**Beltline Bariatric and Surgical Group, LLC**

Charles D. Procter Jr., MD, FACS, FASMBS

| PATIENT INFORMATION | | |
|---|---|---|
| FULL NAME | First M.I. Last | |
| DATE OF BIRTH | M / D / Y | AGE: |
| SOCIAL SECURITY # | | SEX: MALE or FEMALE |
| STREET ADDRESS | | APT/SUITE #: |
| CITY, STATE, ZIP | City State Zip | |
| MARITAL STATUS | Circle One: SINGLE or MARRIED or WIDOWED | |

| CONTACT INFORMATION | | |
|---|---|---|
| HOME # | | |
| MOBILE # | | |
| WORK # | | |
| EMAIL ADDRESS | | |
| EMERGENCY CONTACT NAME | | PHONE #: |
| RESPONSIBLE PARTY IF MINOR | | RELATIONSHIP: |

| REFERRING DOCTORS | | |
|---|---|---|
| 1. REFERRING DOCTOR NAME | | PHONE # |
| ADDRESS | | |
| 2. PRIMARY CARE DOCTOR | | PHONE # |
| ADDRESS | | |

| PHARMACY INFORMATION | | |
|---|---|---|
| NAME | | PHONE # |

**Beltline Bariatric and Surgical Group, LLC**

| ADDRESS | |
|---|---|



Name_________________________________ Birth Date ____________________ Today's Date _________________

Reason for visit ________________________________________________________________________________

If you have any of the following medical problems with or without surgery please check and describe below:

___Lung trouble/ Emphysema ___Anemia ___Allergies

___Asthma ___Bleeding Disorder ___Penicillin

___High Blood Pressure ___Blood clots ___Novocain

___Heart Attack/Angina ___Diabetes ___Iodine Dye

___Liver Trouble/ Cirrhosis ___Arthritis ___Sulfa

___Stomach Ulcers ___Gout ___Latex (rubber)

___Kidney Trouble ___Cancer ___Tape

___Hernia ___Epilepsy/Seizures ___Others

___HIV/ AIDS ___Thyroid Trouble ___No known Drug Allergies

___Other – explain below

Do you smoke? ☐ YES ☐ NO How often: _______________ How many years: _________

Drink alcohol? ☐ YES NO ☐ How often: _______________

Have you ever had a colonoscopy? YES ☐ NO ☐ How long ago? ________________________

# Beltline Bariatric and Surgical Group, LLC

**Medical problems:**

____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________

**Previous Surgery with dates:**

____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________

## MEDICATIONS - DOSAGE/HOW OFTEN

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

☐ **NO MEDICATIONS**

## REVIEW OF SYMPTOMS

Please circle any current symptoms you may have:

**CONSTITUTIONAL:**
Recent fevers/ sweats
Unexplained weight loss/ pain
Unexplained fatigue/ weakness

**Eyes:**
Change in vision

**EARS/NOSE/THROAT/MOUTH:**
Difficulty hearing/ ringing in ears
Hay fever/ allergies/ congestion
Trouble swallowing

**CARDIOVASCULAR:**
Chest pains/discomfort
Palpitations
Short of breath with exertion

**BREAST:**
Breast lump
Nipple discharge

**RESPIRATORY:**
Cough wheeze
Coughing up blood

**GASTROINTESTINAL:**
Heartburn/ reflux
Blood/change in bowel movement
Nausea/ vomiting/ diarrhea

**GENITOURINARY:**
Pain full/bloody urination
Leaking urine
Night time urination
Discharge: penis or vaginal
Unusual vaginal bleeding
Concern with sexual functions

**MUSCULOSKELETAL:**
Muscle/joint pain
Recent back pain

**SKIN:**
Rash
New or change in mole

**NEUROLOGICAL:**
Headaches
Memory Loss
Fainting
PSYCHIATRIC
Anxiety/Stress
Sleep problems

**BLOOD/ LYMPHATIC:**
Unexplained lumps
Easy Bruising/ Bleeding
Varicose veins/Spider veins

**ENDO:**
Cold/ Heat intolerance
Increase thirst/appetite

## FAMILY HISTORY

Please indicate the family member & their current status. (i.e. parent, grandparent, sibling, etc.)

