REGISTRATION
(PLEASE PRINT)

IMTIAZ ALAM, M.D.
2200 Park Bend Drive
Bldg. #1, Ste. 300, Box 5
Austin, TX 78758

Telephone: (512) 719-4370

Date _____ Home Phone (____)_____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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IMTIAZ ALAM, M.D., P.A.

Board Certified in Gastroenterology and Hepatology
Clinical Assistant Professor of Medicine, UT Southwestern

Office Policies & Procedures

Please... read, initial, and sign on the back

(Initial)____ Financial Responsibility: I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including: co-payments, co-insurance, and deductibles. Claims will be filed for PPO, HMO, and Medicare participants. Payment will be made directly to Dr. Imtaiz Alam.

(Initial)____ Insurance Coverage: I understand that I am responsible for providing the office with any and all insurance coverage at each and every visit. I will be responsible for any balances due as a result of not disclosing this information.

(Initial)____ Laboratory Fees: I understand that the office uses Quest Diagnostic Laboratory. The office can not guarantee my insurance will cover any lab/pathology performed at or ordered. If my insurance requires use of a different lab, I understand it is my responsibility to inform the office for proper handling.

(Initial) I DO____ **I DO NOT**____ Consent to necessary examinations and/or treatments performed and prescribed by my provider of care as is necessary in his/her judgment, with my approval. **Separate consent forms will be signed for procedures.**

(Initial)____ Release of Information: I do hereby authorize the office to release information to Referring Provider, North Austin Medical Center, St.David's, Seton Facilities in the event of a scheduled surgery, procedure, or emergency care. I authorize the release of any medical records or other information necessary to process my insurance claims.

(Initial)____ HIPPA and Office Procedure Policy: I acknowledge that I have received a copy of the office Notice of Privacy Practices and Office Policy.

(Initial)____ FEE for Forms Completion: I understand that I will be responsible for paying $25 for forms completion by the physician or staff. Please allow up to two weeks for completion of paperwork. (Example: Disability, FMLA, etc.)

(Initial)____ FEE for NO SHOW: I understand that a $25 'NO SHOW' fee will be accessed for appointments that I do not keep.

Please turn the page over to finish completing.....

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(Initial)_____Prior Authorizations on procedures: our office provides the courtesy of calling your insurance carrier for authorizations, however even when we have taken the proper steps your insurance may choose not to pay for those services rendered and the patient is liable. It is imperative you call your insurance to verify what your benefits are as well.

(Intial)_____APPOINTMENTS/ MEDICAL ASST. PHONE CALLS: PLEASE allow the staff 24 to 72 hours to return your phone calls. If you call more than once we will go according to your last message. IF YOU ARE HAVING A MEDICAL EMEREGENCY PLEASE CALL 911 OR GO TO YOUR NEAREST ER.

(Initial)_____THE PHYSICIAN LINE IS FOR PHYSICAINS ONLY!
If you call on the Physicians line you will be redirected or asked to hang up and press the appropriate line/extension

(Initial)_____IT IS THE PATIENTS RESPONSIBILITY TO INFORM OUR OFFICE OF ANY CHANGES CONCERNING YOUR DEMOGRAPHICS AND NEW INSURANCE INFORMATION. Failure to do so in a timely manner will be documented, if your new insurance refuses to make payment because we did not get the proper information in a timely manner, Patient will be responsible for charges incurred.

(Initial)_____REFERRALS: Our office does not generate referrals. It is the patient's responsibility to contact primary care physician and insurance carrier CONCERNING all the referrals needs. If we are aware you need a referral and you have not generated one with your PCP we will reschedule your appointment.

(Initial)_____LAB RESULTS: Our office will NOT call you with your lab results unless it's critical values or abnormal test results. At that time the Medical Assistant will contact you and schedule an appointment to speak further with Dr.Alam.

