Vikram S. Jayanty, M.D., P.A.
Certified by the American Board of Internal Medicine in Gastroenterology
10837 Katy Freeway Suite 175, Houston, Texas 77079
Phone: 713-932-9200 Fax: 713-932-6152

Julien Fahed, M.D. **Vikram Jayanty, M.D.**

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointment, Dr. Jayanty's staff will call you on the number provided and send email reminders 2 days prior to your appointment.

If your schedule changes and you cannot keep your appointment, please contact the office at (713) 932-9200 so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24-hour notice.

If you do not cancel or reschedule your appointment within at least 24-hour notice, we may assess a $50.00 "No-Show" service charge to your account. This "No-Show Charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "No-Show" policy of Dr. Vikram Jayanty and agree to the charge of $50.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

Date: _____

Name: _____

Signature: _____

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Patient Record

(Please read carefully and complete all questions)

Patient Name: _____Birthdate: _____ DATE: _____
Gender(circle one) : Male Female Social Security: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Email: _____ ___
Home #: _____ Cell#: _____Work #: _____
___ Marital Status: ____Single ____Married ____Divorced ____ Widow/Widower ____
Race: _____ Ethnicity: _____Preferred Language: _____
PCP/Referring Physician: _____ Phone #: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____
Employment Status: _____Full-Time _____Part-Time _____Unemployed _____Retired
Employer: _____ Phone: _____
Employer Address: _____ ___
Student Status: _____ Full-Time ____ Part-Time _____ Not a student
Primary Insurance Holder Name: _____ Birthdate: _____ ___

PLEASE READ CAREFULLY AND SIGN

This is to certify that I/we, authorize the administration of all treatments and operation, and the administration of any anesthetics, which, in the judgment of my physician may be considered necessity or advisable. I/We, the undersigned, agree to be financially responsible for the charges incurred by the patient and to make payments upon receipt of the periodic statements for the patient. In the event of non-payment, I/We agree that if the account is referred to an agency for collection I/We shall be required to pay all of the collection expense. I understand Vikram S. Jayanty M.D., PA & Anesthesia Care by Doctors LLP is in compliance with the laws and guidelines of the HIPAA regulations. All services and records are confidential and private to protect the patient.

_____

Signature of Patient or Legal Guardian

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Medication Sheet

Patient Name: _____ **Date of birth:** _____

Pharmacy Name & Address: _____

Pharmacy phone number: _____

Allergies to any medications

Medication Name	Type of Reaction

Medication list

Name of Medication	Dosage? & How often?	Reason for taking meds?	When did you start taking medication?	Prescribing Doctor's Name

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JULIEN FAHED, M.D. VIKRAM JAYANTY, M.D.

Name: _____ **DOB:** _____

Duration: _____

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

Diabetes? ☐ **Yes** ☐ **No**

Heart Disease? ☐ **Yes** ☐ **No**

High Blood Pressure? ☐ **Yes** ☐ **No**

Crohns disease or Colitis? (circle one if yes) ☐ **Yes** ☐ **No**

Lung Disease? ☐ **Yes** ☐ **No**

Kidney Disease? ☐ **Yes** ☐ **No**

Cancer:

If so, what kind? _____ **And what age?** _____

Have you been tested for HIV: ☐ **Yes** ☐ **No** **Positive** ☐ **Negative** ☐

Screened for Hepatitis? **Yes** ☐ **No** ☐ **Positive** ☐ **Negative** ☐

If positive what type? **Type A** ☐ **Type B** ☐ **Type C** ☐

Have you had a colonoscopy in the past? Yes ☐ **No** ☐ **Performed by whom:** _____

If you have when was your last colonoscopy? _____ **Results:** _____

Have you had any surgery performed in the past? **Yes** ☐ **No** ☐

When? _____ **What?** _____

Mental Health? (ex. Anxiety, Depression, Bi-Polar) _____

Do you presently use NSAIDS: (ex: Aspirin, Ibuprofen, Naprosyn? _____

Vaccine Record

Have you had the Hepatitis A & B vaccine? **Yes** ☐ **No** ☐

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Patient Name: _____ DOB: _____

SOCIAL HISTORY

What type of diet do you follow? _____

Do you exercise?_____ If so, how much?_____

Are you a smoker?_____ If so How Much?_____
If not: Former Smoker ☐ Never a smoker ☐

What is your sexual preference: Heterosexual ☐ Homosexual ☐

Do you drink alcohol? Yes ☐ No ☐ How much during a week?_____

FAMILY HISTORY

Have you or any family member ever had any of the following **cancers** listed below?

Colon/Rectal:_____ Family Member: _____ Age:_____

Uterine /Endometrial:_____ Family Member: _____ Age:_____

Ovarian: _____ Family Member: _____ Age:_____

Stomach, small intestine:_____ Family Member: _____ Age:_____

Bile duct, liver, pancreas:_____ Family Member: _____ Age:_____

Other Cancer: _____ Family Member: _____ Age:_____

Have you or anyone in your family been tested for hereditary risk of cancer? Yes ☐ No ☐
Please explain:_____

Family History of Diabetes? Yes ☐ No ☐
Family history of High Blood Pressure? Yes ☐ No ☐
Family history of Heart Disease? Yes ☐ No ☐

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security #: _____

I request that _____
release my medical records to the following:

Vikram S. Jayanty, M.D., P.A.