| Alcoholism: | High Cholesterol: | Cancer (Specify type): |
|---|---|---|
| High Blood Pressure: | Stroke: | Heart Disease: |
| Depression/Suicide: | Bleeding/Clotting Disorder: | Genetic Disorder: |
| Asthma/COPD: | Diabetes: | Other: |



## Beltline Bariatric and Surgical Group Financial Policy

Our staff is concerned with the costs associated with your healthcare and wish to address current issues related to medical services provided in our office setting. Considerable care has been taken in the establishment of our fee schedule and we want to assure you our charges accurately reflect the complexity of care rendered along with the skill and expertise required in providing quality care to you.

# Beltline Bariatric and Surgical Group, LLC

Items listed below are not covered by your insurance carrier and will be priced accordingly when the request is received by our office:

- All services will be filed with your insurance carrier with the exception of records request, FMLA or other associated paperwork, cancellation notices and returned check fees. Any medical service(s) not covered by your insurance plan will become your financial responsibility.
- Payment for services are due and payable with each visit. Deductible, co-payments, and co-insurance payments are due and payable at the time of service. If you are unable to provide payment of items deemed your financial responsibility, your appointment will be rescheduled for a later date and time.
- If you have an HMO plan, it is your responsibility to ensure you have the appropriate referral from your primary care physician. If you do not have the appropriate referral and our office must obtain one, a fee of $25.00 will be applied to your account.
- Returned checks will result in a $30.00 fee applied to your account.
- **A 24 hour cancellation notice is required for office visits**. If you are unable to make your scheduled appointment and do not provide a 24 hour notice to cancel, a $30.00 fee will be applied to your account.
- A request for medical records must be made in writing to our office. Upon receiving the request, our office will process the records request within a 72 hour period. The fee for Medical Records is $15.00 and is due and payable at the time of the request.
- Requests for the completion of the medical documents such as Disability leave, Cancer, Life or other health insurance forms, Employment exams, School physicals exams, Family Medical Leave (FMLA) or other documents required by a third party other than your insurance carrier will have a $25.00 fee due at the time of request for said documents. Upon receiving the request our office will process the records request within a 72 hour period.

We encourage you to contact your benefits coordinator through your employer or contact your insurance carrier directly to verify your own benefits, eligibility, and other services that may or may not be covered. Whether you have insurance coverage or not, the ultimate responsible party for services provided by our office staff and physicians will be you.

I, ____________________________________________, have read and understand my financial responsibilities as explained in this Financial Policy.

_______________________________________________      ______________________

**Patient Signature**      **Date**

# Surgery Cancellation Policy for Piedmont Atlanta Hospital, Piedmont Newnan Hospital and Buckhead Surgery Center

A time has specifically been reserved for your scheduled surgical procedure whether at Piedmont Atlanta Hospital, Piedmont Newnan Hospital or the Buckhead Surgery Center. A cancellation policy is in place with regards to your surgical procedure which is designed out of respect for you, other patients and our surgeons.

If you are unable to keep your surgical procedure at the specific date and time you have scheduled, a **48 hour** cancellation notice is required.

****If proper notification is not received, a $150.00 fee will be applied to your account****

By signing below, you acknowledge you have read and understand the cancellation policy for Beltline Bariatric and Surgical Group, LLC as described above, and have had the opportunity to ask questions pertaining to this cancellation policy. This form applies once surgery is scheduled.

______________________________________________________________

**PATIENT SIGNATURE**

______________________________________________________________

**PRINTED NAME**

_________________________________

**DATE**

## SURGICAL ASSISTANT SERVICE – PATIENT DISCLOSURE FORM

Your surgeon may request or require the services of a Surgical Assistant for your upcoming surgical procedure. There will be a separate fee for these services. The fee for the Surgical Assistant **IS NOT** included in or a part of the Surgeon's fee or hospital charges.

Even though your Surgeon may determine that a Surgical Assistant is medically necessary for your procedure, your ***insurance may not cove*r** the Surgical Assistant services or may consider the Surgical Assistant to be a non-participating, out of network, non-contracted or non-recognized provider.

