THOMAS E. DUCKER, M.D. – GASTROENTEROLOGY
1001 Water St., Ste. D-200, Kerrville, TX 78028
Phone: (830) 896-5005 Fax: (830) 896-4747
Email: ducker.office@gmail.com Website: www.mssk-docs.com

PATIENT NAME: _____ **DATE of BIRTH:** _____

Please complete ALL questions. If none or does not apply, write NONE or N/A.

REASON FOR VISIT: _____

Allergy/sensitivity and reaction (medicine, foods, insects, contrast media, latex, etc.):

Allergy	*Reaction*

Please list **ALL** medications you are currently taking including vitamins, over the counter medications and herbal medications and anything taken only as needed **OR** provide list with all information.

Medication / Supplement Name	*DOSE: Strength (mg, mcg, mL, etc.)*	*SIG: # Pills, #Times per Day*

Please indicate any of the following medical conditions that HAVE EVER applied to you:

A-fib	COPD / Emphysema	Hyper / Hypo - Thyroid
Aids	Depression / Anxiety	Kidney Stones
Anemia	Diabetes / Gout	Lupus
Arthritis	Fibromyalgia	Mental Illness
Asthma	Heart Attack / Stroke	Migraines
Bleeding Disorder	Hypertension	Seizures / Epilepsy
CHF	High Cholesterol	Venereal Disease

GI Symptoms:
Colitis / Crohn's Disease
Irritable Bowel Syndrome
Heartburn / Reflux / GERD
Ulcer (Type: _____)
Cirrhosis
Hepatitis (Type: _____)

Have you ever been diagnosed with the following?
Colon or rectal POLYPS: □ NO □ YES (□ Before age 50 □ Age 50 or older)
Colon or rectal CANCER: □ NO □ YES (□ Before age 50 □ Age 50 or older)

Other cancers or diseases: _____

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Surgery	*Date of Surgery*	*Surgery*	*Date of Surgery*
Appendectomy		Gallbladder Removal	
Breast		Hernia Repair	
Tonsillectomy		Colon Surgery	
Hysterectomy		Prostatectomy	
Other:		Other:	
Other:		Other:	

_____I have had an EGD (upper scope) Date: _____ Doctor: _____
_____I have had a flexible sigmoidoscopy Date: _____ Doctor: _____
_____I have had a colonoscopy Date: _____ Doctor: _____
_____I have NEVER had an EGD, flexible sigmoidoscopy or colonoscopy

Alcohol use: □ Daily □ Some Days □ Former □ Never in my life
Caffeine use: □ Daily □ Some Days □ Former □ Never in my life
Tobacco use: □ Daily □ Some Days □ Former □ Never in my life
Years: _____ # PPD: _____ Have you ever used smokeless tobacco? **Y / N** E-cigarettes? **Y/ N**
Recreational drugs use (Type: _____): □ Daily □ Some Days □ Former □ Never in my life

Are there any diseases that run in your family? If grandparent, specify **maternal** or **paternal**).

Diabetes: father mother brother sister son daughter other_____
Heart disease: father mother brother sister son daughter other_____
High Blood Pressure: father mother brother sister son daughter other_____
High cholesterol: father mother brother sister son daughter other_____
Cirrhosis of Liver: father mother brother sister son daughter other_____
Colitis or Crohn's: father mother brother sister son daughter other_____
Colon Cancer: father mother brother sister son daughter other_____
Colon Polyps: father mother brother sister son daughter other_____
_____: father mother brother sister son daughter other_____
_____: father mother brother sister son daughter other_____

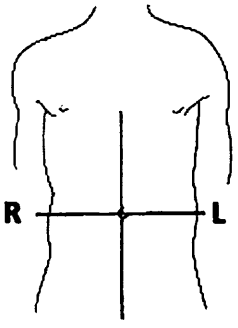
□Adopted □No significant family history □Family history unknown

Do you have a **first-degree relative** (mother, father, brother, sister or child) with any of the following conditions diagnosed before age 50?:
Colon or rectal cancer : □ NO □ YES (Specify :_____)
Cancer of the uterus, ovary, stomach, small intestine, urinary tract (kidney, ureter, bladder), bile ducts, pancreas, or brain?: □ NO □ YES (Specify:_____)
Do you have 3 or more relatives (parents, siblings, children, grandparents, aunts, uncles or cousins) with a history of colon or rectal cancer? □ NO □ YES (Specify :_____)

What was your highest level of education? _____
Do you live alone? _____ If not, with whom do you live? _____

PATIENT NAME: _____ **DATE of BIRTH:** _____

Please indicate any **CURRENT** symptoms you are having. Mark location of GI-related pain / discomfort on model:



ENT/MOUTH: Mouth sores Hoarseness Poor Hearing Trouble swallowing Painful swallowing Food/pills sticking on occasion Jaw pain/popping with chewing