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Phone: (713) 932-9200 Fax: (713) 932-6152

The records requested pertain to the following:

- ☐ COLONOSCOPY
- ☐ EGD
- ☐ PATHOLOGY
- ☐ ALL RECORDS
- ☐ LABS
- ☐ IMAGING (RADIOLOGY)
- ☐ PROGRESS NOTES

Patient Signature_____

Date: _____

Staff Use Only:

Date Sent ____/____/____
Initials: _____

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Confidentiality Agreement

1. Please list the family members or other persons, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

   _____

   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

   Name_____Phone#_____

   Name_____Phone#_____

3. Please print the address of where you would like your billing statements if different from your home address.

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   Yes ☐ No ☐

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:_____

"I am fully aware that a cell phone is not a secure and private line"

6. Can confidential messages (i.e. appointment reminders) be left on your voicemail?

   Yes ☐ No ☐

Patient/Guardian Name_____ (Guardian if under 18 years)

_____ _____

Patient/Guardian Signature **Date**

ANESTHESIA CARE BY DOCTORS
10837 Katy Freeway Suite 175, Houston, Texas 77079
Phone: 713-932-9200 Fax: 713-932-6152

Patient Name: _____ **DOB: _____**

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE : You need to make a choice about receiving these health care items or services.

We expect that your insurance may not pay for the item(s) or service(s) that are described below. Your insurance does not pay for all of your health care costs. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Ritht now, in your case, **your insurance may not pay for:**

Items or Services: ☐ Anesthesia

Because: Insurance Termination, Pre-Existing Condition, Policy Ryder or Exclusion, Non-Covered due to global limits, Due to Medical Necessity, and Routine or Preventative Services not covered.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you.

PLEASE CHOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN AND DATE** YOUR CHOICE

____Option 1. YES. I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. I am aware this information must be submitted to my insurance carrier, which may, in turn, apply additional deductible and coinsurance that will be my responsibility to pay. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance companies decision.

_____Option 2. NO. I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance won't pay.

_____ _____

Date **Signature of patient or person acting on patient's behalf**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is sunmitted to your insurance company, your health information on thes form may be shared with your insurance company. Your health information which your insurance company sees will be kept confidential by your insurance company.

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Patient Name: _____ **DOB: _____**

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Items or Services: ☐ Colonsocopy ☐ Gastroscopy ☐ Capsule Endoscopy ☐ Bravo Ph Test

Because: Insurance Termination, Pre-Existing Condition, Policy Ryder or Exclusion, Non-Covered due to global limits, Due to Medical Necessity, and Routine or Preventative Services not covered.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you.

PLEASE CHOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN AND DATE** YOUR CHOICE

____Option 1. YES. I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. I understand my colonoscopy will be performed for colon cancer screening. If a colon polyp or other pathology is identified during the procedure, I am aware this information must be submitted to my insurance carrier, which may, in turn, apply additional deductible and coinsurance that will be my responsibility to pay. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance companies decision.

_____Option 2. NO. I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance won't pay.

_____ _____
Date **Signature of patient or person acting on patient's behalf**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is sunmitted to your insurance company, your health information on thes form may be shared with your insurance company. Your health information which your insurance company sees will be kept confidential by your insurance company.

VIKRAM S. JAYANTY, M.D.

Houston Endoscopy &  ***Center***

Dr. Jayanty is dedicated to providing the best care to his patients by pursuing and researching the safest and most beneficial treatments for his patient's conditions. Dr. Jayanty has a research center that conducts research trials for major pharmaceutical companies, He has conducted over 90 clinical research trials since 1985 with new and previously approved medications that are presently on the market for the following indications: Irritable Bowel Syndrome (Diarrhea, Alternating as well as Constipation Predominant), Chronic Constipation, Reflux/Heartburn, Stomach Ulcers (healing and prevention), Duodenal Ulcers, Community Acquired Pneumonia, Acute Exacerbation of Chronic Bronchitis, Staph Vaccine in patients undergoing knee or hip replacement, Ulcerative Colitis, Crohn's Disease, Anemia, Anal Fissure and Hemorrhoids.

Dr. Jayanty has a full time dedicated and proficiently trained research staff with a combined experience in coordinating and conducting clinical trials of over 11 years.

The treatments do not require patient insurance to participate and are not charged to the patient. If you would like to be contacted and/or given more information in reference to participating in one of our trials, please complete the section below:

DO YOU GIVE CONSENT FOR YOUR CHART TO BE REVIEWED PERIODICALLY BY DR. JAYANTY'S RESEARCH STAFF FOR POSSIBLE INCLUSION INTO A CLINICAL RESEARCH TRIAL?

YES _____ NO _____

WOULD YOU LIKE TO BE CONTACTED VIA E-MAIL OF DR. JAYANTY'S STUDIES? PLEASE LIST E-MAIL ADDRESS: _____

ADDITIONAL INFORMATION YOU FEEL WILL BE HELPFUL IN DR. JAYANTY'S TREATMENT: _____

_____

_____

PATIENT'S SIGNATURE: _____ DATE: _____

Patient Name: _____ DOB: _____

10837 Katy Freeway Suite 175, Houston Texas, 77079 Tel: 713-932-6446 Fax: 713-932-6466

Email: Houston_endoscopy@yahoo.com