SOUTH TEXAS SURGEONS PROFESSIONAL ASSOCIATION

General and Laparoscopic Surgery — Surgical Treatment of Obesity

Gerardo E. Cárcamo, M.D — J. Keith Wright, M.D.

Patient Demographics

PLEASE WRITE LEGIBLY AND COMPLETE ALL FIELDS

NAME:		**Date of Birth:** **Age:**
Gender: ☐M ☐F	**Marital Status:** ☐S ☐M ☐D ☐W	**Social Security #:** - -
Address:		**City/State/Zip:**
Primary phone: ( ) -		**Secondary phone:** ( ) -
Employer: ☐unemployed		**Occupation:**
Work Phone: ( ) -		**Driver's License #:** **State:**
Email: ☐I do not have an email address		
How did you hear about us? ☐PCP ☐Facebook ☐Google ☐Nix Website ☐Another patient ☐Insurance ☐Word of mouth ☐Referring MD ☐Other:		
Emergency Contact Name:	**Relation:**	**Phone:** ( ) -

PCP:	**PCP Phone:** ( ) -
Referring Doctor:	**Referring Phone:** ( ) -

Preferred Pharmacy:	**Pharmacy Phone:** ( ) -
Pharmacy Address:	**City/State/Zip:**

PRIMARY INSURANCE: **Subscriber same as patient? ☐Yes ☐No (If no, please complete all fields below)**

Insurance Name:	**Group #:**
1 – 800 #: ( ) -	**Policy #:**
Subscriber Name:	
Subscriber Social Security #:	**Subscriber Date of Birth:**

SECONDARY INSURANCE: **Subscriber same as patient? ☐Yes ☐No (If no, please complete all fields below)**

Insurance Name:	**Group #:**
1 – 800 #: ( ) -	**Policy #:**
Subscriber Name:	
Subscriber Social Security #:	**Subscriber Date of Birth:**

Next Page

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY AND OFFICE POLICIES

Thank you for choosing South Texas Surgeons, P.A. We are committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services. **Please be sure that you have read and understand all the information provided in this statement before signing the release. Your signature is both binding and acknowledges your understanding and compliance with our policies.**

PHYSICIAN-PATIENT RELATIONSHIP

It is the policy of this practice to maintain a cooperative and trusting physician-patient relationship with its patients. When such a physician-patient relationship has not been formed or a physician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of this practice to terminate the physician-patient relationship within the bounds of applicable state and federal laws, rules, and regulations; the American Medical Association guidelines, and this policy so that the patient can develop the type of trusting relationship with another physician that is essential to successful continued care and treatment.

Reasons for patient termination may include, but are not limited to, the following*: noncompliance with treatments recommended by the practice or physician • failure to pay, consistent with our payment policy • consistent failure to keep appointments • threatening or abusive behavior directed at office staff, physicians, other healthcare providers, or patients • patient is deceptive or lies • patient abuses medication • patient decides to leave the practice.* PATIENT INITIAL _____

NO CHILDREN POLICY

It is the policy of this practice to provide the best patient care in a safe environment, which is not suitable for children. To fulfill this policy, we ask that if you have children, you make alternative arrangements for childcare during your visits to our office. If you arrive for your appointment with a child or children, you may be asked to reschedule your appointment for a date in which you are able to obtain childcare. PATIENT INITIAL _____

INSURANCE/CHANGES TO INSURANCE

For the convenience of our patients we accept most insurance plans to include Medicare and Medicaid. It is the patient's responsibility to pay all deductibles, co-insurance, co-payments or any other balance not paid by your insurance company. Payer required referrals and authorizations are ultimately the patients' responsibility. It is the patient's responsibility to notify our office of all insurance plans, changes to plan and/or insurance carrier at the time of the change. Failure to notify our office of any insurance changes may result in the patient responsible for any amount not paid by the insurance. PATIENT INITIAL _____

PAYMENT FOR SERVICE

Payment is due at time services are rendered, which consists of deductibles, co-insurance, co-payments and or any other balance not paid by your insurance company. We accept cash, Visa, Master Card, Discover and cashier checks. It is our policy not to accept personal checks. The return of a payment (electronic or paper) and/or a declined credit card for payment agreements will result in a $35 administration fee on the patient's account. PATIENT INITIAL _____

PAYMENT FOR SURGERY

Deductibles, co-insurance, co-payments or any other balance not paid by insurance toward surgery are the patient's responsibility and must be paid 48 hours prior to the date of surgery. If payment is not received prior to the scheduled date of your procedure it may be postponed. The facility, anesthesia and other medical expenses associated with your surgery are a separate cost from our office, which the patient is responsible for obtaining. PATIENT INITIAL _____

SELF-PAY

We welcome self-funded patients. Those without insurance are asked to assume full financial responsibility for the office visit and medical services provided at the times service is rendered. If full payment cannot be made at the time of service, please speak with our Business Office prior to your visit to determine if you qualify for a payment agreement. PATIENT INITIAL _____

FAILURE TO PAY

It is the patient's responsibility to pay all deductibles, co-insurance, co-payments or any other balance not paid by your insurance company. If payment is not received after three notifications, the patient's account will be reviewed and possibly sent to collections. *I understand and agree that an additional 40% will be added to my account in the event that it should be necessary for my account to be forwarded to a Collection Agency.*

PATIENT INITIAL _____

Next Page

CANCELATION AND NO-SHOW POLICY: Our goal is to provide quality individualized medical care in a timely manner.

