Eastside Bariatric & General Surgery *Where Quality Care is the Key*

Patient Registration Form

Date: _____

Patient's Name (Last, First, MI)

Date of Birth: **Age:** **Sex: M F** **Social Security Number:**

Primary Phone Number: **E-Mail Address:**

Address: **Apt. #:**

City: **State:** **Zip:**

Billing Address:

City: **State:**

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Primary Physician:	**Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired [ ] Student**

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____	**Secondary Insurance: _____**
Patient is Subscriber/Policy Holder: Y N	**Patient is Subscriber/Policy Holder: Y N**

INSURED INFORMATION (IF OTHER THAN PATIENT)

Subscriber/ Policy Holder: _____ Relationship to Patient: _____
Address: _____
Social Security Number: _____ Date of Birth: _____

RELEASE OF INFORMATION

It is important for us to honor the confidentiality between patient and physician. Please check your preference below:

____ You may discuss my medical information only with me.

____ I give you permission to discuss my medical information with the following people:

Name(s): _____ Relationship to Patient: _____Cell No: _____

Name(s): _____ Relationship to Patient: _____Cell No: _____

Eastside Bariatric and General Surgery reserves the right to charge a fee for any for

1. **Office visits not cancelled 24 hours prior to scheduled appointment** **$25.00**
2. **Procedures or Surgeries not cancelled 48 hours prior to scheduled dates** **$100.00.**

Patient / Parent or Guardian Signature: _____ Date: _____

HEALTH HISTORY

Personal Information

Patient Name: _____ Birth Date: _____/_____/_____ Age: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous Primary Care Physician:

_____

_____

_____

Medical Information

Please list any MEDICATIONS you are currently taking, prescribed or over the counter.

(Use the back of the page if needed and indicate so):

Medication	Dosage	Frequency

Allergies (Drug or Food-Related):

_____

_____

Preferred Pharmacy: _____

Male:

Date of Last Complete Prostate Exam: _____

Date of Last Colonoscopy: _____

Female:

Date of Last Self Breast Exam: _____

Date of Last Pap Smear: _____

Date of Last Mammogram: _____

If YOU have a history of any of the following, please indicate below:

Arrhythmias	_____	**Type I or II Diabetes**	_____	**Respiratory Disease**	_____
Anemia	_____	**Hypertension (High Blood Pressure)**	_____	**Skin Disease**	_____
Allergies/Hay Fever	_____	**Gynecological Disease**	_____	**Stomach/Colon Disease**	_____
Asthma	_____	**Sleep Apnea**	_____	**Stroke**	_____
Arthritis	_____	**High Cholesterol**	_____	**Seizure Disorder**	_____
Anxiety/Depression	_____	**Heart Attack**	_____	**Thyroid Disorder**	_____
Alcoholism	_____	**Kidney Disease**	_____	**Sexually Transmitted Disease**	_____
Blood Clots	_____	**Liver Disease**	_____	**Other:**	
Cancer, Type/s		**Neurological Disease**	_____	_____	
_____		**Peptic Ulcer Disease** _____ _		_____	

Please list any SURGERIES you have had and include the month/year:

_____

_____

_____

_____

Social History

Tobacco Use:
Do you smoke? _____
No. of years smoking: _____
If so, how many cigarettes/cigars per day? _____
Do you chew tobacco? _____

Alcohol Use:
Do you drink alcohol? _____
How often? _____

Drug Use:
Any history of illegal drug use? _____
If so, what type(s)? _____

Authorization for Claims Payment and Reviews

Please read and initial

____ **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, and other health care benefits ("Insurance Plan(s)") to **EBGS** which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to **EBGS** (or its affiliate).

____ Authorization, Consent of Professional Services and Release of Information- All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments; the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. All copayments are payable at the time of service.

- The above information is true to the best of my knowledge. I hereby authorize **EBGS**, to furnish the insurance companies or their representative's information concerning my (my dependents) illness and treatments. I hereby assign to **EBGS**, all payments for medical services rendered by myself or my dependents and that I am responsible for any amount not covered by insurance.
- I hereby authorize release to doctors and whomever he/she may designate as his/her assistant to administer treatment, physical exam, X-Ray studios, Laboratory procedures, Medical care, or any clinical services that he/she deems necessary in my case.
- I further authorize him/her to disclose all or part of my record to any person or corporation which is or may be liable under contract to the clinic, the patient, a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital and all other health care benefits from my insurance.

____ Patient Information Consent- I understand that **EBGS** may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services, and for the purpose of operating the practice. I consent to the use of my information for treatment purposes, payment and healthcare operations.

- I understand that my consent is not needed if the law requires **EBGS** to report some aspect of my protected health information to a government agency (e.g., suspected abuse, communicable disease, potential bodily harm).
- I understand that I have the right to review **EBGS** privacy notice to request restrictions be put on the use of my information and revoke my consent at a later date.
- I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, **EBGS** may refuse to undertake my care.
- I, the undersigned, hereby consent to treatment: administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in my treatment, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.
- I fully understand that this is given in advance of any specific diagnosis or treatment. I intent this consent will remain in full force until **revoked in writing**. I understand that **EBGS** may include consent at satellite offices under common ownership.

____ **Unauthorized, Non-Covered, or Out of Plan Services** - I agree to be fully responsible for payment to **EBGS** for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

____ **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

____ **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the **EBGS** education programs.

____ **Financial Policy** - **Accepting your insurance does not place any financial responsibilities on our practice. A member of the billing team will reach out to you *at least* 2 weeks prior to your surgical procedure to advise you of your financial obligations. Please note that our team verifies your insurance coverage only as a courtesy; you will be held accountable for any unpaid balances by your Insurance. All patients are required to pay their deductible, copay and/or coinsurance payment at the time of each visit *and or* prior to surgery. At the conclusion of your visits, you may be billed for outstanding balances, provided a refund within 90-120 days or available credit transferred towards any open balances and future visits. Any outstanding balance on the account after a 6-month period will be transferred to collections unless a payment plan arrangement is created.**

____ **Privacy and Security of Emails** - **EBGS** may choose to discontinue e-mail communication at any time. Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer. **EBGS** cannot and does not guarantee the privacy or security of any messages being sent over the internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail. This document along with **EBGS** "Notice of Privacy Practices constitutes a notice of privacy practices for e-mail.

____ **FMLA Forms** - **Our office charges a $50 fee for FMLA forms** filled out by the surgeon. This policy pertains to external documents that require a healthcare provider to authenticate patient health, provide their signature to verify information found within the document, or to approve/provide medical clearance for an external organization. **EBGS** will categorize all external documents that require the attention of a healthcare provider as either a "FORM" or an "ENDORSEMENT" and will charge for the completion of forms. **FMLA forms take 2-4 weeks to process after receipt in our office.**

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above all conditions and terms. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by **EBGS**. **I understand and agree this document will remain in effect for all future in/outpatient or physician office visits to EBGS Surgery unless specifically rescinded in writing by me.**

Patient Name / parent or Guardian Signature: _____ Date: _____