Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

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

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

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

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

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**

Fresh Start
Surgical Weight Loss Program

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
_____ Laboratory Reports
_____ Diagnostic Reports (U/S, CT, MRI)
_____ OTHER _____
_____ Consultation Reports
_____ Operation Reports
_____ Medication List

Reason for release:

_____
_____

I acknowledge, and herby 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

Fresh Start
Surgical Weight Loss Program

Medical History

MEDICAL HISTORY:

- ☐ Diabetes Mellitus
- ☐ Osteoarthritis
- ☐ Obesity
- ☐ GERD
- ☐ Obstructive Sleep Apnea
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ PCOD
- ☐ 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
- ☐ Fever
- ☐ Weight Loss
- ☐ Heat/Cold Intolerance

EYES
- ☐ Glasses/Contacts
- ☐ Blurry Vision

EARS & THROAT
- ☐ Difficulty Hearing
- ☐ Sinus Problems
- ☐ Dentures

CARDIAC
- ☐ Palpitation
- ☐ Chest Pain
- ☐ Irregular Heart Beat

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Poor Appetite
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Stool Caliber Change
- ☐ Stool Color Change

SKIN/BREAST
- ☐ Skin Lesions
- ☐ Breast Mass

URINARY
- ☐ Incontinence
- ☐ Frequency
- ☐ Urgency

NEUROLOGIC
- ☐ Stroke/TIA
- ☐ Weakness
- ☐ Paralysis

HEMME/IMMUNO
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Large Lymph Glands
- ☐ Muscle Sweats

MUSCULOSKELETAL
- ☐ Bone Pain

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

Patient Name: _____

Fresh Start
Surgical Weight Loss Program

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?
o Weight Watchers	_____	_____	_____	YES or NO
o Jenny Craig	_____	_____	_____	YES or NO
o Nutrisystem	_____	_____	_____	YES or NO
o Quick Weight Loss Center	_____	_____	_____	YES or NO
o Atkins Diet	_____	_____	_____	YES or NO
o Optifast	_____	_____	_____	YES or NO
o Medifast	_____	_____	_____	YES or NO
o Alli	_____	_____	_____	YES or NO
o Plexus	_____	_____	_____	YES or NO
o Advocare	_____	_____	_____	YES or NO
o SlimFast	_____	_____	_____	YES or NO
o Herbalife	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO

Medical Weight Loss Attempts

Medication:	Date Started	End Date	Weight Loss	MD Supervised?
o Belviq	_____	_____	_____	YES or NO
o Xenical (Orlistat)	_____	_____	_____	YES or NO
o Contrave (naltrexon)	_____	_____	_____	YES or NO
o Saxenda (liraglutide)	_____	_____	_____	YES or NO
o Amphetamines	_____	_____	_____	YES or NO
o Phen-Fen	_____	_____	_____	YES or NO
o Phentermine *(Apiden, Fastin, Pondimen)*	_____	_____	_____	YES or NO
o Dexfenfluramine	_____	_____	_____	YES or NO
o Meridia (Sibutramine)	_____	_____	_____	YES or NO
o Other Medications	_____	_____	_____	YES or NO
o Other Medications	_____	_____	_____	YES or NO

Patient Name: _____

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
Legal Guardian
Healthcare Power of Attorney
Other (please specify)_____