GASTROENTESTINAL: Bloating Nausea Diarrhea Vomiting Constipation Vomiting of blood or "coffee ground" material Recent change in bowel habits Blood in stool Diarrhea alternating with constipation Abdominal pain Rectal Pain Dark or tarry stools White stools Blood noted on toilet paper when wiping Hemorrhoid problem Trouble holding stool Change in caliber of stool Heartburn

CONSTITUTIONAL: Fever Chills Chronic fatigued I don't sleep well at night

HEMATOLOGICAL/LYMPHATIC: Easy bruising Easy bleeding Any unusual lumps or bumps noted

ALLERGY/IMMUNOLOGY: Allergy to foods Allergy to molds Allergy to pollen Allergy to Insects

ENDOCRINE: Frequent urination Abnormal thirst Poor tolerance to heat / cold Weight loss / gain

EYES: Recent vision change Double vision

CARDIOVASCULAR: Chest pain Chest tightness Abnormal/skipping heartbeats (Palpitations) Swelling legs Swelling hands Pain in legs soon after exercising Chest heaviness

RESPIRATORY: Shortness of breath at rest Short of breath with exercise Short of breath when lying flat Awaken at night gasping for breath Cough up blood Sore throat Dry cough Wet cough Nasal congestion I have been told I snore excessively

GENITOURINARY: Discomfort or pain with urination Blood in urine Dark urine Trouble holding urine Genital discharge Genital lumps or sores Difficulty starting urine stream

MUSCULOSKELETAL: Neck pain Back pain Joint pain Joint stiffness Joint swelling

NEUROLOGICAL: Weakness of one arm/hand or leg Trouble talking Drooling problem Dizziness Seizures Weakness of one side of your face

SKIN: New skin rash Skin cancer Psoriasis

PSYCHOLOGICAL: Anxiety Depression Thoughts of hurting yourself Thoughts of hurting others I need help coping with my stress Trouble staying asleep at night Falling asleep anywhere/anytime

I certify that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Today's Date: _____

Dr. Thomas E. Ducker, M.D. - Gastroenterology

1001 Water St., Suite D-200, Kerrville, TX 78028

Phone: (830) 896-5005 Fax: (830) 896-4747

Email: ducker.office@gmail.com Website: www.mssk-docs.com

PATIENT INFORMATION: Please print. Fill in ALL blanks (or circle where applicable).

Patient Name: _____ **Date of Birth:** _____

Patient *Mailing* Address: _____

City: _____ **State:** _____ **Zip:** _____

Mobile Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Email Address: _____ **Preferred:** cell/home/work/email/mail/portal

Legal Sex: Male / Female **Marital Status:** M / S / D / W / Other **Race & Ethnicity:** _____

Driver's License / ID # and Expiration Date: _____ **SSN:** _____

Employer/Retired: _____

PHARMACY: _____ **Consent to:** □Text □Email □Leave detailed voicemail

Primary Dr.: _____ **Referring Dr.:** _____

EMERGENCY CONTACT / NEXT OF KIN:

Name: _____ Phone: _____ Relationship: _____

PERSON(S) AUTHORIZED TO RECEIVE MEDICAL ANDOR BILLING INFORMATION (Do NOT list your doctor):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

GUARANTOR (INDIVIDUAL WHO RECEIVES BILLING STATEMENTS):

Name: _____ Phone: _____ Relationship: _____

Mailing Address: _____

Insurance Information *(MUST BE COMPLETED IN ADDITION TO PROVIDING COPIES):*

PRIMARY Insurance:	**SECONDARY** Insurance:
_____	_____
Policy Holder Name (*as written on card*):	Policy Holder Name (*as written on card*):
_____	_____
Policy Number/Member ID: _____	Policy Number/Member ID: _____
Group ID (If Any): _____	Group ID (If Any): _____
Start Date: _____ End Date: _____	Start Date: _____ End Date: _____
Address on Back of Card: _____	Address on Back of Card: _____
_____	_____

I certify that the information provided is true and accurate to the best of my ability.

Signature: _____ Today's Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice where it can be easily accessed. You may request a paper copy of this notice or any revised notice at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the business/billing manager.

Disclosures That May Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Public Health, Abuse or Neglect and Health Oversight - We may disclose your medical information to public health activities. Public Health activities are mandated by federal, state or local government for the collection of information about disease, viral statistics (like births and deaths) or injury by a public health authority.

Because Texas Law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect.

Legal Proceedings and Law Enforcement - We may disclose your medical information in the course of judicial or administrative proceeding in response to an order of the court (or the administrative decision-maker) or other appropriate legal process.

Worker's Compensation - We may disclose your medical information as required by workers compensation by law.

Inmates - If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official.

Military, National Security and Intelligence Activities, Protection of the President - We may disclose your medical information for specialized governmental functions such as separation or discharge from military service.

