Tayeb Gastro & Associates

Ghiath Tayeb MD Reem Jarbou DO Seina Farshadsefat DO

Office Policy and Procedures

Please have all paperwork completed before coming to your appointment.

You must bring picture identification, insurance card and current medication list.

Office Hours: Monday-Thursday 8:00am -5:00pm Friday 8:00am – 3:00pm

Appointments

So that we can accommodate all requests for appointments, we require a 48 hour cancellation notice (2 business days). There will be a **$50 fee for missed office appointments and a $100 cancelation fee for all procedures types** or appointments not cancelled in the appropriate amount of time. We provide a remind call and text message to confirm your appointment two days prior. Due to limited space, please have only one person accompany you to your appointment. We discourage you from bringing children. Although we try to schedule appointments accordingly, there may be times when we run behind or have to change your appointment time.

Telephone

Our phones are answered during office hours. If you have an emergency after hours, you should go to the nearest emergency room. The office staff handles all calls during office hours. The Dr. and Assistants do not take calls while seeing patients. A message will be given to them or they or someone from the staff will call you back at times after they have finished with patients. Messages may take 24-48 hours to return.

As a courtesy to the medical staff, cell phones should be turned off prior to entering the exam room.

Prescription and Refills

Please make sure we have your current medication list and current pharmacy at every visit. Medication requests will only be handled during office hours. We request that you give us 48 hour notice for prescription refills. Refills will only be given if you are currently under our care (having been seen within the last 12 months). Many insurance companies are requiring authorizations for some prescriptions and it could take up to 2 weeks to obtain. The authorization requests should come from your pharmacy.

Financial and Insurance

The office staff tries to verify your insurance and co-pay prior to your appointment. Your co-pay should be paid at the time of your appointment. It is the patient's responsibility to know their insurance coverage along with the deductible, co-pay. If a referral is needed, it must be in the office at the time of the appointment. If you do not know what insurance pays, whether you need a referral, or other questions regarding your insurance, it is suggested you call your insurance. The office staff can give you a basic advice in regards to some insurance, be aware many insurance companies change benefits and coverage frequently. If you receive a bill and have questions, please feel free to call the office.

_____ _____

Signature Date

Tayeb Gastro &Associates
811 E South Blvd, Ste 200
Rochester Hills, MI 48307
Phone: (248) 651-0800
Fax: (248) 651-7341

LAST NAME: _____ FIRST NAME: _____ MI _____

ADDRESS: _____

CITY: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE:_____

DATE OF BIRTH: ____/_____/_____ SSN: _____-_____-_____ GENDER: MALE FEMALE

MARITAL STATUS: S M W D EMAIL:_____@_____

EMERGENCY CONTACT NAME & NUMBER: _____

PHARMACY NAME AND NUMBER: _____

PRIMARY CARE PROVIDER: _____

PRIMARY INSURANCE _____POLICY NUMBER_____CO-PAY_____

SECONDARY INSURANCE:_____POICY NUMBER_____CO-PAY_____

I HEREBY AUTHORIZE THE DOCTOR/OFFICE STAFF TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING PERSON(S):

Patient's Personal Representative(s):_____

Relationship to Patient: _____

Patient's Signature: _____ Date: _____

THE INFORAMTION ABOVE IS TRUE AND ACCURATE I UNDERSTAND IT IS MY RESPONIBILITY TO PROVIDE THIS OFFICE WITH NECCESARY INFORMATION TO BILL MY INSURANCE COMPANY. I UNDERSTAND I AM RESPONSIBLE FOR ANY SERVICE NOT COVERED BY MY INSURANCE COMPANY, IT IS MY RESPONSIBILITY TO COMPLY WITH THE REQUIREMENTS OF MY INSURANCE CARRIER. ANY FEES NOT PAID BY MY INSURANCE COMPANY ARE MY RESPONSIBILITY.

