PATIENT INFORMATION (please print)

DOB: _____ SSN: _____ Marital Status: M S W D Sep

Name: _____ Sex: _____
Last Name First Name Middle Initial

Address: _____
Street Name City State Zip Code

Home Telephone: _____ Cellular phone: _____

Patient's Employer: _____
Business Address: _____
Business Telephone: _____

Guarantor's Employer: _____
Business Address: _____
Business Telephone: _____

In case of an emergency, please contact:
Name: _____ Relationship: _____
Last Name First Name Middle Initial

Address: _____
Street Name City State Zip Code

Home Telephone: _____ Alternate Phone: _____

_____ Pharmacy Name _____
Referring Physician / Family Doctor Phone Number

Pharmacy Phone # _____

Health Insurance Information

_____
Name of Insurance Company Telephone Number

Policyholder: _____ Guarantor's DOB: _____
ID Number: _____ Group Number: _____
Guarantor's SSN: _____ Relationship: _____

Secondary Insurance Information

_____
Name of Insurance Company Telephone Number

Policyholder: _____ Guarantor's DOB: _____
ID Number: _____ Group Number: _____
Guarantor's SSN: _____ Relationship: _____

INSURANCE AUTHORIZATION AND MEDICAL RELEASE FORM

I hereby authorize Mahsa Mossadegh, M.D., F.A.C.S. to furnish or obtain medical records concerning my illness and treatment to insurance carriers or medical facilities.

I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for all charges regardless of insurance coverage.

Co-payment is to be paid at the time of my office visit as well as any deductibles.

_____ _____
SIGNATURE DATE

MEDICAL HISTORY

DATE:_____/_____/_____

NAME: _____AGE: _____HAND DOMINANCE: R L

RACE _____ETHNICITY _____PREFERRED LANGUAGE_____

REASON YOU ARE HERE: _____

HISTORY OF PRESENT ILLNESS (FOR YOUR DOCTOR TO COMPLETE):

_____

_____

_____

_____

_____

_____

(To be fully completed by the patient, if a section does not apply, please use N/A; **do not leave any blanks.**)

PAST MEDICAL HISTORY:

ALLERGIES: _____

MEDICATION (including any herbal medications) _____

_____

OPERATIONS: _____

_____

SOCIAL HISTORY:

ALCOHOL USE AND AMOUNT: _____

TOBACCO USE: Every day smoker Occasional Smoker Former Smoker Never Smoked

OCCUPATION: _____

RELIGIOUS PREFERENCE: _____

MARITAL STATUS: M S D W NUMBER OF CHILDREN _____

FAMILY HISTORY:

HIGH BLOOD PRESSURE HEART ATTACKS STROKES CANCER

ALCOHOLISM MENTAL ILLNESS DIABETES

OTHER: _____

HEIGHT: _____ WEIGHT: _____ LAST MENSTRUAL PERIOD: _____

NAME: _____

REVIEW OF SYSTEMS

PLEASE BRIEFLY DESCRIBE "YES" AREAS ONLY. IF ANSWER IS "NO" WRITE N/A.

Past History Of, Or Major Problems With:

SKIN _____

HEAD _____

EYES, EARS, NOSE _____

THROAT _____

HEART (CHEST PAIN, HEART ATTACKS, HIGH BLOOD PRESSURE, ABNORMAL BEATS, VALVE PROBLEMS, HEART FAILURE, ETC.)

_____

_____

_____

BLOOD VESSELS _____

LUNGS (ASTHMA, EMPHYSEMA, COUGH, SHORTNESS OF BREATH, PNEUMONIA, BRONCHITIS, ETC.)

_____

_____

_____

ABDOMEN (STOMACH, GALLBLADDER, INTESTINES, COLON, ETC.)

_____

_____

KIDNEYS/ BLADDER _____

MUSCLES/ JOINTS _____

BLOOD (CLOTTING, LEUKEMIA, ANEMIA, ETC.)

_____

ENDOCRINE (THYROID GLAND, DIABETES, PARATHYROID GLANDS, ETC.)

_____

NEUROLOGIC (STROKES, SEIZURES, NERVE DAMAGE, ETC.)

_____

SPINE _____

PSYCHIATRIC _____

INFECTIONS _____

INJURIES _____

OTHER _____

_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Physician:** X Mahsa Mossadegh, M.D.

