HORIZON
Gastroenterology
& Neurology PC
Sleep & Epilepsy Center

Muhammad S. Siddiq MD
Gastroenterology

WELCOME TO OUR PRACTICE

We appreciate your selection of this practice to provide the gastroenterological services that you desire. Please know that by choosing Horizon Gastroenterology & Neurology, you have chosen quality.

Many insurance companies require a referral from the primary care physician before seeing a specialist. **It is YOUR responsibility to contact your insurance carrier and provide us with a referral if it is required**. If we do not have a referral at the time of service, your visit will be rescheduled.

If you are referred by another physician to our practice, please make sure that you have arranged for your medical records to be forwarded to our office. You may also bring them with you to your appointment. This includes any testing or imaging reports that has been done. On the day of your appointment, please bring your referral (if required), your medical records, list of medications with dosages, your insurance card(s), your driver's license and the enclosed forms (completed). Any co-payment that you have is due at the time of service. Please **DO NOT** mail in these forms.

CLINIC POLICIES

- Clinic hours are from 8:00 a.m. to 4:00 p.m. Monday through Thursday and from 8:00 a.m. to 12:30 p.m. on Friday. Please arrive 15 minutes prior to your appointment so your patient information update may be completed.
- Non-emergent telephone calls will be returned as soon as possible
- Prescription refill requests will take 24 to 48 hours to be called in.
- Only persons listed in your chart may be given information regarding your health. This includes test results.
- For all correspondence to include medical records requests and for completions to include but not limited to time off, return to work, and letters of medical necessity will take 48-72 hours to complete.
- For all billing inquiries or account information, please ask to speak with the billing office at 901-821-0338

MIDTOWN
1325 Eastmoreland
Suite 510
Memphis, TN 38104

ATOKA
340 Atoka McLaughlin Dr
Suite c
Atoka, TN 38004

Phone: (901) 840.1083 ▪ Fax: (901) 840.1085 ▪ horizondoctors.com

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Name _____ Social Security No. _____
Last First MI

Address _____ Phone No. (_____) _____

City _____ State _____ Zip _____ Secondary No. (_____) _____

Date of Birth _____ Sex (M/F) _____ Race _____ Email _____

County _____ Primary Care _____ Marital Status Single Divorced Married Widowed

Employer _____ Occupation _____

Employer Address _____ Phone No (_____) _____
City State

INSURANCE INFORMATION (Please notify us if your insurance has changed)

PRIMARY – Ins. Co. Name _____ I.D No. _____

Group No. _____ Effective Date _____

Subscriber _____ Patients Relationship to Subscriber _____
Last First MI

Secondary – Ins. Co. Name _____ I.D. No. _____

Group No. _____ Effective Date _____

Subscriber _____ Patients Relationship to Subscriber _____
Last First MI

EMERGENCY INFORMATION

Relative or Friend _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone No. (_____) _____

RESPONSIBLE PARTY INFORMATION
(Insurance Policy Holder)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Phone No. (_____) _____ Social Security No. _____ Date of Birth _____

Employer Address _____ **Pharmacy No.** (_____) _____

ASSUMPTION OF FINANCIAL RESPONSIBILITY

In order to obtain services from the physicians and staff of Horizon Gastroenterology and Neurology (HGN), the Undersigned agrees as follows:

1. **I consent to treatment by Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
2. **The undersigned shall be financially responsible for all medical services and supplies provided by any physician, nurse or technician of HGN**
3. **The undersigned hereby assign(s) to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed all of the undersigned's right, title and interest in and to any insurance proceeds payable for the treatment rendered to the patient and further agree to deliver all checks and drafts received by the undersigned from insurance companies, properly endorsed to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
4. **HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed is hereby authorized and requested to furnish any insurance company, other third payor, hospital or physician any and all information it may have concerning the patient named above including, but not limited to, medical history, reports, consultations, prescriptions, treatment, including x-rays, and any and all other requested information and/or documentation pertaining to such patient. A photostatic copy of this authorization shall be considered as valid and reflective as the original.**
5. **If more than one person signs below, each is jointly and severally liable with the other. The undersigned executes this agreement for the purpose of inducing HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed to provide medical services and supplies to patient named above.**
6. **This authorization includes the release of information to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
7. **Patient is responsible for all fees associated with missed appointments, returned checks, collection fees and/or attorney fees.**

_____ _____ _____ _____
PATIENT'S SIGNATURE **DATE** **RESPONSIBLE PARTY'S SIGNATURE** **DATE**

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PATIENT REPRESENTATIVE IDENTIFICATION FORM

Date: _____

Patient Name: _____ Date of Birth: _____

By law, the HIPAA Privacy Rule prohibits Clinic/Center from disclosing your Protected Health information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This rule became effective April 14, 2003.

