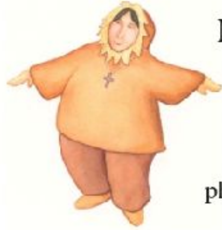
Alaska Bariatric Center



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Anchorage, AK, 99508
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PATIENT INFORMATION FORM

PATIENT INFORMATION

NAME – LAST: ____________________ FIRST: ____ M.I.: ____

DATE OF BIRTH: __________________ SEX: (circle one) M F SOCIAL SECURITY NUMBER: __________________________

HEIGHT: _______________ WEIGHT: ___________ MARITAL STATUS: __________________________________

MAILING ADDRESS: ____ CITY: ____________________ STATE: ______ ZIP: _______

PHYSICAL ADDRESS: _______________________________________ CITY: ____________________ STATE: ______ ZIP: _______

HOME PHONE: ___________________________ CELL: ___________________________ WORK: ___________________________

EMAIL: _______________________________________

PARENT/GUARDIAN/SPOUSE

RELATIONSHIP TO PATIENT______________________________

NAME – LAST: ____ FIRST: ____ M.I.: ____

DATE OF BIRTH: __________________ SEX: (circle one) M F

ADDRESS: ____ CITY: ____________________ STATE: ______ ZIP: _______

HOME PHONE: ___________________________ CELL: ___________________________ WORK: ___________________________

EMAIL: _______________________________________ SOCIAL SECURITY NUMBER: ______________________________

PRIMARY MEDICAL INSURANCE

Date of Accident/Injury:_________________ CARDS SCANNED_____________

____

(Primary Insurance Company Name) (ID#) (Group#)

____

(Policy Holder Name) (INSURED Date of Birth)

SECONDARY MEDICAL INSURANCE

CARDS SCANNED_____________

____

(Secondary Insurance Company Name) (ID#) (Group#)

____

(Policy Holder Name) (INSURED Date of Birth)

EMERGENCY CONTACT INFORMATION

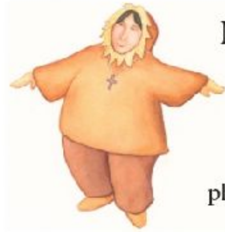
____

(Name) (Phone) (Relationship)

____

(Name) (Phone) (Relationship)

Alaska Bariatric Center



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AGREEMENT FORMS

- May we leave you a detailed message:
  At home? YES NO *Initial*________ Cell? YES NO *Initial*________
- May we use your pictures and generic patient information for the following reasons; medical conventions *and/or* conferences, discussions regarding issues at Bariatric Support Group meetings, use in insurance appeals.
  YES NO *Initial* ________
- May we post your picture on the website (alaskabariatriccenter.com)? YES NO *Initial* ________
- May we show your picture *and/or* video's including pre and post-surgical weight at the ABC Annual Gala?
  YES NO *Initial* ____
- May Dr. Todd and other staff members include your patient information in text messages regarding your care with our office or other providers? YES NO *Initial* ________

Date Signed: ___________Patient Printed Name: ______________________Signature of Patient: ________________________

NOTICE OF SOCIAL MEDIA POLICY

I, the undersigned am aware that any contact with Alaska Bariatric Center and its staff may be documented and included in my medical records. This includes but is not limited to; emails, text messages, and all other forms of social media.

Signature of Responsible Party: ____Date:____________________

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible part also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer.

Signature of Responsible Party: ____Date:____________________

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office, and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

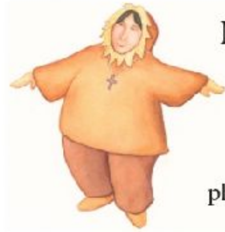
Signature of Responsible Party: ____Date:____________________

AKNOWLEDGEMENT OF EMERGENT CARE PRIORITY POLICY (DR. TODD PATIENTS)

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. We request that you please be patient and courteous to our staff should your appointment be delayed, or rescheduled. Please bear in mind that you shall receive the same priority in service should you ever require emergent medical attention while under Dr. Todd's care.

Signature of Responsible Party: ____Date:____________________

Alaska Bariatric Center



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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1.) Alaska Bariatric may disclose my health information to: ____
Relationship: _________________________

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

2.) Alaska Bariatric may disclose my health information to: ____
Relationship: _________________________

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

SURGERY PAYMENT AGREEMENT

At your last appointment prior to surgery known as your pick up orders you are required to pay 20% of your copay or coinsurance. We will call your insurance once again to verify how much of your out of pocket has been met to calculate the 20% needed to pay.

_____________________________________ Patient Name (please print)

_____________________________________ Print Name of Parent/Responsible Party (if applicable)

_____________________________________ Signature of Patient/Parent/Responsible Party

____/____/____ Date

HIPAA AGREEMENT FORM

Please read and sign below:

The pages accompanying this receipt are our *Notice of Privacy Practices*, which provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure.

Per HIPAA regulations, we are required to ask you to sign this *Acknowledgement of Receipt of Notices of Privacy Practices*. You have the right to refuse our request, in which case, we must document your refusal for the record.

