Bariatric Surgery Patient Information

The following information is very important to your health. Please take time to fully and completely fill out this important information. Thank You.

Name _____ Age _____ Date _____

Height _____ Weight _____ BMI (optional) _____

Most recent weight-loss programs (diets, exercise, or other)

_____

_____

_____

Other weight-loss programs you have tried

_____

_____

_____

Please check medical problems you have or have had:

_____ High blood pressure
_____ Diabetes
_____ High Cholesterol
_____ Arthritis (joint pain) in hip, knee, ankles, feet
_____ Lower back pain
_____ Sleep apnea (difficulties breathing at night)
_____ Gastroesophageal Reflux Disease (GERD)
_____ Depression
_____ Swelling or blood clots in legs
_____ Menstrual Irregularities
_____ Infertility
_____ Urinary Incontinence (leaking of urine when coughing, sneezing, laughing)
_____ Cancer; if yes, which type? _____
_____ Heart problems; which type? _____
_____ Liver problems
_____ Asthma
_____ Glaucoma
_____ Other medical conditions, please list: _____

_____

Do you smoke? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Illicit drug use? _____

_____

Patient's Signature

The above is true and correct to the best of my belief.

Notice of Privacy Practices Acknowledgment

BMI Surgery, S.C.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

BMI Surgery, S.C.

Consent Form

I give permission for BMI Surgery, S.C. to: (please initial each line)

_____ Access my pharmacy benefits data through eRx system. This consent will enable BMI Surgery, S.C. to obtain formulary information, and information about other prescriptions prescribed by other providers using an eRx system.

_____ To contact me by email, text messages, phone, or patient portal, regarding upcoming meetings, appointment reminders, changes in the office, products for sale, or general messages. Test results or private medical information will never be sent via email or text. We encourage each patient to access the patient portal for medical information or upload personal documents.

Please list the information below to receive calls and messages:

Cell Phone number: _____

Home Phone Number: _____

Email Address: _____

_____

Patient Name: (Print)

_____ _____

Patient Signature Date

BMI Surgery, S.C.

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. **DISCLAIMER:** A Quote of Benefits from your insurance is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization

in writing at any time. A photocopy of this Assignment/Authorization shall be as effective and

valid as the original.

_____ _____

Patient Date

BMI Surgery, S.C.

Your Financial Responsibility

1. A pre-payment may be due at the time of your pre-surgical class based upon your insurance benefits (deductible and out-of-pocket expenses). This payment is **only an estimate** for the charges that will be billed to your insurance by BMI Surgery. You may receive an additional bill for any charges not covered in full after your insurance has processed your claims.

2. You will also be responsible for a program fee of **$400.00 due** at the time of your pre-surgical class. If you do not have the money **at your pre-surgical class,** we will reschedule your surgery.

3. **Any outstanding balance** must also be paid at the time of your pre-surgical class, or we will reschedule your surgery until the balance is paid.

4. Co-Payments are due on the day of your appointment no exceptions.

5. There is a **$10.00 fee** (per form) due for the completion of any FMLA and/or short-term disability forms that need to be completed before your surgery. This fee must be paid before the forms are submitted. Please allow 7- 10 days for completion of these forms.

You may also be responsible for any Hospital Charges and/or other Physician's charges that we **do not** bill: Should you have a question regarding an outstanding bill from Silver Cross Hospital, Allied Anesthesia, or any other facility or provider that is not associated with BMI Surgery, you will need to contact that organization directly. Please note: BMI Surgery has no control over how other facilities or providers bill for their services. (Not limited to the following)

Hospital testing, imaging, or labs
Hospitalist during your hospital stay
Psychiatrist Visits
Pulmonologist Visits and testing (sleep study, etc.)
Cardiologist Visits and testing (EKG, stress test, etc.)
Radiologist Fees or Pathologist Fees

Should you have any questions regarding your bill with BMI Surgery, please call us at 815-717-8744.

Please sign below that you agree and understand the above charges regarding your surgery and that all your questions regarding the above information have been addressed to your satisfaction.

_____ _____

Signature of Patient Date

BMI Surgery, SC
Office Policies

We would like to thank you for choosing one our physicians as your medical provider. As your provider we would like to keep you informed of our current office policies. Please take a moment to read and sign this document.

Appointments: If you are unable to attend an appointment, we require that you **notify us at least 24** hours in advance. **Late cancellations** (less than 24 hours notice) will be considered as a "no-show". There will be a charge for "no-show" and missed appointments. Two missed appointments there will be a $10.00 fee. Three missed and any subsequent appointments there will be a $25.00 fee per missed or "no-show" appointments.

To cancel or reschedule an appointment, please call our office at 815-717-8744. If you do not reach the receptionist you may leave a detailed message in our general mail box, with our answering service or email us at office@bmisurgery.org or through the patient portal.

Please note that on occasion our physicians may need to deal with an emergency or be out of the office that may cause a delay or require us to reschedule your appointment. We will do our best to keep you informed and reschedule another appointment that will be convenient for you.

Office Hours: Our office hours are Monday through Friday 8:00 am to 4:30pm.

After Hours & Weekends: Our physicians are available after hours for medical calls. Please call our office number to leave a message and one of our providers will call you back. If having a medical emergency call 911.

