Jim S. Garza, M.D., P.A.
Houston Robotic Hernia Surgery

929 Gessner Rd., Suite 2470
Houston, TX 77024

Office: (713) 932-1001
Fax: (713) 932-0037

PATIENT INFORMATION
(Please Print)

Today's Date: _____

Referred by: _____

Nature of present complaint: _____

Name: _____ Date of Birth: _____ Age:_____

Race: _____ Sex: _____ Marital Status: _____

Address**:** _____

City_____ State: _____ Zip code: _____

Home Phone**:** _____ Work Phone: _____

Cell Phone: _____

Email Address: _____

Social Security #: _____ Driver License #: _____

Employer: _____ Occupation: _____

Length of Employment: _____ Employer Address: _____

Insured Information

Insured Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Employer: _____

Occupation: _____ Address: _____

MEDICAL HISTORY

Verified by: _____

Name: _____ **Height _____ Weight _____**

Have you ever had any of the following?
(Please check all that apply)

_____ High Blood Pressure
_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Rheumatic Fever
_____ Chest Pain/Angina
_____ Shortness of Breath
_____ Heart Attack
_____ Heart Bypass Surgery
_____ PTCA
_____ Nervous Disorders
_____ Stroke
_____ Fainting
_____ Dizziness
_____ Tuberculosis
_____ Emphysem
_____ Liver Disease
_____ Hepatitis
_____ Arthritis
_____ Kidney Disease
_____ Ulcers
_____ Acid Reflux
_____ Hiatal Hernia
_____ Phlebitis or Blood Clots
_____ Cancer
_____ Diabetes
_____ Thyroid Disease
_____ Blood Transfusions
_____ Blood Disorders
_____ Joint Implants
_____ Pacemaker
_____ Epilepsy/Seizures
_____ Persistent Headaches
_____ Asthma
_____ Hayfever
_____ Bowel/Colon Problems
_____ Rectal Disease/Hemorrhoids
_____ Gallbladder Disease
_____ Gout
_____ Kidney Stone
_____ Other: _____
_____

Do you smoke? Yes No How much? _____

Do you drink? Yes No How much? _____

Are you allergic to any medications? (Please list all): _____

_____

Are you allergic to LATEX? : Yes or No

List all medications you are currently taking: _____

_____

Do you have a primary care physician? : Yes No (if yes please list his or her name):_____

_____

Have you ever been hospitalized? Yes No Why? _____

List all previous surgeries and dates:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

****For Women Only****

Last menstrual period: _____ Are your menses regular? _____ Days? _____

Are you pregnant now? Yes / No Number of previous pregnancies? _____ # of Live Births: _____

Last Pregnancy? _____ Are you currently breast-feeding? Yes / N

Hernia Questionnaire

Where on your body do you suspect to have a hernia?

Right groin Left groin Abdomen

How long have you had this condition? _____

Were you injured at work? Yes / No Explain: _____

Date of injury: _____

Is the area bulging? Yes / No

If it bulges out, can you push it back in? Yes / No Not applicable: ___

Does it hurt? Yes / No

Please describe the pain:

_____

Does standing, lifting, straining make it worse? Yes / No

Does it interfere with your work? Yes / No

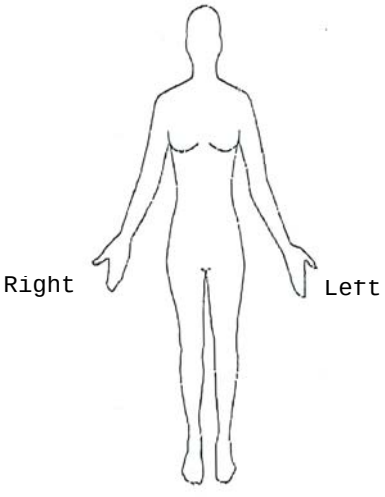
Have you had surgery on the same area that is concerning you? Yes / No