1. **Please list the names of all persons that you wish to have access to your Protected Health Information (PHI).**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

2. **Please list the name of the person(s) with whom we can discuss your bill.**

Name: _____ Relationship to Patient: _____

3. **If applicable, please list the name of your Legal Representative.**

Name: _____ Phone Number: (_____) _____

Relationship:

_____ Parent

_____ Guardian

_____ Next of kin

_____ General Power of Attorney

_____ Heath Care Power of Attorney

PLEASE NOTE: In order for us to disclose your PHI, the above representatives must be able to provide two patient identifiers.

_____ _____ _____ _____

Patient's Signature Date Patient Representative Signature Date

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Medical Records Release

Facility Name: _____

I would like a copy of my medical records released to:

Horizon Gastroenterology & Neurology

Patient Name: _____

Date of Birth: _____

S.S. #: _____

Signature _____

Records being requested (Please check)

- ER notes
- Clinic notes
- Lab reports
- Referral note
- EEG report
- EMG report
- Imaging (MRI, CT, Ultrasound, etc.)
- Endoscopy report
- Colonoscopy report
- Other: _____

Please fax requested records to 901-840-1085 or 901-837-0183

Office Phone Number: 901-840-1083

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1325 Eastmoreland
Suite 510
Memphis, TN 38104

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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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose it.

- We may use and disclose your medical records only for each of the following purposes:
  - Treatment: means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example would be include a physical examination.
  - Payment: means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a claim to your insurance company.
  - Healthcare Operations: include business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

- Any other uses and disclosures will be made only with your written authorization. You may revoke such an authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
  - The right to request restrictions on certain used and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
  - The right to reasonable requests to receive confidential communications of protected health information form used by alternative means or at alternative locations.
  - The right to inspect and copy your protected health information.
  - The right to amend your health information

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective immediately and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing here, I acknowledge that I have received a copy of Horizon's Notice of Privacy Practices

Signature: _____ Date: _____

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Sleep Medicine

Name: _____ Date of Birth: _____ Today's Date: _____

Reason for Visit: _____ Referring MD: _____

ALLERGIES

☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Morphine ☐ Latex ☐ Penicillin ☐ Shellfish ☐ Other: _____

PAST MEDICAL ILLNESSES

☐ None
☐ Colon Cancer
☐ Colon Polyps
☐ Anemia
☐ Crohn's Disease
☐ Ulcerative Colitis
Duration_____
☐ Irritable Bowel Syndrome
☐ Hepatitis
☐ Stomach/Duodenal Ulcer
☐ Hiatal Hernia
☐ Reflux
☐ Diverticulitis
☐ Pancreatitis
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cataracts
☐ Chronic Lung Disease
☐ Cirrhosis of Liver
☐ Depression
☐ Diabetes
☐ Ear Infections
☐ Emphysema
☐ Frequent Urinary Infections
☐ Gallstones
☐ Glaucoma
☐ Gout
☐ Groin Hernia
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol
☐ High Triglycerides
☐ HIV/AIDS
☐ Irregular Heart Beat
☐ Kidney Disease/Failure
☐ Kidney Infection
☐ Kidney Stones
☐ Lupus
☐ Mediastinal Mass
☐ Migraines
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Ovarian Cyst
☐ Parkinson's Disease
☐ Phlebitis
☐ Pneumonia
☐ Polio
☐ Psoriasis
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
☐ Skin Cancer
☐ Sleep Apnea
☐ Stroke or Paralysis
☐ Syphilis
☐ TB (Tuberculosis)
☐ TB Skin Test Positive
☐ Thyroid Disease
☐ Transfusions
☐ Other:_____
☐ Other:_____
☐ Other:_____

PREVIOUS SURGERIES

☐ None
☐ Colonoscopy
☐ EGD
☐ ERCP
☐ Colon Resection
Reason_____
☐ Liver Biopsy
☐ Hysterectomy
☐ Stomach
☐ Obesity Surgery
☐ Gallbladder Surgery
☐ Hemorrhoids
☐ Hiatal Hernia
☐ Colostomy
☐ Appendectomy
☐ Breast
☐ Cardiac Bypass Surgery
☐ Cardiac Valve Surgery
☐ C-Section
☐ Groin Hernia
☐ Joint Replacement
☐ Kidney
☐ Neck/Back
☐ Ovary
☐ Prostate
☐ Thyroid
☐ Tonsillectomy
☐ Tubal Ligation
☐ Uterus
☐ Problems with Anesthesia
☐ Difficult Intubation of Airway
☐ History of Malignant Hyperthermia
☐ Other:_____
☐ Other:_____
☐ Other:_____