Date Completed: _____ **Date of Birth:** _____

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins. **If a column does not apply, please leave it blank.**

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: COLORECTAL CANCER			*Brother*	*36 yrs*	*Aunt* *Cousin*	*44 yrs* *58 yrs*	*Grandpa*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

COLON AND UTERINE CANCER							
Uterine (endometrial):cancer							
Colorectal cancer							
Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer							
10 or more cumulative colon polyps							
MELANOMA							
Melanoma							
Pancreatic cancer							
OTHER CANCER(S) (please write in)							
_____							

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

_____

FOR OFFICE USE ONLY	
☐ Patient appropriate for further risk assessment and/or genetic testing ☐ BRAC*Analysis®* - *A test for Hereditary Breast and Ovarian Cancer Syndrome* ☐ COLARIS® - A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Ca.) ☐ COLARIS *AP®* - A test for Adenomatous Polyposis Syndromes ☐ MELARIS® - A test for Hereditary Melanoma	☐ Discussed hereditary cancer risk with patient ☐ Patient offered genetic testing ☐ ACCEPTED ☐ DECLINED ☐ Follow up appointment scheduled Date: _____

MAHSA MOSSADEGH, M.D., F.A.C.S.

PATIENT QUESTIONNAIRE

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

   NAME RELATIONSHIP DATE OF BIRTH

   _____

   _____

2. Please list the family members or significant others whom we may inform about your medical condition **only in an emergency**:

   NAME RELATIONSHIP PHONE

   _____

   _____

3. Please print the address of where you would like your billing statements/ correspondence from our office to be sent other than your home **(IF YOU PREFER YOUR HOME ADDRESS, PLEASE LEAVE BLANK)**:

   _____

   _____

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

   YES _____ NO _____

5. Please print the **PREFERRED** telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care: _____. If this is a cell phone, please check the following:

   ☐ *I am fully aware that a cell phone is not a secure/private line.*

6. Can confidential messages (i.e., appointment reminder) be left on your home answering machine or voice mail? ☐ Yes ☐ No ☐ N/A

7. I am fully aware that my health information can be transmitted by electronic transmission, by fax transmittal, by internet, or email. ☐ Yes

PRINTED PATIENT NAME_____ (**OR** GUARDIAN IF UNDER 18)

PATIENT/GUARDIAN SIGNATURE AND DATE_____

MAHSA MOSSADEGH, M.D., F.A.C.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____ Date of Birth _____

SECTION B: TO THE PATIENT: Please read the following statements carefully:

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment and health care operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your health information, and of other important matters about your health information. A copy of our notice is available upon request. It is also posted in our office.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revision, at any time by contacting:

Mahsa Mossadegh, M.D., F.A.C.S.
9200 Pinecroft, Suite 220
The Woodlands, TX 77380
Phone (281)296-7377 Fax (281)296-7255

I hereby authorize Mahsa Mossadegh, M.D., F.A.C.S. to furnish or obtain medical records concerning my illness and treatment to insurance carriers or medical facilities.

SIGNATURE: _____ DATE _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:
PERSONAL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO PATIENT: _____

(***RIGHT TO REVOKE:*** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.)

MAHSA MOSSADEGH, M.D., F.A.C.S.

Thank you for choosing me as your health care provider. My staff and I are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of the financial policy. It is **required** that you read and sign it prior to any treatment. All patients must complete the information and insurance form before seeing the doctor.

- **FULL PAYMENT FOR PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE**
- **WE ACCEPT Cash, Checks, Visa, MasterCard or Discover**

Regarding Insurance

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor. Any balances that are your responsibility (e.g., deductibles, coinsurance) are also due within 45 days. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not be considered reasonable and necessary under the Medicare program and/ or other medical insurance, see attached ABN. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

If you do not have insurance, you will be responsible up front for office visits and/or surgery using a pre-set fee schedule.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area per our contracted rates with your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients

Adult patients are responsible for full payment at time of service.

Minor patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Surgery

Deductible, co-insurance and co-payments are due two days prior to surgery date, unless other arrangements have been made.

I have read the above and agree to the stated terms.

Printed Name_____

Signature: _____ **Date:** _____