Subscriber's Employer:** ( same as above) \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
**Claims Address:** \_\_\_\_\_  
**Ins. Phone#** \_\_\_\_\_ **Subscriber Relation to Patient:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Subscriber's Name** \_\_\_\_\_ **Subscriber SS#** \_\_\_/\_\_\_/\_\_\_ **Subscriber Date Of Birth** \_\_\_/\_\_\_/\_\_\_  
**Subscriber's Employer:** ( same as above) \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
**Claims Address:** \_\_\_\_\_  
**Ins. Phone#** \_\_\_\_\_ **Subscriber Relation to Patient:** \_\_\_\_\_

**IS THIS A WORK RELATED INJURY? \_\_\_ IF YES, PLEASE PROVIDE FOLLOWING INFORMATION:**

**Claim Adjustor's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_  
**ClaimNumber:** \_\_\_\_\_ **Contact at Employer:** \_\_\_\_\_ **Contact's Phone:** \_\_\_\_\_

*I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician./Autorizo el hacer disponible informacion sobre mi salud, consejo medico y tratamiento (o el de mi hijo/hija) con el proposito de evaluar y administrar beneficios de seguro. Autorizo pago de beneficios de seguro al Medico.*

\_\_\_\_\_  
**Date/Fecha**

\_\_\_\_\_  
**Signature/Firma**

**FINANCIAL AGREEMENT** – The undersigned agrees, whether he signs as agent or a patient, that in consideration of the services to be rendered to the patient, he/ She is hereby is responsible for paying co-payments, deductibles, estimated facility coinsurance amounts, and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier’s check, credit card, or personal check.

**ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION** – In consideration of services rendered, I hereby transfer and assign to the center and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance.

I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to Northwest Houston Surgical Assoc, LLP, my attending physician and or, consulting physician. I authorize Northwest Houston Surgery Center and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

**MEDICARE PAYMENTS** – (Patient’s Certification, Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I also acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint I might have.

**IF YOU HAVE SURGERY** – I acknowledge that one or more of the physicians providing my treatment at Memorial Hermann Surgery Center, Northwest, Methodist Willowbrook Surgery Center or North Cypress Medical Center may have an ownership interest in the facility where my procedure is being preformed. I also acknowledge that I have the right to choose the provider of my healthcare services.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT’S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

\_\_\_\_\_  
**Date/Fecha**

\_\_\_\_\_  
**Patient, Patient’s Agent or Representative/ Paciente, Persona Responsable**

\_\_\_\_\_  
Witness/ Testigo

\_\_\_\_\_  
Relationship to Patient/ Parentesco con el paciente

## **NHSA Financial Policy**

Thank you for choosing ***Northwest Houston Surgical Associates (NHSA)*** for your surgical care. We are committed to providing you the best possible health care. In order to prevent any misunderstandings, and to serve you better, we ask all patients\guarantors to read and understand our financial policy. We will gladly answer any questions you may have about services provided, fees, financial policy, or any other aspect of your care.

1. **Payment is due at the time that services are rendered**
  - \*Forms of Payment: cash, credit cards, and checks
  - \*co pays are collected at the time services are rendered
  - \*Deductibles, coinsurance, and non-covered services must be paid at the time services are rendered.
  
2. **Insurance acceptance and filing**
  - \*As a courtesy, we will file insurance if it is one in which *NHSA* is contracted.
  - \*changes in insurance should be provided prior to your visit-present your new Insurance card so we can verify & that we are contracted with that plan.
  - \*If you do not inform us of a change, and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balances. All charges are your responsibility regardless of insurance. Any amount due after insurance pays is your responsibility and due upon notification.
  
3. ***Medicare members: Since it can be considered Medicare fraud to waive deductibles and co-payments, you will be billed these amounts following Medicare reimbursement.***
  
4. **Returned checks**
  - \*Returned checks will incur a \$35.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card.
  - \*Once there has been a returned check, we will no longer accept personal checks. Unpaid checks are filed in court and you will be required to appear before a judge.
  
