Gang Quan, M.D.
Gastroenterology & Hepatology
3313 Unicorn Lake Blvd, Suite 152 – Denton, Texas 76210
3012 Communications Pkwy, Suite 200 – Plano, Texas 75093
Ph: (940) 898-8245 or (972) 479-5270 Fax: (940) 898-8247

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ **Social Security Number** _____ ☐ **Male** ☐ **Female**

(Failure to provide your Social Security Number will result in the cancellation of your appointment per our office policy.)

Ethnicity: Non-Hispanic/Hispanic **Race: White/Black/Asian/Other** _____ **Preferred Language**

☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Home Phone Number _____ **Cell Number** _____ **Email Address** _____

Street Address _____

City / State / Zip Code _____

Policy Holder "Guarantor" on Your Insurance Policy _____

Guarantor's DOB _____ **Relationship to patient** _____

****Person to call in case of emergency, RELATIONSHIP** _____ **Phone Number** _____

Primary Care Doctor Name _____ **Phone Number** _____

****Pharmacy Name, Location (Please be specific)** _____ **Phone Number** _____

How did you hear about us? (Name of Referring Doctor, Phone Book, Internet, Hospital, etc) _____

Do you have any Drug allergies? □ **YES** □ **NO** **(If yes, please list below)**

_____

Please list <u>ANY</u> Medications you take on a regular basis. Make sure to include any vitamins or supplements.

□ See List

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE SELECT ALL THAT APPLY BELOW

Medical History

□ Congestive Heart Failure
□ Hepatitis A, B, C,
Type? _____
□ High Blood Pressure
□ Diabetes:Diagnosed in _____(yr.)
□ Iron Deficiency Anemia
□ Colon Cancer
□ Colon Polyps
□ COPD
□ Asthma
□ Coronary Artery Disease
□ High Cholesterol
□ High Triglycerides

□ _____

□ _____

□ _____

□ _____

Surgical Surgery

□ Appendectomy
□ Colon Resection
□ Hernia Repair
□ Hysterectomy
□ Tonsillectomy
□ Adenoidectomy
□ C-Section
□ Gallbladder Removal
□ Pacemaker / ICD Implant
□ Joint Replacement _____

□ _____

Have you ever had a colonoscopy?

□ Yes □ No

If yes, date of last scope?
_____

Family Medical History

□ Alcoholism
□ Asthma
□ COPD
□ Gallstones
□ Depression
□ Diabetes
□ Hepatitis B
□ Hepatitis C
□ Hypertension
□ _____

□ _____

□ _____

Has anyone in your family ever had Colon Cancer?

□ Yes □ No

Who? _____

Tobacco
□ Non Smoker
□ Current Use
How many per day? _____
□ Quit _____
□ Smokeless Tobacco

Alcohol
□ Non Drinker
□ Rare Use
□ Social Use
□ Regular Use
□ Current Alcoholic

Illicit Drugs
□ Never Used
□ Experimented With…
□ Current User of… (please check)
□ Marijuana
□ Cocaine
□ Meth / ICE / Speed
□ Heroin
□ Prescription Abuse

****We are required under the Affordable Care Act to report your smoking status to your insurance company. It is important that you fill out the Tobacco, Alcohol, and Illicit Drugs sections to the best of your abilities for it will be indicated and shown in every office visit that you receive with Dr. Quan.****

CURRENT PROBLEMS

Constitutional

□ Chills
□ Fatigue / Tired
□ Unexplained Fever
□ Night Sweats
□ Weight Loss
□ Weight Gain

Cardiovascular

□ Chest Pain
□ Dizziness
□ Irregular Heartbeat
□ Swelling in Feet and Ankles
□ Tachycardia

Respiratory

□ Chronic Cough
□ Shortness of Breath
□ Coughing up blood
□ Wheezing

Gastrointestinal

□ Abdominal Pain
□ Acid Reflux / Heartburn / GERD
□ Loss of appetite
□ Bloating
□ Difficulty Swallowing
□ Constipation
□ Diarrhea
□ Hemorrhoids
□ Dark, Tarry stools
□ Nausea
□ Vomiting
□ Rectal Bleeding

Psychiatric

□ Anxiety
□ Bi-Polar
□ Depression
□ Feeling Stressed
□ Personality Change
□ Mood Swings
□ PMS
□ Poor Concentration
□ Sleep Disturbance
□ Suicidal Thoughts

Patient Consent

In the course of providing care to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you and in order to obtain payment for our services.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. We are able to refer to this Notice at any time. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided in our office, but also disclosures for your health information may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your information for purposes of payments includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third party payers or insurers for claims review, determination of benefits and payments; our submission of your health information to auditors hired by third party payers and insurer, among other aspects or payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy policies change. You can receive an updated copy from our Office Administrator. By supplying my phone number, email address and any other personal information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances on my account, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

By signing this consent, you signify that you agree that all payment's are deemed your responsibility and are due at the time of service, unless prior arrangements have been made, or you have insurance coverage in which you have provided copies of for filing purposes. North Texas Triangle Gastroenterology, P.A. employs Escallate, LLC as a third party collections agency. I understand and authorize that if I have an outstanding balance greater than $50.00 that my account will be sent to Escallate, LLC in attempts to have my balance collected after 90 days of non-payment or if I refuse payment. My credit may be affected as a result. North Texas Triangle Gastroenterology, P.A. will make 3 mail attempts to collect any past due balances prior to sending my information to Escallate, LLC.

My signature on this form will serve as "SIGNATURE ON FILE" for processing any applicable insurance claims. I understand that my insurance may deny benefits if determined I received an examination too frequently or received examinations by separate doctors for the same illness.

By signing this consent, you signify that you agree that we can, will use, and disclose your health information to treat you and to obtain payment for our services rendered to you.

We may decline treatment should you refuse to sign this consent.

_____	_____
Patient Name (printed)	DOB
_____	_____
Patient Signature	Date
_____	_____
Witness / Office Staff Signature	Date

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HIPAA CONSENT FORM

I, _____, date of birth (_____/_____/_____) hereby give my written consent for

Name:_____ Name:_____

Name:_____ Name:_____

to speak with Dr. Quan and his staff members about my:

( ) Appointment Needs (Scheduling, rescheduling, confirmation, etc.)
( ) Lab / Radiology Results
( ) Procedure Results
( ) Medications and Medication Management
( ) Insurance benefits, guarantor information, authorization, changes, and outstanding balances
( ) Entire Medical Record

( ) I ***do not give my permission*** for Dr. Quan or his staff to speak to anyone regarding any of my private health information. The only person that Dr. Quan and his staff are allowed to speak to regarding my private health information is myself and/or my referring physician if I have one.

I understand that this consent is binding, and Dr. Quan and staff must have written notification should I choose to revoke this person from having access to the above information. Dr. Quan and his staff will only share the information that I have chosen with:

Patient Signature: _____

Date:_____

Patient Print:_____

Witness:_____

Patient Portal Authorization Consent

Patient Name:_____ DOB:_____

Patient Email Address:_____

The Patient Portal is designed to enhance patient-physician communication. The portal is a voluntary option and is free of charge to all patients. The portal is not intended to be used in place of an office visit or for urgent concerns.
Please read this form thoroughly before signing.

Through the portal you will be able to:

Request medication refills; Request an appointment be scheduled; Update your contact and insurance information
Review and update as needed your medical list; Email the office staff securely regarding any medical or billing questions

We will respond to portal inquiries within 24-48 hours. Prescription refills will be handled 24-48 hours after receiving the request. You can access the portal day or night, but we do not have a 24-hour presence on our end. If you are experiencing an emergency or have an urgent medical need, you should call our office. If it is after-hours, we recommend that you go to an Urgent Care facility, the Emergency Room or call 9-1-1.

Bedside manner is complicated via email; it is easy to misread information and/or emotion. Therefore, we will try to keep correspondence brief and clear on the portal. We really appreciate your help on that too. If a message takes a long time to write, it's probably something better done in person at an office visit. **If there is persistent abuse or negligence with the use of the Patient Portal, we reserve the right at our own discretion to terminate offering the patient portal, suspend a user account, or modify services offered through the Patient Portal.**

This method of communication prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depend on two important factors. One, you must make sure we have your correct email address on file and notify us promptly if it ever changes. Second, you must keep unauthorized persons from learning your password. If you suspect your account has been compromised, promptly change your password and notify our office. We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Once this form is agreed to and signed, you will receive a username and password via your personal email. There is a link to the Patient Portal on our website, www.gidrquan.com or by directly visiting www.gotomyclinic.com/gidrquan.

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communication between Dr. Gang Quan and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decided against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Dr. Gang Quan, North Texas Triangle Gastroenterology, P.A. may impose for the online communication. I have had a chance to discuss my concerns with the office and my questions answered clearly to my satisfaction.

PLEASE INITIAL NEXT TO ONE OF THE TWO OPTIONS BELOW:

_____ I consent to participate in the North Texas Triangle Gastroenterology, P.A. Patient Portal program. I understand that the patient portal is not used in the place of an office visit. I understand that if I experience a medical emergency that I should call an ambulance and not depend on the patient portal for an emergency situation. I understand that all responses from the patient portal have a 1 to 2 business day turnaround time.

_____ I decline consent to participate in the North Texas Triangle Gastroenterology, P.A. Patient Portal program.

_____ _____
Patient Name (Printed) Date

_____
Patient Signature

_____ _____
Witness Signature Date