PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last)_____(First)_____(MI) _____

Address: _____

City, State, Zip: _____

Home:_____Cell:_____Work: _____

E-Mail Address:_____DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number:_____-_____-_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Primary Care Provider (PCP) _____ **Referring Provider** _____

Rendering Provider Name (this practice) _____

PHARMACY NAME AND LOCATION_____PHARMACY PHONE_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM____/DD____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number:_____-_____-_____ Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner,

physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date: _____

Printed name of patient or personal representative:_____ Relationship to patient: _____

Last Updated: July 2017

Patient Medical History

MEDICAL HISTORY:

- ☐ Diabetes Mellitus
- ☐ Osteoarthritis
- ☐ Obesity
- ☐ Congestive Heart Failure
- ☐ GERD/Heartburn
- ☐ Obstructive Sleep Apnea
- ☐ High Cholesterol
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Polycystic Ovary Syndrome
- ☐ Urinary Inconsistency
- ☐ Heart Attack
- ☐ Chronic Obstructive Pulmonary Disease (COPD)

Past Surgeries: ☐ None

_____

_____

Current Medications: ☐ None

_____

_____

Medication Allergies: ☐ None:

_____

_____

Family History:

_____

Have you Ever Smoked? ☐ No ☐ Yes If yes, _____packs a day for _____years. Quit? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, _____ drinks a week of ☐ Wine ☐ Beer ☐ Liquor

Check Symptoms you currently have or have had in the past year:

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight Loss
- ☐ Heat/Cold Intolerance

EYES
- ☐ Glasses/Contacts
- ☐ Blurry Vision

EARS & THROAT
- ☐ Difficulty Hearing
- ☐ Sinus Problems
- ☐ Dentures

CARDIAC
- ☐ Palpitation
- ☐ Chest Pain
- ☐ Irregular Heart Beat

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

GASTROINTESTINAL URINARY
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Poor Appetite
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Stool Caliber Change
- ☐ Stool Color Change
- ☐ Incontinence
- ☐ Frequency
- ☐ Urgency

SKIN/BREAST
- ☐ Skin Lesions
- ☐ Breast Mass
- ☐ Muscle Sweats

NEUROLOGIC
- ☐ Stroke/TIA
- ☐ Weakness
- ☐ Paralysis

HEMME/IMMUNO
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Large Lymph Glands

MUSCULOSKELETAL
- ☐ Bone Pain

Other/Explanation: _____

How many years have you been over weight? _____

Previous Weight Loss Surgery? YES or NO

If yes, which surgery? _____ Date of Surgery: _____

Surgeon: _____

Have you ever been treated for Depression? YES or NO

If yes, name of physician or psychiatrist: _____

Have you ever been hospitalized for Mental Illness? YES or NO

Patient Name: _____

Previous Weight Loss Programs

****Please fill out the best of your ability. The more information you provide will be helpful for the insurance process. ****

Programs:	Date Started	End Date	Weight Loss	MD Supervised?
o Weight Watchers	_____	_____	_____	YES or NO
o Jenny Craig	_____	_____	_____	YES or NO
o Nutrisystem	_____	_____	_____	YES or NO
o Quick Weight Loss Center	_____	_____	_____	YES or NO
o Atkins Diet	_____	_____	_____	YES or NO
o Optifast	_____	_____	_____	YES or NO
o Medifast	_____	_____	_____	YES or NO
o Alli	_____	_____	_____	YES or NO
o Plexus	_____	_____	_____	YES or NO
o Advocare	_____	_____	_____	YES or NO
o SlimFast	_____	_____	_____	YES or NO
o Herbalife	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO
o Other Weight Loss Attempts	_____	_____	_____	YES or NO

Medical Weight Loss Attempts

Medication:	Date Started	End Date	Weight Loss	MD Supervised?
o Belviq	_____	_____	_____	YES or NO
o Xenical (Orlistat)	_____	_____	_____	YES or NO
o Contrave (naltrexon)	_____	_____	_____	YES or NO
o Saxenda (liraglutide)	_____	_____	_____	YES or NO
o Amphetamines	_____	_____	_____	YES or NO
o Phen-Fen	_____	_____	_____	YES or NO
o Phentermine *(Apiden, Fastin, Pondimen)*	_____	_____	_____	YES or NO
o Dexfenfluramine	_____	_____	_____	YES or NO
o Meridia (Sibutramine)	_____	_____	_____	YES or NO
o Other Medications	_____	_____	_____	YES or NO
o Other Medications	_____	_____	_____	YES or NO

Patient Name: _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Clear Lake Regional
MEDICAL CENTER
An HCA Affiliated Hospital

Participant Name: _____ (printed)

Consent to Participate in Group Setting and E-mail Use Agreement

Your privacy is very important to Clear Lake Regional Medical Center, and the hospital wants you to understand the following about your participation in the Bariatric Support Group:

When participating in the Bariatric Support Group:

- Other participants will know your first name.
- You will have control over how much sensitive information you want to share with the group. The group leader will not identify your other private information to the group.
- If you wish to receive information via e-mail, we can communicate with you via unencrypted e-mail. . (Please see below for additional information.) Information that we might send you includes upcoming event, insurance eligibility information, etc. You will not receive treatment information or copies of your health records via internet e-mail.
- We will not share your e-mail address with other participants in the program or any third parties.