If you want results and interpretation of your labs PLEASE call the office, as Dr.Alam recommendations are to make a follow up appointment.
OTHER STAFF MEMBERS CANNOT AND WILL NOT GIVE YOU LAB RESULTS

Please turn the page over to finish completing

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Patient Polices and Procedures cont'd

(Initial) _____If I am having a medical emergency I will call 911 or go to my nearest ER

(Initial)_____ Our Office hours Monday-Thursday 8:30am -5:00pm and Friday 8:30am-3pm (Lunch hours 12:30pm-1:30pm) Phone hours Monday – Friday 8:30am-3pm

(Initial)_____INSURANCE CARD(S): YOUR INSURANCE CARD(S) MUST BE PRESENT AT OFFICE VISIT ALONG WITH A PICTURE ID. If you do not have them with you, your appointment will be rescheduled NO EXCEPTIONS

(Initial)_____The lab tech DOES NOT give me my lab results.

(Initial)_____ All prescription refills MUST be called into your pharmacy
PLEASE DO NOT CALL THE OFFICE UNLESS THERE IS A CHANGE IN YOUR PRESCRIPTION

(Initial)_____WE WILL NOT REFILL ANY NARCOTICS / CONTROL SUBSTANCES EARLY (NO EXCEPTIONS!)As of January 1st 2010, Dr.Alam will no longer prescribe Narcotic Medications, with the exceptions of patients who are currently on Hepatitis C therapy. If you need to be seen for chronic pain, a written referral will be sent to a Pain Management Specialist. Routine medications must be requested through your Primary Care Physician.

(Initial)_____MEDICAL RECORDS: all medical records request require 15 days to process
To pick up your medical records there will be a $25.00 fee.
You can sign a release of medical records to physician and we will be happy to fax it free of *charge*.

(Initial)_____Prior Authorizations on medications: It is the patient's responsibility to know what their medication benefits are, if you are unsure please contact your insurance carrier. Our office does give you a courtesy of contacting your insurance, this process may take up to 72 hours to begin the process and up to two weeks to obtain the approval or denial from your Insurance carrier. In most cases prior authorizations will take up to 30 days to approve or deny.
If you have any questions you will need to contact your insurance carrier.

Please turn page over to finish completing

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I, _____, understand if I call for LAB, RADIOLOGY, or PATHOLOGY report(s) the medical assistant may read the result but only the PROVIDER an interpret the finding(s), therefore a follow-up appointment is necessary.

****Please Note****

The lab located in our office, **Quest** is **Not** affiliated with Dr. Imtaiz Alam. It is your responsibility to check with your insurance carrier before having labs drawn. If you have any questions regarding lab billing issues please call 1-800-824-6152.

The Lab Tech can not give lab results.

There is a new office policy. Dr. Alam will no longer prescribe Narcotic Medications, with the exception of patients who currently are on therapy. If you need to be seen for chronic pain, a referral will be issued for you to see a Pain Management Specialist. Routine medications must be requested from your General Practitioner.

An apology is extended for inconvenience that you may experience.

Thank you for understanding and cooperation in this matter.

I authorize Dr. Imtiaz Alam and/or staff permission to fax and/or provide my medical information to the following:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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(Initial)_____I understand DR.ALAM DOES NOT MAKE PHONE APPOINTMENTS

Initial_____ cell phones: We ask you give us the courtesy and respect of turning your cell phones off when being directed from waiting room by the Medical assistant.

If you wish to use your cell phone, care cannot be provided to you, we will ask you to wait in the waiting room until you are finished with your phone call which will delay your office visit.

We reserve the right to refuse service as decided by this practice

(Initial)_____ This office reserves the right to terminate a patient immediately if:

- **verbally abusive to staff members , Doctor's and other patients**
- **Refuse to pay my co-pay/ balances owed at the time of visit**
- **physically abusive to staff members, Doctor's and other patients**
- **non complaint with medication directions**
- **refusal to complete and sign the required paperwork**

I have read and fully understand the office policies listed above, including financial arrangements and responsibility, custom fees for professional services provided. Prescription refill guidelines. Substance abuse issues, medical records processing fees, late cancellation and missed appointment fees, HIPPA privacy guidelines and general practice protocol.

Patients Signature:_____ Date: _____

Please do not hesitate to ask for a copy of these office policies, as the original your signed stays in your file.

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

Ph: _____ Phone_____

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates.

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____