



TEXAS SURGICAL ARTS

PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced Employed By: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

In Case of an Emergency, Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our practice? \_\_\_\_\_

Have you had any testing done recently?  Yes  No (If Yes, please list name of test, date & place of service below)

What is the purpose of today's visit:  Cosmetic Surgery  Weight Loss Surgery  General Surgery

If here for weight loss surgery would you be interested in cosmetic surgery in the future? \_\_\_\_\_

**MEDICAL HISTORY:** (Check all appropriate boxes that you currently have or have been diagnosed with in the past)

- Heart Attack / Heart Failure
- History of Heart Stent Placement
- Diabetes – Non-Insulin
- Diabetes – Insulin
- High Blood Pressure
- High Cholesterol
- Blood Clots (i.e. Legs)
- Sleep Apnea
- Musculoskeletal or Autoimmune conditions
- Pulmonary Embolism
- Cirrhosis of the Liver
- Taking Steroids (i.e. Prednisone)
- Fatty Liver
- History of Stroke
- Hepatitis B / C
- HIV Positive
- Osteoarthritis
- Reflux/GERD
- Back Pain
- Asthma
- Pregnancy

Other: \_\_\_\_\_

**MEDICATIONS:**

(List all medications you are currently taking or provide a separate Medication list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY:**

(List all previous surgeries. If there is no history of surgeries, indicate 'no surgeries')

Year:	Type of Surgery:	Complications: (If any)

**FAMILY HISTORY:** (Check all appropriate boxes)

Disease:	Relationship to Patient:
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Other (Please write)	

**HEALTH HABITS:** (Check all appropriate boxes)

Habit:	How often?
<input type="checkbox"/> Caffeine & Type	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Illegal Drugs	
<input type="checkbox"/> Alcohol	

Have you ever had a blood transfusion?

- No  
 Yes – Approximate Date: \_\_\_\_\_

**REVIEW OF SYSTEMS:** (Check all appropriate boxes of symptoms you currently have)

General

- Chills
- Dizziness
- Fainting
- Fever
- Headache

Gastrointestinal

- Rectal Bleeding
- Constipation
- Diarrhea
- Nausea
- Hemorrhoids

Eye, Ear, Nose, Throat

- Bleeding Gums
- Double Vision
- Earache Difficulties
- Hay Fever
- Hoarseness

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Painful Urination

Muscle/Joint/Bone

**Pain, Weakness or Numbness in:**

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

Cardiovascular

- Chest Pain
- Irregular Heart Beat
- Blood Clots

Skin

- Bruise Easily
- Hives
- Itching
- Change in Moles
- Sores that do not heal

Women Only:

- Last Menstrual Period:
- Pregnancies How many\_\_\_\_\_

**To the best of my knowledge**, the above information is complete and correct.

I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian  
 or Personal Representative

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Date



**FINANCIAL POLICY**

Welcome and thank you for choosing Texas Endosurgery for your healthcare needs. We strive to work hard to provide you with the best quality of care. If we are filing with your insurance carrier, you are responsible for **ANY** charges that your insurance carrier does not pay. We will verify your insurance and pre-certify procedures; however, **this does not guarantee payment for services**. Any dispute regarding unpaid claims must be addressed with your insurance carrier. It is **your** responsibility to contact your insurance carrier and resolve the problem.

Any past due balances, co-pays, and or co-insurance for office visits, treatment and surgery, are due **before services are rendered**.

We accept cash, money orders, or VISA/MASTERCARD/DEBIT. **NO personal checks will be accepted.**

There is a \$25 charge for copies of medical records and/or any paperwork that needs to be filled out by Dr. Bonnor/staff such as, disability, FMLA, or any paperwork that you bring. Such paperwork will not be processed until after payment has been received. Paperwork can sometimes take up to 4-5 business days to complete. Payment can be made in person or over the phone using a credit card.

In the event that we need to reimburse you, you will be issued a check that will need to be picked up from our office. If your payment was made using a credit card, there will be a credit card processing fee that will be deducted from the amount refunded.