The Surgical Assistant will file their claim separately from that of the surgeon and facility with your insurance. **If your insurance denies benefits** for services rendered by the Surgical Assistant you will be financially responsible for a payment of $350.00. The Surgical Assistant will bill this amount directly to you. It will be payable in full within 30 days of the invoice date. Failure to pay this patient contractually agreed amount may result in penalties and late charges.

Regarding the above, and all other information contained on this form, I (the undersigned) acknowledge, understand, and agree as follows:

- **_______ (Patient Initials)** I authorize the payment of insurance benefits be made on my behalf to the Surgical Assistant for any surgical Assistant Services rendered to me. Prior to disbursing payment for Surgical Assistant Services, my insurance may require documentation from my medical records in order to process claims and approve payments. I hereby authorize any and all such releases of my protected personal medical records.

- **_______ (Patient initials)** My insurance **may not cover** Surgical Assistant Services. I am personally and fully responsible for such services that are non-covered, deemed medically not necessary and/or denied by my insurance, as well as for any and all applicable health insurance deductibles, co-pays and co-insurance payments. I assume full financial responsibility for any balance for Surgical Assistant Services that my insurance does not pay.

- **_______ (Patient initials)** I have been informed and fully understand that if my insurance plan does not allow for benefits to be paid for a Surgical Assistant Service, I will be solely responsible for the Surgical Assistant professional charge of $350.00 for the associated procedure and date of service.

- **_______ (Patient initials)** I am the patient who will receive surgery (or such patient's legal and/or personal representative). I have read and understand the Surgical Assistant Service – Patient Disclosure Form and all information contained herein. I have had full opportunity to ask any questions I may have had regarding this form and any such information contained within. All such questions (if any) have been answered to my complete and full satisfaction.

**Patient (or Legal Representative):**

**Signature**: ________________________________________________ Relationship to Patient: ________________

**Print Name**: _______________________________________________ **Date**: ______________________________

## Beltline Bariatric and Surgical Group

### AUTHORZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION: Page 1

I hereby authorize the use or disclosure of my individuality identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization/persons authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I authorize Beltline Bariatric and Surgical Group, LLC to disclose the following information from the medical records of:

***Patient Name**: ____________________________________________________________________

*__Date of Birth__: ________________________ ***Telephone**: ________________________________

***Address**:_________________________________________________________________________

**Information to be disclosed:**

____Complete health record(s), including all images (x-rays, photographs, etc.)

____Complete health record(s), excluding all images

**OR**

**Select from the following (check as many as apply):**

____History & Physical Examination

____Consultation Reports

____Progress Notes

____Follow-up Office Visit Reports

____Mental Health care or services

____Laboratory Tests

____X-Ray Reports

____Treatment for Alcohol and/or Drug Abuse

____AIDS or HIV infection

____Photographs, video tapes, digital image

### This information is to be disclosed to the following entities or individual(s):

(Medical records may be released to entities such as doctors, family members, etc.)

***Name**: __________________________________ *__Relationship__: _____________________________

Address: ______________________________________________*__Phone__: ________________________

***Name**: __________________________________ *__Relationship__: _____________________________

Address: ______________________________________________*__Phone__: ________________________

***Name**: __________________________________ *__Relationship__: _____________________________

Address: ______________________________________________*__Phone__: ________________________

## AUTHORZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION: Page 2

The patient or the patient's representative must read and initial the following statements:

A. I understand that unless earlier revoked, this authorization will expire on date: ____________________ or on the event of____________________________________________

*Initials*: ____________________

B. I understand that I may revoke this authorization at any time by notifying Beltline Bariatric and Surgical Group, LLC in writing. If I do it won't have any effect on any actions Beltline Bariatric and Surgical Group, LLC took before it received the revocation.

*Initials*: ____________________

C. I understand that Beltline Bariatric and Surgical Group, LLC cannot make me sign this authorization as a condition to receive treatment, provide me with research-related treatment, or provide me with health care solely for the purpose of creating protected health information for disclosure to someone else.

*Initials*: ____________________

Beltline Bariatric and Surgical Group LLC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

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____________________________________________ ***Signature of Patient or Representative**

____________________________________________

***Print Name**

______________________________

***Date**