

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Form fields for Patient Information including Name, Address, Phone, Insurance, and Demographics.

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Form fields for Responsible Party Information including Name, Address, and Contact Details.

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Primary Insurance Information including Company Name, Policy Number, and Dates.

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Secondary Insurance Information including Company Name, Policy Number, and Dates.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. Patient (or Responsible Party) Signature Date

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Printed Name of Witness

Employee Job Title

Signature of Witness

Date



Surgical Specialist of Clear Lake

450 Medical Center Blvd, # 600A
Webster, TX 77573

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information (Last Name, Middle Initial, (Maiden/Other)

Date of Birth

Social Security Number

Phone Number

I hereby authorize:

Doctor's Name / Practice: _____

Address: _____

Phone: _____

Fax: _____

I hereby authorize and request you to release to:

Khoi H. Du, MD, FACS

Surgical Specialist of Clear Lake
450 Medical Center Blvd., Suite 600A
Webster, Texas 77598

My authorization extends only to the data elements/documents initiated below:

- | | |
|---|----------------------------|
| _____ History & Physical Examination | _____ Consultation Reports |
| _____ Laboratory Reports | _____ Operation Reports |
| _____ Diagnostic Reports (U/S, CT, MRI) | _____ Medication List |
| _____ OTHER _____ | |

Reason for release:

I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I Understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may not be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Patient Signature

Witness

Date

Medical History

MEDICAL HISTORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> GERD | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> PCOD |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Urinary Inconsistency |

Past Surgeries: None

Current Medications: None

Medication Allergies: None:

Family History:

Have you Ever Smoked? No Yes If yes, _____ packs a day for _____ years. Quit? _____

Do you drink alcohol? No Yes If yes, _____ drinks a week of Wine Beer Liquor

Check Symptoms you currently have or have had in the past year:

- | | | | |
|--|---|---|---|
| CONSTITUTIONAL | CARDIAC | <input type="checkbox"/> Poor Appetite | NEUROLOGIC |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Constipation | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Heat/Cold Intolerance | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stool Caliber Change | <input type="checkbox"/> Paralysis |
| EYES | RESPIRATORY | <input type="checkbox"/> Stool Color Change | HEMME/IMMUNO |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Shortness of Breath | SKIN/BREAST | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Cough | <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Blood Transfusions |
| EARS & THROAT | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Breast Mass | <input type="checkbox"/> Large Lymph Glands |
| <input type="checkbox"/> Difficulty Hearing | GASTROINTESTINAL | URINARY | <input type="checkbox"/> Muscle Sweats |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Incontinence | MUSCULOSKELETAL |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Frequency | <input type="checkbox"/> Bone Pain |
| | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Urgency | |

Other/Explanation: _____

How many years have you been over weight? _____

Previous Weight Loss Surgery? YES or NO

If yes, which surgery? _____ Date of Surgery: _____

Surgeon: _____

Have you ever been treated for Depression? YES or NO

If yes, name of physician or psychiatrist: _____

Have you ever been hospitalized for Mental Illness? YES or NO

Weight History

Previous Weight Loss Programs

***Please fill out the best of your ability. The more information you provide will be helpful for the insurance process. ***

Programs:	Date Started	End Date	Weight Loss	MD Supervised?
<input type="radio"/> Weight Watchers	_____	_____	_____	YES or NO
<input type="radio"/> Jenny Craig	_____	_____	_____	YES or NO
<input type="radio"/> Nutrisystem	_____	_____	_____	YES or NO
<input type="radio"/> Quick Weight Loss Center	_____	_____	_____	YES or NO
<input type="radio"/> Atkins Diet	_____	_____	_____	YES or NO
<input type="radio"/> Optifast	_____	_____	_____	YES or NO
<input type="radio"/> Medifast	_____	_____	_____	YES or NO
<input type="radio"/> Alli	_____	_____	_____	YES or NO
<input type="radio"/> Plexus	_____	_____	_____	YES or NO
<input type="radio"/> Advocare	_____	_____	_____	YES or NO
<input type="radio"/> SlimFast	_____	_____	_____	YES or NO
<input type="radio"/> Herbalife	_____	_____	_____	YES or NO
<input type="radio"/> Other Weight Loss Attempts	_____	_____	_____	YES or NO
<input type="radio"/> Other Weight Loss Attempts	_____	_____	_____	YES or NO
<input type="radio"/> Other Weight Loss Attempts	_____	_____	_____	YES or NO

Medical Weight Loss Attempts

Medication:	Date Started	End Date	Weight Loss	MD Supervised?
<input type="radio"/> Belviq	_____	_____	_____	YES or NO
<input type="radio"/> Xenical (Orlistat)	_____	_____	_____	YES or NO
<input type="radio"/> Contrave (naltrexon)	_____	_____	_____	YES or NO
<input type="radio"/> Saxenda (liraglutide)	_____	_____	_____	YES or NO
<input type="radio"/> Amphetamines	_____	_____	_____	YES or NO
<input type="radio"/> Phen-Fen	_____	_____	_____	YES or NO
<input type="radio"/> Phentermine <i>(Apiden, Fastin, Pondimen)</i>	_____	_____	_____	YES or NO
<input type="radio"/> Dexfenfluramine	_____	_____	_____	YES or NO
<input type="radio"/> Meridia (Sibutramine)	_____	_____	_____	YES or NO
<input type="radio"/> Other Medications	_____	_____	_____	YES or NO
<input type="radio"/> Other Medications	_____	_____	_____	YES or NO

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Surgical Specialists of Clear Lake, PLLC

PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** may utilize the services of a third party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** any insurance or other third-party benefits available for health care services provided to me. I understand **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse

Guarantor

Surgical Specialists of Clear Lake, PLLC

PATIENT NAME _____ **DATE OF BIRTH** _____

Parent

Healthcare Power of Attorney

Legal Guardian

Other (please specify) _____