Tony N. Tsen, M.D.
SOUTHWEST GASTROENTEROLOGY, P.A.

Demographic Sheet (page 1 of 3)

Todays Date: _____

PLEASE PRINT

Last Name_____First_____Middle _____
Mailing Address_____
City_____State_____Zip_____
Date of Birth _____/_____/_____ __ Social Security Number_____
Home Phone (_____)_____Cell Phone (_____)_____
Email:_____ Preferred method of contact: □ text □ call
Gender (at birth): □ Male □ Female
Marital Status: □ Married □ Single □ Divorced □ Widowed
Race: □ American Indian/Alaskan Native □ Asian □ Black □ Caucasian/E. European
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino

Responsible Party/Guarantor If other than above:
Name _____
Address_____
City_____State_____Zip_____
Home Phone (___)_____Work Phone (___)_____Cell Phone (___)_____
Relationship to Patient _____

Insurance Information □ Medicare □ Medicaid □ Commercial □ No Insurance □ Tricare
Primary Insurance _____Policy # _____Group #_____
Policy Holder Name _____DOB_____Relationship _____
Policy Holder SSN _____Effective Date _____

Do you have secondary insurance? □ Yes □ No If yes, complete below:
Secondary Insurance_____Policy #_____Group #_____
Policy Holder Name _____DOB_____Relationship _____
Policy Holder SSN _____Effective Date _____

Emergency Contact:
Name _____
Address_____
City_____State_____Zip_____
Home Phone (_____)_____Work Phone (_____)_____
Relationship to Patient _____

Employment Status □ Full Time □ Part Time □ Retired □ Not Employed
Student □ Full Time □ Part Time □ Not in school
Employer _____
Address _____
Phone (_____)_____ extension _____

Primary Physician _____Phone_____ Referring Physician_____Phone_____
I, the undersigned, attest that the above information is true and complete, to the best of my ability:

Signature: _____Date _____

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Demographic Sheet (page 2 of 3)

Please read and initial next to each statement.

_____1. **Permission for Treatment**: I hereby authorize the physician and/or assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations or treatments that may be ordered to be performed by clinical personnel. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

_____2. **Permissions for Release of Medical Information**: I understand and agree that any of the above information may be used, if necessary, for purposes of the communication for appointment changes, accounts receivable, emergencies, etc. Information from any medical records may be released, if necessary, for insurance purposes.

_____3**. Assignment of Benefits**: I hereby authorized my insurance company(s) to make payment(s) as stipulated in my policy for any services furnished and that such payment(s) be paid directly to the provider of the services.

_____4. **Payment for Services Rendered**: I also understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered and I agree to pay upon demand or as agreed for the related changes of remaining charges following my insurance payment(s).

_____5. **Referrals & Authorizations**: I also understand that any prior authorizations or referrals from my primary care provider is ultimately my responsibility as required by my insurance (specifically HMO or Tricare). If prior authorization is not obtained by day of my appointment, I understand that I will be asked to rescheduled my appointment or pay the full amount for all services on the day of service.

_____ 6. **Cancellation Policy**: I understand that reminder calls are made as a courtesy and that I am responsible for remembering my scheduled appointment. If I find that I need to cancel my office appointment or procedure, I agree to give 48 hours advance notice of cancellation.

Yes	**No**	
□	□	Do you have an Advanced Directive?
□	□	Do you or your spouse work for a company that provides you with health insurance?
□	□	Is this illness or injury the result of an automobile accident or other injury?
□	□	Is this illness or injury the result of an accident or illness that occurred at work?

Patient's Signature:_____Date: _____/_____/_____

Patient's Agent or Representative Signature: _____Date: _____

Relationship to Patient: _____

Tony N. Tsen, M.D.
SOUTHWEST GASTROENTEROLOGY, P.A.

Demographic Sheet (page 3 of 3)

TELEMEDICINE CONSENT

Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications tehcnology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to our location if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

The benefits of a telemedicine consultation are:

1. You may not need to travel to the consult location.
2. You have access to a specialist through this consultation

Consent for Treatment. I hereby authorize to be interviewed by the physician and/or assistants to participate in my medical care through the use of telemedicine. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I acknowledge that the physician's advice, recommendations, and/or decisions may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of images that may result from electronic transmission.

I hereby release Southwest Gastroenterology and its personnel and any other person participating in my care from any and all liabilty which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of telemedicine consultation and I hereby consent to participate in the telemedicine visit under the conditions described above.