Research, Organ Donation, Coroners, Medical Examiners and Funeral Directors - When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organs.

Required by Law - We may release your medical information when the disclosure is required by law.

Your Rights Under Federal Law

The US Department of Health and Human Services created regulation intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions - You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

Receiving Confidential Communications by Alternative Means- You may request that we send communication of protected health information by alternative means or to an alternative location. This request must be made in writing to the business/billing manager.

Inspection and Copies of Protected Health Information - You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing. Please send your request to the business/billing manager. We charge a reasonable fee of $25 to release medical information directly to the patient. We do not charge a fee to send medical records to other physicians involved in your health care.

Accounting and Certain Disclosures - HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are for purposes other than treatment, payment, health care operations or made via an authorization signed by you or your representative. Please submit any request for an accounting to the business/billing manager. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders / NO-CANCELLATION FEE, Treatment Alternatives and Other Benefits

We may contact you by telephone, email, mail or patient portal to provide appointment reminders, information about treatment alternatives, lab results or other health-related benefits and services that may be of interest to you. Patients are responsible for their own health-care and the office will not be held accountable for failing to remind patients of their appointments. Patients are held primarily responsible for their healthcare and will be charged a $25 NO-CANCELLATION FEE if they fail to attend an appointment without first cancelling or rescheduling. Patients may cancel or reschedule at any time before the start time of their appointment without incurring a fee but we do ask that to be notified as soon as possible so that another patient may be treated in their stead.

Medication Information

To better serve our patients, we request permission to access prescription history from their pharmacy.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the business/billing manager. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. The contact information for the USDHHS: US Dept. of Health and Human Services - HIPAA Complaint 7500 Security Blvd., C5-24-04, Baltimore, MD 21244. The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplain.pdf. You may not be penalized in any way for filing a complaint.

Our Promise to You

We are required by law and regulations to protect the privacy of your medical information, to provide you with this notice of our practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Information for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact: Business/Billing Manager 1001 Water St., Ste. D-200, Kerrville, TX 78028; Phone: (830) 896-5005, Fax: (830) 896-4747.

Patient Signature: _____ Date: _____

Financial Policy

By signing this agreement, you are confirming you have requested medical services from Dr. Thomas Ducker on behalf of yourself and/or your dependents, and understand that by making this request, you become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

It is our intent to treat our patients in a courteous and professional manner with regard to financial matters. Our goal is to obtain a desirable financial arrangement for our services. However, our office is a business which provides services to patients and sometimes provides supplies that we purchase from other vendors. Our physician is here to provide medical advice, services and treatment to his patients, not to discuss financial arrangements. All financial arrangements are made through the business office.

Our policy requires payment at the time services are rendered. If you do not have insurance to help you with your medical costs or have deductibles and/or co-insurance that your insurance holds you responsible for, we ask for payment of such liabilities prior to or directly after services are provided. If Dr. Ducker suggests a procedure or surgery, it is the patient's responsibility to discuss and meet their financial obligations with business office personnel and be aware of costs that the insurance will cover and whether there will be an out-of pocket payment due. If you are unable to pay at the initial time set forth, we are willing to discuss options that are available and come to a mutual agreement. We are not able to provide services and/or supplies to patients free of charge; however, we will be happy to recommend you to other facilities and services in the community who can assist you. We are here to discuss those options with you if you so desire.

We are contracted with several insurance companies and have made prior arrangements with many insurers and health plans to accept an assignment of benefits. It is the patient's responsibility to ensure Dr. Ducker is "in network" with their insurance policy and be aware if their insurance requires prior authorization. If we are not "in-network" or the service is "not covered" with the insurance policy or the insurance company has not provided prior authorization, the patient may be held fully responsible for the cost.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that you will pay at the time of service and your insurer may reimburse you. If you have a co-payment assigned by your insurance, you will be required to pay that at the time of service.

We will bill your health plan for all services provided by our physician. Any balance due is your responsibility and due upon receipt.

For minor patients, we look to the accompanying adult for payment.

Procedures

SmartPills and Capsule Endoscopies are done in the office and won't incur additional fees. All other procedures (colonoscopies, EGD's, flexible sigmoidoscopies, etc.) are done in collaboration with Peterson Health and therefore have separate charges from that of our office. Our office only bills for Dr. Ducker's services; other fees may come from Peterson Health, the anesthesiologist and pathologist (if biopsies are obtained). It is the patient's responsibility to work with Peterson's financial department about these other charges. We obtain a pre-certification for all procedures. This does not ensure coverage. After the procedure, the patient's insurance is billed and the remaining balance is the patient's responsibility. It is the patient's duty to be aware of their out-of-pocket cost. If the patient receives a bill they are unsure about, they should contact the company from which it was received using the phone number on the statement.

Patient Signature: _____ Date: _____