Digestive and Liver Disease
Center of San Antonio

Setting the standard of quality, personalized care.

Robert M. Narváez, MD, MBA

Patient Questionnaire

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

II. Please print the address of where you would like your billing statements and /or correspondence from ou office to be sent if other than your home:

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

YES_____ NO_____
If marked "YES" there will be a $5.00 administrative fee to cover stamps, certified mail fee, courier, etc.)

IV. Please print the telephone number, if any, where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than you home phone number:

( ) _____--_____

V. Can confidential messages (i.e. appointment reminders) be left on the following:
- home answering machine YES _____ NO _____
- Voicemail YES _____ NO _____
- E-mail address _____ @ _____.com YES _____ NO _____

VI. If you don't have voicemail, can a confidential message be left at your place of employment?

YES _____NO _____

Assignment of Insurance Benefits

I, hereby authorize direct payment of surgical/medical benefits to Dr. Robert M. Narváez M.D., M.B.A. for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I, hereby authorize Dr. Robert M. Narváez M.D., M.B.A. to release any medical or incidental information that may be necessary for either care or in processing application for financial benefits. If you DO NOT want any information concerning your medical condition to be transmitted by fax, please initial here _____. Otherwise, we will assume it is acceptable to use fax communications in the discretion of your doctor and his staff.

Medicare – Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payments for authorized benefits are made on my behalf. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.

Office Policy

We require that you provide current patient demographic information in order to complete billing requirements on your behalf. Such information includes a valid Driver's License, Medical Insurance Card, and Social Security Number.

It is policy of this office to occasionally use digital and or cordless telephones, therefore to expedite your health care and in the interest of convenience, your physician my use digital and or cordless telephones to discuss your condition with other physicians. Although there is the possibility unauthorized persons may intercept or overhear such conversations, this is not routinely anticipated. By seeking care at this office, you are considered to have accepted this policy.

There will be a charge for appointments, which are not cancelled within a 24- hour time period, prior to your scheduled appointment; $50.00 for an office visit and $75.00 for procedures.

Please Print Patient Name: _____

Patient/Guardian Signature: _____

Date: _____