Sign your acknowledgement below for having received our *Notice of Privacy Practices* and then return this page to our staff.

Thank You!

<u>Patient's acknowledgement of receiving notice of Privacy Practices</u>

I acknowledge that I was provided my personal **copy of my health** care provider's ***Notice of Privacy Practices*** to read **and keep as my own**.

_______________________________ Patient Name (please print)

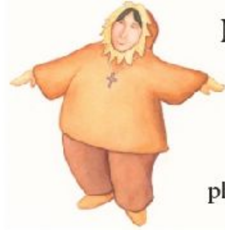
_______________________________________ Signature of Patient (or Responsible Party)

____/____/____ Date

____/____/____ Patient's Date of Birth

____________-_____________-___________ Patient's Social Security Number

Alaska Bariatric Center



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BILLING FORMS

NOTIFICATION OF NON-COVERAGE OR POSSIBLE NON-COVERAGE

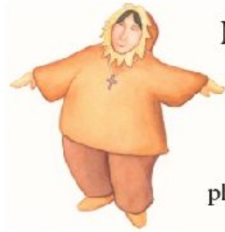
- Telephone Assessment (98966) ex: *Telephone Touchbase*
  - Charge- $55.00
    - Tricare- not covered
    - Medicare- not covered
    - Medicaid- not covered
    - Private- specific to your individual plan
- Medical Nutritional Therapy (97802-97804) ex: *Dietary Evaluation*
  - Charge- $280.00
    - Tricare- not covered as available on base
    - Medicare- ONLY covered if you have Diabetes or Renal Failure
    - Medicaid- ONLY covered if you are under 21 or pregnant
    - Private- specific to your individual plan
- Homocysteine Lab (83090)
  - Charge- $204.00
- Insurance Lifetime Maximum
  - It is possible for a covered procedure to have a lifetime maximum payable amount. In these cases, the patient is responsible for the remaining balance. We encourage patients to verify with their insurance company for coverage and benefits to avoid unforeseen patient expenses.
- Usual and Customary
  - Insurance companies have set allowable amount. If a patient's insurance company is not contracted with our office, the patient is responsible for any difference between insurance allowable and charges accrued.

PLEASE SIGN BELOW AFTER READING THE ABOVE INFORMATION. YOUR SIGNATURE ACKNOWLEDGES THAT YOU ARE AWARE THAT THESE SERVICES MAY OR MAY NOT BE COVERED BY YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT.

Signature: ____ Date:______________

Printed Name: ____

Alaska Bariatric Center



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PATIENT NOTICE OF BILLING PRACTICES

PLEASE READ, INITIAL WHERE INDICATED, AND SIGN BELOW.

Payments for medical services provided by Alaska Bariatric Center is due at the time of service. We accept cash, most credit cards, personal checks, and money orders. Payment i**n full** at time of service is required when:

- You do not have insurance coverage
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A referral or prior authorization was not obtained.
- Any procedures or treatments we believe are not covered by insurance.

Patient responsibility:

(Initial)

____ Insurance coverage is not a guarantee of payment.

____ We will bill your insurance company as a courtesy, if you present your insurance card(s) at the time of your appointment.

____ Any co-payments or "patient responsibility" must be paid at the time of service.

____ Any remaining balance, after all applicable insurance payments have been applied, is due upon receipt of billing statement.

____ **Prior to receiving a surgery date, your account balance must be paid in full.**

____ If payment in full is not received within 90 days from the date of the first statement, your account may be turned over to cornerstone credit services.

____ Cancelled appointments require 24 hours' notice; otherwise they will be subject to a $25 charge.

____ If we do not receive response from your insurance company within 45 days from the date we bill them, then the balance will become **patient responsibility**.

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons may include, but are not limited to:

- Your deductible has not been met.
- You have not received the proper referral or preauthorization for the visit or procedure.
- The services or procedures are not covered by your insurance company. ***We will inform you when we know a treatment/procedure will not be covered. Some insurance policies have exclusions for bariatric surgery. If there is any uncertainty about coverage, we would be happy to provide you with an estimate of your fees prior to treatment. You are responsible for all non-covered services at the time of your visit.***

We may choose to use an independent laboratory. If so, this lab will bill separately for these services. We will provide your insurance information to the lab so that they may file a claim with your carrier. The lab will then bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill. This also applies to any other testing we may order for you that is performed by another provider.

By signing my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them

Signature: ______________________________ Date: ______________

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CANCELLATION AND NO SHOW POLICY

Dear Patient,

If you are unable to keep your scheduled appointment, please call the office before your appointment to reschedule in order to accommodate another patient.

A total of 3 no shows within a 6 month timeframe may result in a discharge as a patient and you will be required to find another Primary Care Physician.

If you are more than 15 minutes late you will be asked to reschedule your appointment.

Thank you for your cooperation.

____
Patient Name (please print)

____
Print Name of Parent/Responsible Party (if applicable)

____
Signature of Patient/Parent/Responsible Party

____/____/____
Date

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MEDICAL HISTORY QUESTIONAIRE

Patient Name: ________________________ **DOB:** ___________

Medications: ________________________________
____
____
____
____

Herbs/Supplements: ________________________
____
____

Medication Allergies (specify reaction)
____
____
____

Surgeries (Please include Date)

Tonsils ____________ Thyroid ____________
Appendix ___________ Hernia _____________
Gallbladder__________ Breast _____________
Stomach ____________ Uterus _ ____________
Kidney _____________ Ovaries_____________
Colon ______________ Prostate_____________
Other:_____________________________________
____
____

Immunization (Indicate what year)

Tetanus _______________________
Measles/Mumps/Rubella _________
Influenza _____________________
Pneumonia (Prevnar) ____________
Pneumonia (Pneumovax) _________
Hepatitis A ___________________
Hepatitis B ___________________
Shingles ______________________
Other: ________________________

Habits

Current smoker (packs/day) _________
Former smoker (date quit) __________
Chew (Times per week) ____________
Alcohol (Drinks per week)___________
Other substance use ________________
Caffeinated beverages (per day)_______
Exercise: Type _____________________
How many minutes per:
Day ______ Week: ______

Preventative Care

Colonoscopy: Year _____
Normal? ☐Yes ☐ No
Pap: Year: _____________
Normal? ☐Yes ☐ No
Mammogram: Year _____
Normal? ☐Yes ☐ No
DEXA scan: Year _______
Normal? ☐Yes ☐ No

Family Health History (Which family member [sibling, parent, or child] **AND** age of diagnosis)

Diabetes ___________________________________ Osteoporosis ________________________________
Heart Disease _______________________________ Colon Cancer________________________________
High blood pressure ___________________________ Breast Cancer________________________________
Obesity_____________________________________ Prostate Cancer______________________________
Gout _______________________________________ Other Cancer ________________________________

Updated on:

Date: __________ Initials: ______ Date: __________ Initials: ______
Date: __________ Initials: ______ Date: __________ Initials: ______
Date: __________ Initials: ______ Date: __________ Initials: ______
Date: __________ Initials: ______ Date: __________ Initials: ______
Date: __________ Initials: ______ Date: __________ Initials: ______
Date: __________ Initials: ______ Date: __________ Initials: ______

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PERSONAL HEALTH HISTORY

General

- ☐ Tire easily/weakness
- ☐ Marked weight changes
- ☐ Night sweats
- ☐ Persistent fever
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Lumps/Masses felt

Neurological

- ☐ Alzheimer's Dementia
- ☐ Seizures or Epilepsy
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis

Skin

- ☐ Acne
- ☐ Cold sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Skin cancer or pre-caner

Mental Health

- ☐ Anxiety
- ☐ Depression
- ☐ Addiction to drugs
- ☐ Alcoholism
- ☐ Insomnia

Eye, Ear, Nose, & Throat

- ☐ Visual impairment
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Sinusitis, frequent
- ☐ Ear infections, frequent

Kidney

- ☐ Kidney failure
- ☐ Kidney stones

Lung and Respiratory

- ☐ Asthma
- ☐ Sleep apnea
- ☐ Emphysema (COPD)
- ☐ Tuberculosis or positive PPD
- ☐ Chronic cough

Allergy, Immune

- ☐ Seasonal or environmental allergies
- ☐ Other non-medication allergies Specify: ___________________
- ☐ Anaphylaxis
- ☐ Urticaria (hives), frequent

Heart and Vascular

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Angina (cardiac chest pain)
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Atrial fibrillation
- ☐ Congestive heart failure

Endocrine

- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Thyroid disorder
- ☐ Vitamin D deficiency
- ☐ Long term steroid treatment

Gastrointestinal

- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Colon polyps
- ☐ Hemorrhoids
- ☐ Hepatitis (type) ___
- ☐ Irritable bowel syndrome
- ☐ Reflux disease (GERD)
- ☐ Ulcers (Stomach or Duodenal)

Genitourinary, STD, Reproductive

- ☐ Genital herpes
- ☐ Genital warts
- ☐ HIV/AIDS
- ☐ Prior Chlamydia or Gonorrhea
- ☐ Syphilis
- ☐ Infertility
- ☐ Erectile dysfunction
- ☐ Prostate enlargement (BPH)
- ☐ Endometriosis
- ☐ Menopause (age) ____
- ☐ Urinary tract infections, frequent
- ☐ Urinary incontinence
- ☐ Vaginal yeast or infections, frequent

Number of pregnancies ______
Number of live births ________
Miscarriages/abortions _______
Current method of birth control
____

Musculoskeletal

- ☐ Back pain
- ☐ Gout
- ☐ Neck Pain
- ☐ Osteoarthritis (specify locations) ___________________________
- ☐ Rheumatoid arthritis

Cancers and Blood

- ☐ Anemia (low blood count)
- ☐ Blood clots (specify location) ___________________________
- ☐ Cancer (specify type) ___________________________
- ☐ Blood transfusion

Other Illness or Significant Injuries
____
____
____