Requirements:

- MAC/PC/Linux/Chromebook with camera, microphone, and speakers
- Internet connection with at least 750kb/s download and upload speeds
- Google, Chrome, Mozilla Firefox or Safari 11+ (latest versions)
- Latest operating systems preferable (Windows 10 or MacOS Catalina)
- Javascript enabled

Patient's Signature:_____Date: _____/_____/_____

Patient's Agent or Representative Signature: _____Date: _____

Relationship to Patient: _____

Southwest Gastroenterology, P.A.
Dr. Tony N. Tsen

Date:_____
Name: _____ Date of Birth: _____Age: _____

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

Please state briefly the problems that have brought you to the doctor's office:

_____
_____

PERSONAL INFORMATION

Children: How many? ____ Any problems with their health and if so, who and what?

Occupation: _____

Smoking: How many packs per day? _____ How long?_____

Alcohol (plus beer): How much? _____ How frequently? _____

Does it ever bother you? _____

Which pharmacy do you use? _____phone #: _____

PATIENT'S MEDICAL HISTORY

SURGICAL: (HAVE YOU HAD AN OPERATION ON?) YES NO DATE

Tonsils and Adenoids _____

Appendix _____

Gallbladder _____

Urinary Bladder_____

FEMALE ORGANS
- Hysterectomy (uterus) _____
- Tubes _____
- Ovaries _____
- C-Section _____
- Tubal Ligation _____

Stomach or Intestines _____

Hemorrhoids _____

Heart _____

Lungs _____

Vein Stripping _____

Hernia repair _____

Vasectomy _____

Other _____

MEDICAL: (HAVE YOU HAD ANY OF THE FOLLOWING?) YES NO DATE

Date of last Covid vaccination: _____/_____/_____
Covid _____

Pneumonia _____

Lung Disease / Emphysema _____

Hypertension (High Blood Pressure) _____

Angina _____

Stroke _____

Diabetes _____

Thyroid Disease _____

Kidney Disease _____

Cancer _____

Gout _____

Migraine headaches _____

(Peptic) Ulcer Disease _____

Gallbladder _____

Liver Disease _____

Hepatitis / Yellow Jaundice _____

Diverticulosis / Diveritculitis _____

Spastic colon / Irritable Bowel Syndrome _____

Inflammatory Bowel Disease – Crohn's disease/ileitis/regional enteritis/ulcerative colitis _____

Polyps of colon _____

Other _____

DO YOU HAVE ANY OF THESE CONDITIONS OR ANY OTHER PROBLEMS THAT YOU WISH THE DOCTOR TO KNOW ABOUT?

Headaches/Migraine headaches _____

Problem with vision _____

Problem with hearing _____

Chewing and/or swallowing difficulties _____

Shortness of breath: asthma, emphysema _____

Heart beating fast or skipping a beat (palpations), chest pain _____

Heart murmur _____

Mitral valve prolapse _____

Elevated triglycerides/cholesterol _____

Swelling of feet or hands _____

Pain on urination: frequency of urination _____

Urinating at night _____

Hemorrhoids _____

Other _____

FAMILY HISTORY: (Parents, Grandparents, Aunts, Uncles, Brothers, Sisters)

Hypertension (High Blood Pressure) _____

Heart Disease_____

Heart Attack_____

Stroke_____

Kidney Disease _____

Thyroid Disease _____

Goiter _____

Diabetes _____

Lung Disease / Emphysema _____

Tuberculosis _____

Bleeding Tendency _____

Leukemia _____

Cancer _____

Migraine Headaches _____

Gallstones _____

Hepatitis _____

Liver Disease _____

Peptic Ulcer Disease (Stomach/Duodenal Ulcers) _____

Irritable Bowel Syndrome/spastic colon/"colitis" _____

Inflammatory Bowel Disease – Crohn's disease/ulcerative colitis _____

Polyps of Colon _____

Arthritis _____

Epilepsy _____

Gout _____

MEDICATIONS: Bring medication list or list all medications currently taking including over-the-counter medications and prescription medications, and how much of each.

Aspirin _____Tylenol _____

Arthritis Medicine _____Hormones/Birth Control Pills _____

Blood Pressure _____

Antacids (Including Tums, Rolaids, Alka Seltzer, Maalox, Mylanta, Riopan, Digel, Gaviscon) _____

Other _____

ALLERGIES: Are you allergic to any medications? _____

If so, which ones? _____

Do you want your clinical summary? (circle): yes / no If yes, please pick up at office within 3 bus days.