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1998 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFROMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE, THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: _____

SIGNATURE: _____DATE: _____

PAST SURGICAL AND MEDICAL HISTORY

Medical History	YES	NO	DATE	SURGICAL HISTORY	YES	NO	DATE
Anorexia/Bulemia	YES	NO		Colon	YES	NO	
Arthritis/Joint Swelling	YES	NO		Stomach	YES	NO	
Asthma	YES	NO		Heart:	YES	NO	
				Stent/Bypass	YES	NO	
				Valve	YES	NO	
				Pacemaker	YES	NO	
				Defibrillator	YES	NO	
Bleeding Disorder	YES	NO		Joint Replacement	YES	NO	
Blood/Infectious Disease	YES	NO		Gallbladder	YES	NO	
Cancer, Type:	YES	NO		Hysterectomy	YES	NO	
Coronary Artery Disease	YES	NO		Appendix	YES	NO	
Colon Polyps	YES	NO		Prostate	YES	NO	
Crohn's Disease	YES	NO		Bladder	YES	NO	
Diabetes	YES	NO		C-Section	YES	NO	
Epilepsy/ Seizures	YES	NO		Breast	YES	NO	
Gallstones	YES	NO		Other Surgeries			
Headaches/Fainting/Dizziness	YES	NO		Other Surgeries			
Heart Problems/Chest Pain	YES	NO		Other Surgeries			
Hepatitis/ Liver Problems	YES	NO		Other Surgeries			
Hiatal Hernia/ GERD	YES	NO		Anesthesia Problems	YES	NO	
High/Low Blood Pressure	YES	NO		Previous EGD	YES	NO	
Kidney Disease	YES	NO		Previous Colon	YES	NO	
Lung Disease	YES	NO		Vaccinations	YES	NO	
Pacemaker/Internal Defibrillator	YES	NO		Hepatitis A	YES	NO	
Sleep Apnea	YES	NO		Hepatitis B	YES	NO	
Stomach Problems/ Ulcers	YES	NO					
Stroke	YES	NO					
Thyroid Problems	YES	NO					
Tuberculosis	YES	NO					
Ulcerative Colitis	YES	NO					
CURRENT MEDICATIONS:							
Medications	DOSAGE	Times Per Day		Medications	Dosage	Times Per Day	
ALLERGIES:				REACTION:			

Name: _____ DOB:_____ DATE:_____

SOCIAL HISTORY: (PAST OR CURRENT)				
Alcohol	YES	NO	Quit	Duration & Amount
Coffee/Caffeine	YES	NO	Quit	Duration & Amount
Substance Abuse	YES	NO	Quit	Duration & Amount
Tobacco	YES	NO	Quit	Duration & Amount
Blood Transfusions	YES	NO	When?	
Tattoos	YES	NO		
Do you exercise?	YES	NO	How much?	
FAMILY HISTORY: Please indicate any RELATIVES with the following diseases.				
Alcoholism	YES	NO		
Cirrhosis/Jaundice	YES	NO		
Colon Cancer	YES	NO		
Colon/Rectal Polyps	YES	NO		
Crohn's/Ulcerative Colitis	YES	NO		
Diabetes	YES	NO		
Gallstones	YES	NO		
Hemachromatosis	YES	NO		
Heart Disease	YES	NO		
High Blood Pressure	YES	NO		
Liver Disease	YES	NO		

SYMPTOM REVIEW Check if you have current symptoms			
☐ Weight Loss	☐ Cough	☐ Frequent Urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor Vision/Double Vision	☐ Heartburn	☐ Difficulty urinating	☐ Anxiety
☐ Dry Mouth	☐ Nausea/Vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent Nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold Sensitivity
☐ Hearing Loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal Congestion	☐ Abdominal pain	☐ New/Chronic rash	☐ Easy bruising
☐ Hoarseness	☐ Diarrhea	☐ Nail changes	☐ Excessive bleeding
☐ Chest Pain	☐ Constipation	☐ Headaches	☐ Swollen lymph nodes
☐ Irregular heart beat	☐ Blood in stool	☐ Seizures	☐ Swelling of ankles/legs
Other:			
Other:			

Physician notes if needed:

_____

_____

Other Physicians Who Are Actively Treating You:	
Doctor:_____	Condition:
Doctor:_____	Condition:

PATIENT SIGNATURE:

Date: