

Please Bring Insurance, Driver's License, and co-pay. We do accept debit/credit, but the CREDIT CARD company will add a 3.95% charge.

Check and Cash is accepted.

Name: _____ Age: _____ Date of Birth: _____

Sex (circle) M F Marital Status (circle): Single Married Widow Divorced Separated

Social Security No: _____ Referring
Doctor: _____

Email _____ Phone: _____ Alternate
phone: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Occupation: _____ Employer: _____

Pharmacy: Local _____ City _____ St _____

Mail Order: _____

Emergency Contact: _____ Relationship: _____ Phone
#: _____

Primary Insurance Company _____ Policy #:

Subscribers Name: _____ Date of Birth:

Relationship to Patient:
_____ Employer: _____

Secondary Insurance Company _____ Policy #:

Subscribers Name: _____ Date of Birth:

Relationship to Patient:
_____ Employer: _____

I hereby authorize the treating physician to furnish the above insurance company(s) all information which said insurance

company(s) may request. I hereby assign to above named physician all money in which I am entitled for medical and / or surgical expense relative to medical services rendered but not to exceed my indebtedness to above named physician. I understand that I am financially responsible to treating physician for all medical services rendered and for charges not covered by this assignment.

I understand that any co-payments required by my insurance is my responsibility and is due at the time of my office visit.

I agree to notify the office of any changes of address, telephone number, or insurance carrier promptly. If I fail to do so, I will be responsible for the charges.

This gives Dr. Eloubeidi the authorization to file and receive any direct payment from my insurance company for all medical care provided to me either at his office or as an outpatient or inpatient at the hospital.

In the event of non-payment for medical charges rendered, I agree to pay all costs of collection, including a reasonable attorney's fee, court cost, and I further agree to pay the legal rate of interest on the account until paid in full. I waive, to the extent allowed by the law, all personal property rights of exception under the constitution and laws of the State of Alabama, or any other state, in connection with or related to the collection of any indebtedness incurred by me in the connection with medical services rendered.

Signature: _____ Date: _____

NO Show appointments will be charged to your account if we do not get a 72 hour notice of a cancellation or reschedule. \$25 for office visit no show, \$200 for procedure (hospital no show)

Eloubeidi Gastroenterology & Associates
Mohamad Eloubeidi, MD
912 Snow St
Oxford, AL 36203

HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective As the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITY'S IN THE FUTURE.

Please Print your Name

Please Sign your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
____ First name only ___ Proper Sir Name ___ Other _____

Please list any other parties who can have access to your health information:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm my appointments, treatment & billing information via:

Cell phone Confirmation text message to my Cell phone
 Home Phone confirmation Email Confirmation
 Work Phone confirmation Any of the Above

I authorize information about my health be conveyed via:

Cell phone Confirmation text message to my Cell phone
 Home Phone confirmation Email Confirmation
 Work Phone confirmation Any of the Above

I approve being contacted about special services, events, fund raising efforts or New Health info on behalf of this facility via:

Cell phone Confirmation text message to my Cell phone
 Home Phone confirmation Email Confirmation
 Work Phone confirmation Any of the Above

In signing this HIPAA patient acknowledgement form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus rule, provide you this information with your knowledge and consent.

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- Other (please Describe) _____

Signature of privacy Officer

**Dr. Mohamad Eloubeidi Eloubeidi Gastroenterology & Associates
912 Snow St Oxford, AL 36203**

Personal History New Patient

Today's Date:

Name: _____ Age: _____ Date of Birth: _____

Referred By: _____ Primary Care Physician: _____

Describe the reason for your visit: _____

Medications: Please list all your current prescription and non-prescription medications, vitamins and supplements. If you have a list you may bring the list with you at your visit.

€ None

Do you take any blood thinners? No Aspirin, Coumadin, Xarelto, Plavix, Effient, Brilinta, Pradaxa?

If you need more room you may bring a complete list of medications or write on back. Thanks

Name of Medication	Strength	When to take/how often

Allergies: None Penicillin Sulfa Aspirin Iodine Latex Others: _____

Past Medical History: Please circle all that apply

- | | | | | |
|------------------------|---------------------|--------------------------|-----------------------|-----------------------|
| Acid Reflux | Cirrhosis of liver | Groin hernia | Kidney stones | Psoriasis |
| Anal Fissure | Colon Cancer | Heart Attack | Lupus/Scleroderma | Radiation Therapy |
| Anemia | Colon Polyps | Heart Failure | Migraines | Rheumatic Fever |
| Arthritis | Crohn's Disease | Heart Murmur | Milk Intolerance | Sciatica |
| Artificial Heart Valve | Depression | Hepatitis | Mitral Valve Prolapse | Seizures |
| Asthma | Diabetes | Hiatal Hernia | Multiple sclerosis | Sleep apnea |
| Bleeding Disorder | Diarrhea | High Blood Pressure | Osteoporosis | Stroke or Paralysis |
| Blood Clots | Diverticulitis | High Cholesterol | Ovarian Cyst | Tuberculosis(TB) |
| Blood Transfusion | Duodenal Ulcer | HIV or Aids | Pacemaker | TB skin test positive |
| Cancer | Emphysema | Irregular Heart beat | Pancreatitis | Thyroid disease |
| Chest pain/ angina | Fatty Liver | Irritable Bowel Syndrome | Parkinson's disease | Ulcers |
| Chronic Anxiety | Glaucoma | Kidney Disease/failure | | Ulcerative colitis |
| Chronic lung disease | Atrial Fibrillation | Scoliosis | | |

Surgeries or Procedures

- | | | | | |
|------------------|-----------------|--------------------|---------------|-----------------|
| None | Colostomy | Groin Hernia | Hiatal Hernia | Obesity surgery |
| Appendectomy | C-Section | Heart bypass | Hysterectomy | Ovary |
| Breast | EGO | Heart Stent | Joint | Prostate |
| Colon Surgery | ERCP | Heart Valve | Kidney | Sigmoidoscopy |
| Colonoscopy | Gallbladder | Hemorrhoid surgery | Liver biopsy | Stomach |
| Thyroid | Tonsillectomy | Tubal ligation | Uterus | Other |
| Knee Replacement | Hip replacement | | | |

Previous Hospitalizations

Reason	Date

Mohamad Eloubeidi, M.D. Eloubeidi Gastroenterology & Associates

Name: _____ **DOB:** _____

Family History

	Father	Mother	Grandparents	Siblings	Children
Healthy					
Deceased					
Colon Polyps					
Colon Cancer					
Ulcer Disease					
Liver Disease					
Pancreas Disease					
Crohn's Disease					
Ulcerative colitis					
Stomach Cancer					
Diabetes Mellitus					
Heart Attack					
Breast Cancer					
Other Cancer					