**Failure to notify our office in advance to cancel or reschedule an appointment with Dr. Bonnor will result in the following fees:**

- \$50.00** Fee will be processed if the appointment is missed or rescheduled without giving a 24 hour notice to our office.
- \$100.00** Fee will be processed if testing is scheduled with Dr. Bonnor (Endoscopy, Manometry, etc.) and the appointment is not cancelled or rescheduled within at least 2 weeks' notice in advance.
- \$250.00** Fee will be processed if surgery appointment is not cancelled or rescheduled at least 3 weeks' notice in advance

***\*\*\*These fees are non-refundable and are due before rescheduling and/or before any services are rendered.***

**After Hours Calls:**

After hours calls are for URGENT issues ONLY. Please do not call our physician after-hours to make appointments, discuss non-urgent issues that can wait for the next business hours. We reserve the right to bill you for any after hour call that we deem was unnecessary. We do not refill medications after hours. Please call in refill requests during business hours only.

**Termination of Doctor-Patient relationship:**

You as a patient can terminate your relationship with us at any time. We , as your physician, can also elect to terminate our relationship with you . Once our relationship has been terminated, we are no longer responsible for your care.

Texas State Law allows a doctor to terminate a relationship with a patient without giving a reason. However, we often have reasons when we exercise this right.

Examples of behaviors that can lead to termination of your care at our clinic includes, but not limited to:

1. Fraudulent activity
2. Abusive to our staff, physician, or other patients
3. Repeated missed appointments
4. Refusal to pay for services

**I attest to all of the following information above.**

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Print Name	Signature	Date
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TEXAS SURGICAL ARTS

**PHOTO CONSENT**

I hereby acknowledge that I have been advised that photographs and video will be taken of me or parts of my body before, during and after surgery. I hereby give my consent for Texas Surgical Arts to use the photographs/video under the following circumstances: Please initial ONLY ONE of the following selections:

**WEBSITE & MEDIA \_\_\_\_\_**

Photographs, electronic images and video footage taken of me or parts of my body as well as details regarding medical service I have received at Texas Surgical Arts may be used in any print or electronic media, including but not limited to our website, Facebook, Snapchat, Instagram, Real Self, and YouTube to inform the public about cosmetic surgery methods.

**WEBSITE ONLY \_\_\_\_\_**

Photographs, electronic images and video footage taken of me or parts of my body as well as details regarding medical services that I have received at Texas Surgical Arts, may be used only on our website in order to inform the public about cosmetic surgery methods.

**MEDICAL ONLY \_\_\_\_\_**

Photographs and electronic images taken of me or parts of my body can be solely used for the purpose of my medical care with Texas Surgical Arts. The photographs and electronic images and details regarding medical services rendered to me will be kept confidential in my medical file at Texas Surgical Arts

I acknowledge that I will not receive any compensation for the use of my representation and hereby release Texas Surgical Arts, Ricardo M. Bonnor, M.D., F.A.C.S. and the personnel from any and all claims which arise out of, or are in any way connected with such case.

I do further certify that I am of legal age and possess full legal capacity to execute the preceding authorization and release.

I have read this release before signing below, and fully understand the conditions of this release.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



TEXAS SURGICAL ARTS

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby authorize my doctor/medical provider to disclose any information needed by:

**Texas Surgical Arts**  
**21720 Kingsland Blvd Katy, TX 77450**  
**Phone: (281) 579-5638**  
**Fax: (281) 579-5636**

Please release the following:

- ALL MEDICAL RECORDS**
- OTHER (Please specify)** \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

- YES, I CONSENT TO THE RELEASE OF THIS INFORMATION**
- NO, I DO NOT CONSENT TO THE RELASE OF THIS INFORMATION**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patients is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire 180 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure and the information, I can contact the office at (281)579-5638

**I understand that Texas Endosurgery Associates may disclose with other doctors reason for medical records needed.**

\_\_\_\_\_  
Signature of Patient or (Legal Representative) \_\_\_\_\_  
Date



TEXAS SURGICAL ARTS

**AUTHORIZATION OF DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I hereby authorize Texas Surgical Arts to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and healthcare.

I understand that this authorization is valid until the time if and when it is revoked in writing.

YES

Name:	Phone Number(s):	Relationship to Patient:

NO

I hereby authorize medical information to be discussed with me via: (Check all that may apply)

- Phone
- Email
- Leave on voicemail or answering service

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date