If you had surgery, when was it done? _____

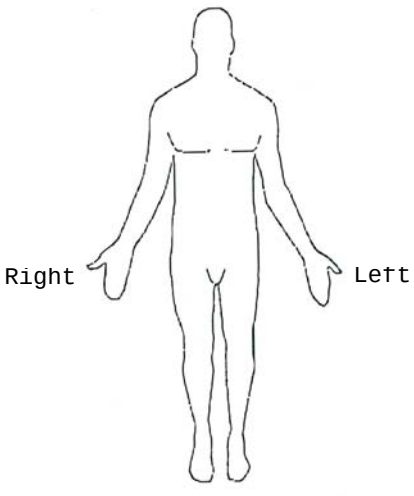
What is the name of the doctor that performed the surgery? _____

Please indicate on the drawing below where on your body you are having discomfort;

Female



Male



Patient Signature: _____

Disclaimer

Our office staff verified benefits with your insurance company to determine the effective date of coverage and if pre-existing applies. You have been informed of this information prior to your visits (s).

We have informed your insurance company the type of service(s) you are having and the diagnosis. Although benefits have been verified, we have no way of knowing if there are any special clauses, provisions, special criteria and/or exclusions that may apply to your policy that could prevent payment. It is the responsibility of the member to inform us of any such provisions and/or any changes on the policy.

A disclaimer was read to us from your insurance company stating that although benefits were given to our office, they can not guarantee payment of any claim. Therefore, we must inform you that although we have verified your benefits we can not guarantee payment from your insurance company of any claim(s).

I have read the disclaimer and understand that I am the guarantor of this account. Should my insurance company default payment or deny coverage of **any** reason, I am responsible for payment to Dr. Jim S. Garza for the services rendered.

Authorization to Release Information and Assignment of Benefits

I hereby authorize Jim S. Garza M.D., P.A. to release any information acquired in the course of my examination and/or treatment to my insurance company. I further authorize Dr. Jim S. Garza M.D., P.A. secretary to inquire as to the status of any insurance claims which have been filed on my behalf. Furthermore, I hereby make an assignment of benefits and authorize payment to Jim S. Garza M.D., P.A. for the medical and surgical benefits otherwise payable to me for the services as described.

A photo static copy of this authorization is as valid as the original.

_____ _____

Patient/Guarantor Signature Print Name (Patient/ Guarantor)

_____ _____

Legal Guardian/Guarantor Signature Print Name (Legal Guardian/Guarantor)

_____

Date

Guarantor Information:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____Work Phone: _____

FAMILY AND FRIENDS CONTACT FORM

The people who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, prescriptions, health benefits, etc. Please let us know what person we may share information with. (**Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form).**

Please list two emergency contacts whom we may share your medical information with.

Name: _____Relationship: _____ Telephone: _____

Name: _____Relationship: _____ Telephone: _____

What is the best phone number for us to contact you?

Phone number: _____

Can we send a text message with appointment and clinical information?	□Yes	□ No
Can we leave a message with appointment and clinical information?	☐Yes	☐ No
May we have your permission to take your photo?	☐Yes	☐ No
Can we use your photos for chart records?	☐Yes	☐ No
Can we use your photos for Medical teaching presentations?	☐Yes	☐ No
Can we use your "pre"&"post" photos to educate other office patients?	☐Yes	☐ No
Can we use your photos on office materials including brochures?	☐Yes	☐ No

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Patient or Legal Representative Relationship to Patient

Jim S. Garza, M.D., P.A.

929 Gessner, Ste 2470
Houston, Texas 77024

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **04/14/03** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under

certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. **If you request copies, we will charge you no more than $25.00 for the first 20 pages and $0.15 per page for every copy thereafter. Fees for copying x-rays will be according to the Texas State Board regulations, depending upon the type of x-rays to be duplicated**. An additional fee for postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. **Contact us using the information listed at the end of this Notice for a full explanation of our fee structure**.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ivy Nguyen.

Telephone: 713-932-1001 Fax: 713-932-0037

Address: 929 Gessner Rd., Ste 2470, Houston, Texas 77024

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929 Gessner Rd., Ste 2470
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Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____
_____
_____