Prescription refills: Please ask your pharmacy to fax a refill request to our office at 815-717-8339. please allow at least 2 days for refill requests.

Demographic Information: Please notify our office of any changes to your demographic information; change in mailing address, phone numbers, email, etc. It is important that we have this information so that we may contact you regarding any medical issues.

Medical Records: We will provide you a copy of your medical records upon request per HIPAA guidelines. You will need to sign a letter of release. There may be a fee for copies of your medical records, which needs to be paid prior to receiving your records. Copies of records our released in .pdf or electronic format only.

By signing below the patient understands and agrees to the above policies.

_____ _____

Signature of Patient, Guardian or Representative Date Signed

BMI Surgery S.C.

Refund Policy for Purchased Products

As part of the Bariatric Program there are items that may not be covered by your health insurance. These items include, but are not limited to the following:

Bariatric Vitamins and Protein Supplements
Program Fee (list of items is available upon request)
Garmin products
Books, shaker bottle, etc.

Since most insurance plans do not cover these services/items, payment will be do at the time of service. We **will not** submit a claim to your insurance. We will, however, give you a copy of the receipt should you wish to submit this to your insurance, HSA, or Flex Benefit Plan for reimbursement. Letters are provided upon request.

Refunds will be given for products (vitamins, protein powder, etc.) only if they are **returned within 60 days of receipt,** the seal on the item has not been broken or tampered with, and the product is in its original packaging and has not been opened.

We **will not accept** or refund for any products that have been opened or used. We encourage you to purchase samples of our protein as every one's taste may vary.

A refund or partial refund will be given for the program fee, only if your surgery is cancelled and all items have been returned in their original condition and unused. Refunds will be issued only if you have a zero balance on your account.

Signing below means that you have received and understand this notice. You may also request a copy for your records.

_____ _____

Signature of Patient, Guardian or Representative Date

BMI Surgery, S.C.

Collection Policy

Our office is committed to providing you the best possible medical care and working with you to avoid financial barriers to your care. As a courtesy, we will make you aware of your insurance benefits. You will need to pay the following at the time of your appointment.

- Office co-payments
- Non-covered services or products not paid by your insurance
- Balances determined to be your monetary responsibility

For you to receive the maximum benefits of your insurance, we will need a copy of **all** your insurance cards. Please provide a copy of the front and back of your insurance card, at least **10 days** prior to your appointment so we may verify your benefits. You may fax a copy to 815-717-8339 or email us at office@bmisurgery.org.

If we are unable to verify coverage, obtain authorization or a referral, prior to your appointment, you will be responsible for the self-pay fee at the time of service.

Any balances not covered by your insurance will be your responsibility. You will be notified when you have an outstanding balance either electronically through your patient portal, by phone, email, or regular mail. Payments can be made on website at www.bmisurgery.org on the home page scroll down and click on "Pay Online" or you may call our office during regular business hours at 815-717-8744.

Unpaid Accounts over 60 days: Should collection proceedings or other action become necessary to collect an overdue account, the patient understands that the provider has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient understands that he/she is responsible for all costs of collection including, but not limited to, all court costs, Attorney's fees, **and a collection fee at a minimum of 35% which will be added to any outstanding balance.** Unresolved collection balances with an outside collection agency maybe reported to the credit bureau.

We encourage you to keep an active credit/debit card on file so that your balance is paid on time. It is also your responsibility to inform us of any changes in insurance and mailing address.

Signing below means that you have received and understand this notice. You may also request a copy of this notice for your records.

_____ _____

Signature of Patient, Guardian or Representative Date Signed

BMI Surgery S.C.
Credit/Debit Card Information
For Current and/or Future Balances and/or to Set-up Payment Plans

In order to keep health care cost down and prevent future collections issues regarding your account, we are requesting that all of our patients complete this form.

I Authorize BMI Surgery, S.C. to keep my signature on file and to charge my credit/debit card account as indicated below:

☐ **Balance of charges not paid by insurance within 60 days and/or not to exceed $_____ unless notified by BMI Surgery.**

☐ **(Use this option for monthly payment plans) Recurring Charge of $_____ every**

_____ (# of days or monthly) from _____ to _____ (time period for withdraw – if not specified will be until balance is paid in full.

I understand that I have the option to cancel this authorization at any time in writing. However, I am still responsible for any outstanding balance still on my account.

I also understand that I need to notify this office of any changes regarding my credit/debit card information in order to continue the processing of future payments.

If payment is denied by my credit card company for whatever reason, or I fail to notify this office of any changes, or fail to make payments, **my outstanding balance will be referred to an outside collection agency.**

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel this authorization through written notice to the healthcare provider.

Please Complete: (Please Print)

Cardholder Name: _____

Card Number: _____

Expiration date: Month: _____ Year: _____ SVC code: _____

Address associated with this card if different than Patient's Address: _____

_____

City: _____, State: _____, Zip Code: _____

Cardholder Signature: _____ Date: _____

Our office is fully approved and accredited user of Authorize Net which will enable you to use your credit card to automatically cover amounts not paid by your insurance. All credit card information will be securely stored in the Authorize Net system and will not be accessible to unauthorized users and will be securely blocked-out once the information is entered into this system.