What does unencrypted e-mail mean?

- Encryption is a method of coding an internet e-mail transmission to provide protection from possible interception of the e-mail as it is in transit. Encryption also requires special handling to be able open or view the e-mail upon receipt. Unencrypted e-mail does not have this protection.

Other safeguards to protect e-mail communications:

- To reduce the risk of an e-mail being sent to an incorrect e-mail address, we ask you to verify your e-mail address for us in writing.
- You can safeguard your e-mails by providing your correct e-mail address and by limiting the person who can access your e-mail account

By signing below, I _____ (print participant name), agree:

☐ To participate in the Bariatric Support Group

☐ To receive information via unencrypted e-mail as stated above.

Participant's Date of Birth: _____ Email address: _____

Date: _____ Participant Signature: _____

Date: _____ Participant Representative Signature: _____
(As appropriate)

Printed Name and Relationship to Participant: _____

Patient name: _____
Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, SURGICAL SPECIALISTS OF CLEAR LAKE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge SURGICAL SPECIALISTS OF CLEAR LAKE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to SURGICAL SPECIALISTS OF CLEAR LAKE any insurance or other third-party benefits available for health care services provided to me. I understand SURGICAL SPECIALISTS OF CLEAR LAKE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to SURGICAL SPECIALISTS OF CLEAR LAKE, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to SURGICAL SPECIALISTS OF CLEAR LAKE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for SURGICAL SPECIALISTS OF CLEAR LAKE, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that SURGICAL SPECIALISTS OF CLEAR LAKE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or SURGICAL SPECIALISTS OF CLEAR LAKE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____

Disclosure Process and Fee Explanation Letter

Dear Patient:

As a patient, you have a right to copies of your medical information. In addition, medical records are legal documents that must be maintained by Surgical Specialists of Clear Lake. To assure we are doing everything we can to comply with HIPAA rules and protect the privacy of our patients, we have partnered with BACTES, a national Release of Information provider, to assist us with this process.

Under federal and state law, BACTES is allowed to recover certain costs related to making copies of your medical records available to you. The fee we charge is cost-based to include labor, materials and postage as defined by HIPAA and highlighted by the Omnibus Final Rule. How the record is stored and delivered are variable factors affecting the fee.

To minimize this fee, we encourage you to limit your request to just the records that you truly need. *Note that on the attached authorization form, there is an option to select a 2-year abstract plus 5 years of labs, radiology, and diagnostics*. For many patients, this option is sufficient for their purposes and keeps their bill lower than it otherwise would be.

Please fill out the attached authorization form completely and submit via fax or mail.

Surgical Specialists of Clear Lake
450 Medical Center Blvd, Suite 600
Webster, TX 77598

Please note that the BACTES quality control process does extend the turn-around-time for your request to be fulfilled. However, you can expect that an invoice will be mailed to the address on your request within 5-7 business days. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by Check or Credit Card.

Check Status 5-7 business days after submitting request:	https://recordstatus.sharecare.com/
Pay by Phone:	(800) 560-3800 Press #2 for Customer Service
Pay Online	http://www.bactes.com/ Click on Pay Online - Top left selection - https://payment.bactes.com/Payments/ Enter your email address for Receipt – Invoice # - Amount of Invoice

Your request will be fulfilled upon payment. For questions, please contact BACTES at **(800) 560-3800** and press 2 for BACTES Customer Service.

Thank you again for your confidence in Surgical Specialists of Clear Lake

HCA®

Authorization For Use or Disclosure of Medical Record Information
Surgical Specialists of Clear Lake

BACTES a sharecare company

TX10975

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize **Surgical Specialists of Clear Lake** to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose: ◯ Personal ◯ Continuing Care/ Referral ◯ Insurance ◯ Legal ◯ Transfer (*Explain*) ◯ Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: The information released pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state privacy laws **Surgical Specialists of Clear Lake** will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

◯ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

◯ Please provide my entire medical record for dates: From_____To_____

◯ Please provide my entire billing record for dates: From_____To_____

◯ Please provide *only* the following records within the date range listed below:

☐ Progress Notes/Consults ☐ Labs ☐ Radiology Reports ☐ Pathology ☐ Billing ☐ Other (*Explain Below*)

From _____ To _____

Comments/ Authorization Specifications: _____

NOTICE: This Authorization is valid for 180 unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Las Palmas Del Sol Urgent Care, except to the extent that **Surgical Specialists of Clear Lake** has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

Authorization to Release Protected Information

REQUIRED: Please complete the check boxes below indicating how protected information should be handled, even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial below to confirm your choice

I ☐ **DO** ☐ **DO NOT** want information about communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. _____

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here Date Here

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

Description and Proof of Authority to Act on Patient's Behalf

Know Your Rights
Refer to the HIPAA **"Notice of Privacy Practices"**

Document Updated: 11/9/2016

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.