SOCIAL HISTORY (MARITAL STATUS)

☐ Single ☐ Separated ☐ Married
☐ Divorced ☐ Widowed

NUMBER OF CHILDREN

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ None

SOCIAL HISTORY (ALCOHOL)

☐ Never ☐ Less than 2 Days/Week
☐ Daily ☐ Quit Using Alcohol
☐ More than 2 Day/Week How Long? _____

SOCIAL HISTORY (TOBACCO)

☐ I use tobacco products Packs per day? _____
☐ I quit using tobacco products How long? _____
☐ I have never used tobacco products

SOCIAL HISTORY (OCCUPATION)

Patient Occupation: _____

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Name: _____ Date of Birth: _____ Today's Date: _____

GASTROINTESTINAL

- ☐ None
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black Stools
- ☐ Bloating
- ☐ Change Bowel Habits
- ☐ Constipation
- ☐ Dairy Intolerance
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Flatulence
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Mucous in Stool
- ☐ Nausea
- ☐ Pain with Bowel Movement
- ☐ Rectal Bleeding
- ☐ Rectal Urgency
- ☐ Soiling Stool
- ☐ Vomiting
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

URINARY

- ☐ None
- ☐ Kidney Disease/Failure
- ☐ Frequent Urinary Infections
- ☐ Change in Urinary Frequency
- ☐ Sexually Transmitted Disease
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Sexual Difficulty
- ☐ Other:_____

MALE

- ☐ Testicle Problem

FEMALE

- ☐ Heavy Periods
- ☐ Breast Lump

SKIN

- ☐ None
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Suspicious Lesions
- ☐ Other:_____

CARDIOVASCULAR

- ☐ None
- ☐ Ankle Swelling
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath when Lying Flat
- ☐ Shortness of Breath with Exercise
- ☐ Other: _____

NEUROLOGICAL

- ☐ None
- ☐ Dizziness
- ☐ Frequent Headaches
- ☐ Numbness in Extremities
- ☐ Other:_____

ENDOCRINE

- ☐ None
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Hair Change
- ☐ Other:_____

CONSTITUTIONAL

- ☐ None
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Inability to Concentrate
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other:_____
- ☐ Other:_____

PSYCHIATRIC

- ☐ None
- ☐ Anxiety/Panic
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Loss of Interest in Enjoyable Activities
- ☐ Loss of sexual desire
- ☐ Suicidal Thoughts

EYES

- ☐ None
- ☐ Night Sensitivity
- ☐ Pain
- ☐ Visual Decline
- ☐ Other:_____

HEMATOLOGIC

- ☐ None
- ☐ Easy Bruising
- ☐ Prolonged Bleeding
- ☐ Swollen Glands
- ☐ Other:_____

EARS, NOSE AND THROAT

- ☐ None
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Other:_____

MUSCULOSKELETAL

- ☐ None
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Other:_____

RESPIRATORY

- ☐ None
- ☐ Cough up Blood
- ☐ Coughing
- ☐ Wheezing
- ☐ Home Oxygen
- ☐ CPAP Machine
- ☐ Other:_____

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FAMILY HISTORY

	FATHER	MOTHER	CHILD(REN)	BROTHER(S)	SISTER(S)
Healthy	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
(age at diagnosis)	_____	_____	_____	_____	_____
Colon Polyps	☐	☐	☐	☐	☐
(age at diagnosis)	_____	_____	_____	_____	_____
Crohn's Disease	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Bleeding Tendency	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Problems with Anesthesia	☐	☐	☐	☐	☐

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Name: _____ Date of Birth: _____ Today's Date: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Current Weight? _____ Weight gain over the past year? _____ Are you trying to lose weight? ☐ Yes ☐ No

Weight loss over the past year? _____ Meals per day? _____

If you are allergic to any medications, please list what reaction you have. _____

MEDICATION LIST (please list all medications that you are currently taking)

Medication	Dose	Frequency

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Name: _____ Today's Date: _____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If your score is 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene, and/or need to see a sleep specialist.

Use the following scale to choose the most appropriate number for each situation:

0 = would ***NEVER*** doze or sleep
1 = ***SLIGHT*** chance of dozing or sleeping
2 = ***MODERATE*** chance of dozing or sleeping
3 = ***HIGH*** chance of dozing or sleeping

Please fill out your answers and see where you stand.

SITUATION	Chance of dozing or sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped in traffic for a few minutes while driving	
TOTAL SCORE (add the scores up)	

1. Do you snore? _____yes _____no
2. Do you wake up gasping? _____yes _____no
3. Do you wake up several times during the night? _____yes _____no
   Why? (if you answered yes) _____
4. Do you move your legs a lot at night? _____yes _____no

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