SOUTHWEST GASTROENTEROLOGY, P.A.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

If you have any questions about this notice, please contact:

Privacy Officer:
Melanie Tsen
911 S. Hwy 123 Bypass
Seguin, Texas 78155
(830) 372-9042

This Notice tells how this Practice, its physician(s), or other health care professionals who work under contract or under the direction of our Practice and our staff, may use and disclose medical information about you. Other personnel affiliated with our practice who are authorized to have access to your medical records, are subject to this notice. In addition, this Practice, in cooperation with other healthcare facilities, providers and/or insurance carriers may share medical information with each other for treatment, payment, or health care operations described in this notice. This Notice also describes your rights and our obligations regarding the use and disclosure of this information. Additionally, this Notice applies to all your records created and/or maintained by this Practice.

We understand that medical information about you and your health is personal. We are committed to protecting this information. Each time you visit our Practice, a record of the care and services you receive is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, plan for future care or treatment, and billing record. This record serves as a:

- basis for planning your care and treatment;
- means of communication among the many health care professionals who contribute to your care;
- means by which you or third-party payers (insurance) can verify that services billed were actually provided;
- tool for educating health professionals;
- source of information for public health officials; and
- tool for assessing and continually working to improve health care rendered.

Our Responsibilities:

This Practice shall:

- make every effort to maintain the privacy of your health information;
- provide you with notice of our legal requirements and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of this **NOTICE OF PRIVACY PRACTICES**;
- accommodate reasonable requests you may have to communicate with you by alternative means or to different locations.

The Reasons Why We May Use and Disclose Medical Information About You:

Listed below are different ways we may use and disclose your medical information. Examples serve only as illustrations and do not include every possible use or disclosure.

- **For Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care services. For example, we may share your information with other specialists to whom you are referred for treatment.
- **For Payment:** We will use and disclose medical information about you so that you, your insurance company, or a third party may be billed for services. For example, we may need to disclose protected health information to a health plan (insurer) in order for your health plan to pay us for the services rendered to you. We may also tell your health plan about a treatment or procedure you are going to receive in order to obtain prior approval and to determine whether your plan will cover the expenses for the procedure.
- **For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run this Practice in an efficient manner and ensure that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of health care services to determine appropriateness and quality of health care treatment. In addition, medical records are audited for documentation and billing purposes.

- **For Appointment Reminders:** We may use and disclose medical information in order to remind you of an appointment. For example the Practice may send you a written notice or telephone reminder that your next appointment is coming up.

- **As Required by Law:** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

- **For Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another medication for the same condition. All research projects are subject to a special approval process. We will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you to medical or law enforcement personnel to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **For Distribution of Health Care Information and/or Marketing:** This Practice does not share patient's health information with outside firms for product marketing. We may use certain information (name, address, telephone number, dates of service, age, and gender) to send you information about the Practice's health programs, services, and growth. If you do not wish to receive this information, please write to the Practice Manager whose address is listed on the front page of this notice.

Special Situations:

- **Organ and Tissue Donation:** If you have indicated in writing your desire to be an organ donor, we may release medical information to organizations that handle procurement of organs, eyes, or tissue transplantations.

- **Military and Veterans:** If you are or were a member of the armed forces, we may release medical information about you as required by military or other authorities.

- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Qualified Personnel:** We may disclose medical information for management audit, financial audit, or program evaluation. The personnel involved in these operations may not identify you in any report, audit, or evaluation, or otherwise disclose your identify in any way.

- **Law Enforcement:** We may release medical information if asked by a law enforcement official or required by a court order or subpoena. We may release information if we determine that there is a probability of imminent physical injury to you or to another person, or immediate mental or emotional injury to you. [This paragraph may not apply to very specific patients who are Practice Patients under particular and specific circumstances.]

- **Physician Sale of Practice:** We may use and disclose medical information about you to another physician or healthcare facility in the sale, transfer, merger, or consolidation of this physician's practice.

- **Public Health Risks:** We may disclose medical information about you for public health activities. These activities generally include the following:

    - To prevent or control disease, injury, or disability;
    - To report births and deaths;
    - To report child abuse or neglect;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate governmental authority if we believe a patient has been the victim of abuse, neglect,

  or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for specific activities. Health oversight agencies are authorized by law to oversee the health care system. For example, an oversight agency may perform audits, investigations, inspections, and evaluations for licensure. These activities are necessary for the government to monitor government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or in administrative disputes, we may disclose medical information about you in response to court or administrative orders.

- **Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

- **Inmates:** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility so that the facility can provide you with treatment.

Your Rights Regarding Your Medical Information:

You have the following rights concerning your medical information.

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. You must submit a request in writing to the Practice Manager and/or this office's Privacy Officer if you wish to inspect and copy medical information that may be used to make decisions about you. If you request a copy of the information, this Practice may charge you a fee for copying, mailing, or summarizing your medical records. You must submit a written request if you wish to view your psychotherapy notes.

  We may deny your request to inspect and copy your records because of special circumstances. If you are denied access to medical information including psychotherapy notes, you may request that we review our denial. Another licensed health care professional chosen by this Practice will review your request and our denial. The person conducting the review will not be the person who denied your initial request. This Practice will comply with the outcome of the review.

- **Right to Amend:** If you feel that medical information maintained about you is incorrect or incomplete, you may ask the Practice to amend the information. You have the right to request an amendment of your information for as long as the information is kept by the Practice.

  To request an amendment, your request must be made in writing and submitted to the Practice Manager and/or Privacy Officer of this Practice. In addition, you must provide a reason to support your request.

  We may deny your request to amend your medical records if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by this Practice unless the person (doctor) or other health care entity that created the information is no longer available to make the amendment for you;
  - Is not part of the medical information about you kept by the Practice;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete as is.

- **Right to Accounting of Disclosures:** You have the right to request an accounting of disclosures of your medical information made by the Practice for purposes other than treatment, payment, or health care operations.

  To request this accounting, you must submit your request in writing to the Practice Manager and/or Privacy Officer of this Practice. Your request must state how long a period of time you wish the accounting to cover. The accounting cannot exceed a period of six (6) years beginning April 14, 2003. Your request should indicate in what format you want the accounting (paper or electronically). The first accounting you request within a 12-month period will be free. You may be charged for additional accountings within the same 12-month period. We will notify you of the cost so that you may choose to withdraw or modify your request if costs seem excessive.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information the Practice uses or discloses for your treatment, payment or health care. You also have the right to request a limit on the medical information the Practice discloses about you to someone outside the Practice for care or payment. **This Practice is not required to agree to your request.** Should this Practice agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to the Practice Manager and/or Privacy Officer of this Practice. In your request, you must indicate:

  1. what information you want to limit;
  2. whether you want to limit your information for our own use and disclosure;
  3. to whom you want the limits to apply.

- **Right to Request Confidential Communications:** You have the right to request that this Practice communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that this Practice contact you only at work or by mail.

  If you want to request that we communicate with you in a certain manner, you must make your request in writing to the Practice Manager and/or Privacy Officer of this Practice. You do not have to state a reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish the communication to be directed.

- **Right to Question Your Bill and Billing Procedures:** If you wish your bill sent to another address, or if you have questions regarding your bill and the Practice's billing procedures, you may direct you questions and concerns to this Practice's Office Manager.

Changes to This Notice:

We reserve the right to change our practices and to make new provisions effective for all the protected health information we maintain. Should our information practices change, we will post the amended **NOTICE OF PRIVACY PRACTICES** in the office waiting area and on our website (if applicable). You may request that a copy be provided to you by contacting the Practice Manager and/or Privacy Officer of this Practice.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the Practice Manager and/or Privacy Officer of this Practice or with the Office for Civil Rights, U.S. Department of Health and Human Services.

To file a complaint with this Practice, contact: Privacy Officer: Melanie Tsen (830) 372-9042

All complaints to the Office for Civil Rights should be submitted in writing.

The address for the Office of Civil Rights is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

You will NOT be penalized for filing a complaint.

Southwest Gastroenterology, P.A.
Tony N Tsen, M.D.

ACKNOWLEDGEMENT OF RECEIPT
OF THE
NOTICE OF PRIVACY PRACTICES

Patient Name: _____Date of Birth: _____

I acknowledge that this Practice has provided me with a written copy of the Notice of Privacy Practices.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the Privacy Officer by calling 830-372-9042.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

I understand that I may revoke this consent in writing, except to the extent that Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows: _____
_____
_____

May we release health information about you to family member(s) or another individual or care giver(s)? [ ] yes [ ] no

Please list who you want to release information to:

_____ _____
Name How related

_____ _____
Name How related

_____ _____
Patient Signature Today's Date

_____ _____
Personal Representative Signature