Gastro Star
Dr. Desh B Sharma, MD
Board Certified Gastroenterology & Hepatology

Patient Information

Date**:** _____

Last Name: _____, First Name _____

Address Include City, State, Zip

_____

DOB: _____ Gender: M( ) F ( )

Social Security #: _____

Telephone Numbers: Mobile # (____) _____-_____

Email Address: _____

Insurance Information:

Primary: _____

Secondary: _____

Emergency Contact

Name: _____

Relationship to patient: _____

Primary Number: (_____) _____-_____

Primary Care Information

Name & Phone #: _____

Pharmacy Information

_____

3303 Rogers Road, Suite 250 San Antonio, TX 78251
Ph # 210-405-3410; Fax # 210-405-3411

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AUTHORIZATION TO RESLEASE MEDICAL CARE INFORMATION

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary of narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

___ Progress Notes ___ Labs ___ Medication

___ Procedure ___ Communicable disease (including HIV & AIDS

__X_ All Records

Release my protected health information to the following Physician/facility/entity and/or those directly associated in my medical care:

Name: **Gastro Star**

Address:**3303 Rogers Rd Suite 250**

City, State: Zip Code: **San Antonio, TX 78251**

Phone: **210-405-3410**

Fax: **210-405-3411**

For the purpose of: CONTINUITY OF CARE

_____ _____

Patient Signature Date

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Appointment & Procedure Cancellation Policy

Office appointments are generally made for a time based on your needs, we know your time is valuable and we take this into consideration we expect the same in return. Please keep in mind when a colonoscopy or endoscopy procedure appointment is scheduled with us, we reserve a block of time especially for you. In that situation, it will include the MD, an anesthesiologist (CRNA) and multiple RN's, which all charge for time, irrespective of whether you show up or not. Also, if you do not appear for your procedure, that block of time is unavailable to someone else who is waiting for our care.

We require 2 BUSINESS DAYS to cancel or reschedule a procedure.

If you fail to give the required notice in the allotted time, you will be subject to a fee that will not be covered by your insurance.

Office Visit (24 HR NOTICE)	$25 CANCELLATION FEE
Colonoscopy/Endoscopy Appointment (48 HR NOTICE)	$100 CANCELLATION FEE

****To avoid any fee's please give our office a call before your appointment****

Please sign stating that you have read and understand our Procedure Cancellation Policy.

_____ _____

Signature of Patient/Guardian **DATE**

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FINANCIAL RESPONSIBILITY //AGREEMENT TO PAY

I accept FULL FINANCIAL responsibility from Kesar Family PLLC dba Gastro Star. Should my insurance company deny a pay for a portion of a visit, I understand that I will be required to pay for these services IN FULL.

Patient Full Name: _____

Patient's Signature: _____

Date: _____

We understand that unexpected financial problems may affect the timely payment of your balances. We encourage you to communicate any problems with us or the billing department so we can assist you in the management of your account.

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