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.

BMI SURGERY, SC

PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. (Print your name) "Physician" shall be understood to mean Christopher Joyce, M.D., or Dr. Brian E. Lahmann, M.D. and BMI Surgery, S.C.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Surgery and/or American Society of Metabolic and Bariatric Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____

Physician Patient/Guardian

_____ _____

Effective from Date of Treatment: Date of Signature

BMI Surgery, S.C.

EMAIL CONSENT FORM

_____

Patient Name

_____

Patient e-mail address

Please note that in this document BMI Surgery refers to Providers, office and nursing staff employed by BMI Surgery.

1. RISK OF USING E-MAIL

BMI Surgery offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail however has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an email.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

BMI surgery will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks as set out in section 1, BMI Surgery cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by BMI Surgery's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
b. BMI Surgery may forward e-mails internally to providers and/or staff necessary for diagnosis, treatment, reimbursement, and other handling. BMI Surgery will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although BMI Surgery's staff will endeavor to read and respond promptly to an e-mail from the patient, BMI surgery cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. **Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.**
d. If the patient's e-mail requires or invites a response from BMI surgery, and the patient has not received a response within a reasonable time period, it is the

patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing BMI Surgery's staff of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. BMI Surgery is not liable for breaches of confidentiality caused by the patient or any third party.
h. BMI Surgery shall not engage in e-mail communication that is unlawful, such an unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Inform BMI surgery of changes in his/her email address.
b. Put the patient's name in the body of the e-mail.
c. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing question).
d. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to BMI Surgery.
e. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
f. May withdraw consent only by e-mail or written communication to BMI Surgery.

4. PATIENT PORTAL

BMI Surgery has established a patient portal that will allows their patients secure access to review their medical records, send secure emails to BMI Surgery, review and make changes to patient demographic information, request appointments, print of forms and etc. We encourage our patients to communication through the patient portal verses standard email as this is the best way to make sure that your questions and information is secure. However, you are always welcome to email us directly. We will periodically send out emails to our patients informing them of upcoming meetings, changes in the office or products available for sale. We will never share your email with any other person outside this office without your consent.

5. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent for. I understand the risks associated with the communication of e-mail between BMI Surgery and myself, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that BMI Surgery may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Signature _____

Date _____

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.

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for BMI Surgery, S.C. to access my pharmacy benefits data through eRx system. This consent will enable BMI Surgery, S.C. to:

- Determine the pharmacy benefits and drug co-pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to local and Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using an eRx system.

_____

Patient Name: (Print)

_____ _____

Patient Signature Date

BMI Surgery, S.C.

AUTHORIZATION

Permission to Receive Prerecorded Messages and/or Text Messages and/or Email Messages

As a service to our patients, we provide courtesy appointment reminder calls and when we can text and/or email messages. We also may place other important calls, send text and email messages using a prerecorded or automated message service. In order to authorize receiving the calls, text and email messages, please fill out the information below and provide the phone number and/or email where you wish to receive these messages.

Important note: By providing your **cell phone number** below, you consent to receiving appointment reminder calls, important calls and/or text messages on your cell phone. If you would like us to utilize a different number, please provide that number below *instead of* your cell phone number.

This authorization permits us to leave messages, call or text you on the phone number or email that you provide below. If you provide your cell phone number, you will receive automated or prerecorded messages on your cell phone. We are required by law to advise you of this.

If you do not wish to receive courtesy reminder calls, text messages or other important calls and/or emails, please print your name and mark the box that states this.

☐ I **do not** wish to receive prerecorded and/or text and/or email messages

Patient Name _____

Patient Signature _____ Date: _____

Phone number authorized by Patient to receive calls and messages as set forth above:

Cell Phone Number: _____

Home Number: _____

Email address: _____ (please print)

BMI Surgery, S.C.
Christopher D. Joyce, M.D. & Brian E. Lahmann, M.D.

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.

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.

Payments Due Prior to Surgery

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 current outstanding balance must also be paid at the time of your pre-surgical class. Co-Payments are due at on the day of your appointment no exceptions.

4. 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
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 of 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 and cannot wait for a call back, dial 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.

HIPAA: Our office cares about your privacy. Everyone is required to sign a HIPAA agreement form. Please inform our office if there is anyone who should or should not have access to your records other than yourself or your spouse (i.e. parents, friend, etc).

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

Insurance: You are responsible for any co-pays, co-insurance, deductibles or non-covered services not paid by your insurance. Any patient balance is due upon receipt of a statement and/or at the time of service.

- **HMO Plans**: Please be ware that if you have an HMO plan it is **your responsibility to obtain a referral from your Primary Care Physician** prior to your visit. The referral needs to list necessary procedures (i.e. Band Adjustment) as well as examination. Services cannot be provided without this referral and you will need to reschedule your appointment. If you wish to be seen without a referral, the visit will be your responsibility and must be paid at the time of service.

- **Medicare Advantage Plans or Replacement Plans:** If you have replaced your Medicare with another insurance plan, please be aware that you may be responsible for any co-pays, co-insurance or deductibles associated with that plan. **If you have switched to a POS or HMO plan you may need to obtain a referral** from your Primary Care Physician prior to your appointment. Please be aware that we **do not accept all Medicare Advantage plans.** We will need to verify coverage and network benefits. If your insurance has changed please contact us prior to your appointment. Copies of insurance cards can be emailed to Nicole @bmisurgery.org or faxed to the office at 815-717-8339.

- **Medicaid or Medicaid replacement plans:** Please be aware that BMI Surgery does not accept Medicaid replacement plans. **If you have one of these plans you will be considered self-pay.** Please be aware that you may be responsible for any co-pays, co-insurance, spend-down, etc. per your benefits with Illinois Medicaid. We do not accept out of state Medicaid plans.

- **No insurance:** If you have no insurance or receive services that are considered non-covered by your insurance, payment will be due at the time of service.

Return Checks: A $25.00 charge will be added to your account for any check returned by your bank for any reason.

Medical Forms: A $10.00 fee will be charged for all forms (FMLA or Short-term Disability) that need to be completed, this charge **will need to be paid at the time you drop off the forms.**

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 at the time of your request. **Please allow 10-14 days for the copy of your records**. There may be charge for copies of your medical records, which needs to be paid prior to receiving your records.

By signing below, the patient agrees to accept full financial responsibility for services rendered. The patient's signature verifies that the patient authorizes the assignment of benefits, has read the disclosure statement, understands the patient's responsibilities, and agrees to the terms and conditions described therein. The patient has certified that the insurance information provided is correct and that you will notify our office of any changes in your insurance or demographic information.

_____ _____

Signature of Patient, Guardian or Representative Date Signed

BMI Surgery S.C.

Disclaimer for Uncovered Services

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, **you will be responsible for payment 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, or Flex Benefit Plan for reimbursement.

Refunds will be given for products (vitamins, protein powder, etc.) 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.

Full reimbursement 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 do not have an outstanding balance or insurance balance.

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.

Financial 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 financial responsibility

In order 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, 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.

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. Notify patient before running card regardless of balance: ☐ YES or ☐ NO**

☐ **(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.