5. **Accounts turned over to a collection agency**
  - \*A \$20.00 fee is assessed and notice of dismissal from the practice may be given.
  - \*Accounts with no payment activity for 60 days may be turned over to collection temporary financial problems may affect timely payment, so we encourage communication of such problems to us at 713-426-2400 or 281-807-5100 so that your account can be properly handled.**
  
6. **Missed appointments**
  - \*please let us know 24 hours in advance if you cannot keep your appointment. We reserve the right to charge for missed appointment. Continued violation of this policy may result in dismissal from this medical office.

We are happy to help maximize the allowable benefits with your health insurance plan. It is, however your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and referral/authorization requirements. We will assist when possible to help you in this often-challenging endeavor.

---

Patient / Guarantor(s)

---

Date



*General and Laparoscopic Surgery*

S. Manny Ayyar, M.D.  
 Jorge I. Leiva, M.D.

Penni M. Russo-Going, M.D.  
 Jay K. Raman, M.D.

Ziad Amr, M.D.

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Date: \_\_\_\_\_

I authorize **Northwest Houston Surgical** to  Release to:  Release from:

\_\_\_\_\_  
 Person or Organization Address  
 \_\_\_\_\_  
 Telephone Number Fax Number (If Applicable)

Information/copies from the medical records on:

\_\_\_\_\_  
 Patient Date of Birth Social Security

**INFORMATION TO BE RELEASED:**

- Operative Report  Lab Work  Pathology Report  Billing Records
- X-ray Reports  Ultrasound  CT Scans  HIDA Scans
- ALL  Other: \_\_\_\_\_

This information is being released for the following purpose:

- Continued Care  Attorney/Litigation  Insurance  Disability Services
- Other: \_\_\_\_\_

**PLEASE FAX OR MAIL RECORDS TO THE FOLLOWING ENCLOSURE:**

**NORTHWEST HOUSTON SURGICAL ASSOCIATES**  
**1631 N LOOP WEST, STE# 220**  
**HOUSTON, TEXAS 77008**  
**TELEPHONE: 713-426-2400**  
**Fax: 713-426-3204**

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, (i.e. 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) prohibits 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

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Print Name of Legally Authorized Representative Date

\_\_\_\_\_  
 Witness – Printed Name/Signature



General and Minimally Invasive Surgery

S. Manny Ayyar, M.D.  
 Jorge I. Leiva, M.D., F.A.C.S.  
 Jay K. Raman, M.D., F.A.C.S., F.R.C.S.  
 Penni M. Russo-Going, M.D.  
 Ziad Amr, M.D.  
 Office: 713-426-2400 Fax: 713-426-3204

*THANK YOU FOR CHOOSING NORTHWEST HOUSTON SURGICAL ASSOCIATES  
 (NHSA) FOR YOUR HEALTHCARE NEEDS.  
 WE WELCOME THE OPPORTUNITY TO MAKE YOUR SURGICAL EXPERIENCE A  
 PLEASANT ONE.*

PLEASE ALLOW *NHSA* TIME TO OBTAIN THE FOLLOWING INFORMATION  
 BEFORE SCHEDULING:

PHYSICIAN AVAILABILITY  
 INSURANCE VERIFICATION  
 PRE- OP DIAGNOSTICS TESTING  
 PCP CLEARANCE IF NEEDED

FACILITY ACCOMODATIONS  
 PRE-CERT IFICATIONS REQUIRED  
 PRE-OP LAB  
 REPORTS FROM REFERRING M.D.

Please arrive to the facility at least 1-1/2 hour prior to surgery the day of surgery.

**NOTE: YOU WILL NEED SOMEONE TO DRIVE YOU HOME FROM THE SURGERY.**

**You may need one or more of the following test prior to your surgery. If so, you will be given written orders before leaving your doctors office.**

- ❖ Blood tests such as complete blood count, electrolytes, liver function tests, and PT, PTT may be necessary, depending on your age and medications.
- ❖ An EKG within six month of surgery is necessary if you are older than 50.
- ❖ If you have an abnormal EKG or history of heart disease, you may need a stress test of echocardiogram. Your surgeon will discuss with you.
- ❖ A chest X-ray may be necessary if you have a history of lung disease or smoking.
- ❖ If you need to have a clearance, please call us as soon as you schedule your appointment with your cardiologist.
- ❖ **If you have taken any of this test within the past 30 days please inform your physician.**