BELTLINE BARIATRIC AND SURGICAL GROUP, LLC

PATIENT INFORMATION			
FULL NAME: First	M.I.	Last	
DATE OF BIRTH: M / D / Y			**SEX:** ☐ MALE ☐ FEMALE
SOCIAL SECURITY #:			
STREET ADDRESS:			**APT/SUITE #:**
CITY, STATE, ZIP: City	State	Zip	
PRIMARY INSURANCE:		**POLICY ID #:**	
SECONDARY INSURANCE:		**POLICY ID #:**	

CONTACT INFORMATION	
• Please **check the boxes** for the ways you authorize us to leave medical information and/or correspondence. (voicemails, surgery instructions, patient portal access, appointment reminders, prescriptions notice, billing, etc.)	
☐ **MOBILE PHONE #:**	☐ HOME PHONE #:
☐ **EMAIL ADDRESS:** *(Please note: if you do not check this box, you will not have access to your patient portal.)*	
☐ **EMERGENCY CONTACT & RELATIONSHIP:** *(Checking this box, authorizes he/she to also speak on your behalf.)*	**PHONE #:**

REFERRAL INFORMATION					
HOW DID YOU HEAR ABOUT US?					
☐ Google	☐ Friend	☐ Referring Doctor	☐ TLC TV Series	☐ Social Media	☐ TV Commercial
REFERRING DOCTOR:				PHONE #:	
PRACTICE NAME/ADDRESS:				FAX #:	
PRIMARY CARE DOCTOR:				PHONE #:	
PRACTICE NAME/ADDRESS:				FAX #:	

PHARMACY INFORMATION	
NAME:	**PHONE #:**
ADDRESS:	

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I've been offered a copy of the Privacy Practices Policy of Beltline Bariatric and Surgical Group.

☐ **I accept** a copy of the policy ☐ **I decline** a copy of the policy

_____ _____ _____

***PATIENT SIGNATURE** ***PRINTED NAME** ***DATE**

MEDICAL HISTORY

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:

PERSONAL & FAMILY MEDICAL CONDITIONS					
	SELF	FATHER	MOTHER	G.FATHER	G.MOTHER
NO CONDITIONS	☐				
Diabetes	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Abdominal Pain	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Fatty Liver	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐
GERD	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Hernia	☐	Type: ☐ Abdominal ☐ Umbilical ☐ Hiatal			
Other: _____ _____ _____					

ALLERGIES	
NO ALLERGIES	☐
Penicillin	☐
Lidocaine	☐
Iodine Dye	☐
Sulfa	☐
Latex (rubber)	☐
Tape	☐
Codeine	☐
Other: _____	

OTHER MEDICAL HISTORY		
Do you smoke?	☐ Yes ☐ No	How Often? How Many Years?
	☐ Quit	When?
Do you drink alcohol?	☐ Yes ☐ No	How Often?
	☐ Quit	When?
Are you on dialysis?	☐ Yes ☐ No	How Often? ☐ M ☐ T ☐ W ☐ R ☐ F
Are you an LVAD patient?	☐ Yes ☐ No	

Name: _____ Birth Date _____ Today's Date _____

MEDICATIONS: DOSAGE/HOW OFTEN	
□ **See Attached (Separate sheet provided)**	□ **NO MEDICATIONS**

PREVIOUS SURGERIES/PROCEDURES		
Bariatric Surgery?	□ Yes □ No	When?
Gallbladder Surgery?	□ Yes □ No	When?
EGD (Upper Endoscopy)?	□ Yes □ No	When?
Colonoscopy?	□ Yes □ No	When?
Other:		
Other:		

SLEEP STUDY QUESTIONNAIRE

QUESTIONNAIRE REQUIRED IF YOU ARE CONSIDERING BARIATRIC SURGERY

If you answered YES to 2 or more questions on the STOP portion, you are at risk for Obstructive Sleep Apnea (OSA). The more questions you answer YES to on the BANG portion, the greater your risk of have moderate to severe OSA. It is recommended that you consult with a board-certified sleep physician for further evaluation.

S	Have you been told you snore? *(excessive snoring)*	□ Yes □ No
T	Are you abnormally tired during the day? *(excessive daytime fatigue)*	□ Yes □ No
O	Do you know if you stop breathing or has anybody witnessed you stop breathing while asleep?	□ Yes □ No
P	Do you have high blood pressure or are on medication to control high blood pressure?	□ Yes □ No
B	Is your body mass index greater than 28?	□ Yes □ No
A	Are you 50 years old or older?	□ Yes □ No
N	Is your neck circumference greater than… (male) 17 inches, or (female) 16 inches?	□ Yes □ No
G	Are you a male?	□ Yes □ No

THIS PORTION WILL BE SIGNED AT YOUR CONSULTATION WITH THE PHYSICIAN.
YOU MAY DECLINE IF YOU ARE CURRENTLY UNDER TREATMENT FOR OBSTRUCTIVE SLEEP APNEA.

□ **I decline** to have a Sleep Study performed. I understand the risk of not having this test done prior to having my bariatric procedure.

□ **I consent** to have a Sleep Study performed.

_____ _____ _____

***PATIENT SIGNATURE** ***PRINTED NAME** ***DATE**

FINANCIAL POLICY

Our staff is concerned with the costs associated with your healthcare and considerable care has been taken in the establishment of our fee schedule. We assure you our charges accurately reflect the complexity of care rendered.

OFFICE FEES			
	SERVICE/CHARGE	**FEE**	**REQUIREMENTS**
	FMLA / Disability Paperwork / Documents required by a third party	$25.00 (initial) $15.00 (additional)	• Due at the time of the request • Processing Time: 3-7 business days
	Medical Records Request	$15.00	• Due at the time of the request • Process time: 3-7 business days. • Request must be made in writing
	Office Visit Late Cancellation Policy	$30.00	• **24-Business Hours Notice Required** • Due before rescheduling
Initial	**Surgery Late Cancellation Policy (General Surgery)**	$150.00	• **7-Day Notice Required** • Due before rescheduling • Hernia, Gallbladder, Endoscopy, etc.
	Surgery Late Cancellation Policy (Bariatric Surgery)	$400.00	• **14-Day Notice Required** • Due before rescheduling • Sleeve, Bypass, Duodenal Switch, Revision, etc.
	Returned Check	$12.00	• Due before the next appointment.

PAYMENTS & CLAIMS	
	• All services will be filed with your insurance carrier except for the above listed services/charges. • Medical services not covered by your insurance plan will become your financial responsibility. • Required referrals that are not received prior to your visit will become your financial responsibility.
	• Payment for all office appointments are due at the time of service. • Failure to pay at the time of service will require that your appointment is rescheduled for a later date.
Initial	• ***Verification of your benefits and preauthorization of your surgery is not a guarantee of payment.*** • If your insurance denies your preauthorization or claim, it will become your financial responsibility. • ***We encourage you contact your insurance to obtain benefits, eligibility, and exclusions on your policy.***
	• Surgery estimates provided by our office are ***solely for the physician's fee***. • ***Hospital and other fees are separate*** and are only provided by the hospital financial department.

SURGICAL ASSISTANT SERVICE	
	• All surgeries require an Assistant to ensure quality care and a safe operation. Endoscopies are excluded.
	• The Surgical Assistant fee IS NOT included in or a part of the Surgeon's fee or hospital charges. • Your ***insurance may not cover*** this service and, if denied, it will become your financial responsibility. • The Surgical Assistant fee can range from $250 - $450.
Initial	• ***Medicare does not cover*** surgical assistant services.
	• You authorize release of your protected personal medical records to process claims for this service.
	• If received, you agree to deposit your insurance check (paid to you for this service) into your account and pay Beltline Bariatric and Surgical Group for the same amount that the insurance check was for.

_____ _____ _____

***PATIENT SIGNATURE** ***PRINTED NAME** ***DATE**

AUTHORZATION FOR RELEASE OF MEDICAL RECORDS

Name: _____ Birth Date _____ Today's Date _____

I authorize Beltline Bariatric and Surgical Group to disclose my medical records to the authorized individuals:

DISCLOSURE TERMS	
□ **RELEASE** □ **DECLINE**	DATES OF SERVICE: _____/_____/_____ to _____/_____/_____

AUTHORIZED PHYSICIANS				
1	**NAME**			
	PHONE #		FAX #	
	ADDRESS			
2	**NAME**			
	PHONE #		FAX #	
	ADDRESS			

AUTHORIZED FAMILY / FRIENDS / ETC.				
1	**NAME**		**RELATIONSHIP**	
	ADDRESS		PHONE #	
2	**NAME**		**RELATIONSHIP**	
	ADDRESS		PHONE #	

I understand that I have a right to revoke this authorization at any time in writing. I understand that this authorization is voluntary, and that I do not need to sign this form in order to receive treatment. 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.

_____ _____ _____

***PATIENT SIGNATURE** ***PRINTED NAME** ***DATE**

MEDIA RELEASE

U.S. Federal law guarantees a patient's right to maintain privacy of medical information.
Photographs are required as part of the patient's chart for the medical management of the patient.

I authorize Beltline Bariatric and Surgical Group to use my photographs/videos on the following marked platforms:

☐ I DECLINE ALL PLATFORMS *(excludes the patient's chart)*	☐ PRIVATE FACEBOOK GROUP	☐ GENERAL SOCIAL MEDIA
	☐ TV ADVERTISEMENT	☐ PRINT MARKETING

_____ _____ _____

***PATIENT SIGNATURE** ***PRINTED NAME** ***DATE**