Appointments: Late cancellations and No Shows (includes arriving more than 15 minutes late) create inconvenience and prevent scheduling of other patients who need access to medical care in a timely manner. Patients who do not show up for their office appointment without a call to cancel or notify the office of a late arrival are considered a No Show and will be subject to a **$50 No Show fee.** PATIENT INITIAL _____

Surgical Procedures: Patients who do not show up for their surgical procedure without a call to cancel within 48 hours of their scheduled time, are considered a No Show and will be subject to a $100 No Show fee. Patients who are forced to cancel their procedure on the scheduled day as a result of: failure to follow the Surgeon's medical instructions and facility policy or displays inappropriate behavior with the professional staff will be subject to a **$100 cancellation fee**.
PATIENT INITIAL _____

Changing Surgical Procedures: Surgical procedures are discussed and agreed on between the Surgeon and patient, before submitting to the insurance for approval. If the patient decides to change their surgical procedure after their clinical case file has been submitted to the insurance, the patient is required to follow-up with the Surgeon to discuss the procedure change and will be subject to a **$100 Surgery Change Fee.** PATIENT INITIAL _____

MEDICAL RECORDS

Medical records belong to South Texas Surgeons, P.A. or facility where they were made. You, the patient, have a right to obtain copies of your records if you make a written request that they be provided to you and not to anyone else. To cover the administrative cost of making the copies of your medical records, our medical records fees are as follows: $25 (1-25 pages) and $25 + $1.00 per page (>26 pages). *Please note; nutrition and psychological records are not included with medical records.* PATIENT INITIAL _____

FMLA and DISABLITY PAPERWORK

We are happy to assist you with necessary FMLA, short-term and long-term disability paperwork. To cover the administrative cost of completing these forms, patients will be subject to a $45 fee, for a 10-day return and $75 fee, for a 3-day return. *It is our policy that we do not participate in Social Security Disability forms.* PATIENT INITIAL _____

WORKER'S COMPENSATION

We must have prior authorization for service from either the employer or the insurance carrier. Should the employer or carrier subsequently deny validated worker's compensation service, any charges will be the financial responsibility of the patient. PATIENT INITIAL _____

NUTRITION AND PSYCHOLOGICAL SERVICES

Nutrition and Psychological services are essential to your weight loss success. Visits with our Dietitian and Psychologist are not covered by insurance, being an out-of-pocket expense. Patients are financially responsible for the office visit at the times service is rendered. If full payment cannot be made at the time of service, please speak with our Business Office prior to your visit to determine if you qualify for a payment agreement. *Patients must have a zero balance prior to surgery.* PATIENT INITIAL _____

ADVERTISING/MARKETING PATIENT WEIGHT LOSS SUCCESS

I give permission to South Texas Surgeon, P.A. to release my personal contact information and/or photos for the purpose of; volunteer programs, website promotions or display my success through photos, stories, television or miscellaneous advertising of my weight loss journey.

YES, I GIVE PERMISSION: PATIENT INITIAL _____ **NO, I DON'T GIVE PERMISSION:** PATIENT INITIAL _____

I hereby acknowledge that I have read, understand, and agree to comply with all policies outlined above.

_____ _____

[PRINT NAME] [SIGNATURE] [DATE]

Next Page

Acknowledgement of Review of **Notice of Privacy Practices**

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment of Your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
    - **I wish to object or opt out of this section:** ☐ **Yes** ☐ **No**

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180-days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.
To file a complaint with the Secretary of the United States Department of Health and Human Services, mail to: Secretary of the United States Department of Health and Human Services, 200 Independence Ave. S.W., Washington, DC 20201; or call 202-619-0257 (or toll free 877-696-6775); or go to the website for the Office of Civil Rights, www.hhs.gov/ocr/hipaa/ for more information. There will be no retaliation against you for filing a complaint.

I ACKNOWLEDGE RECEIPT OF A COPY OF THIS NOTICE OF PRIVACY PRACTICES

_____ _____

[PRINT NAME] [SIGNATURE] [DATE]

I authorize South Texas Surgeons, PA to disclose my health information to the following individual(s):

_____ _____

Name Relationship

_____ _____

Name Relationship

Thank you and we look forward to seeing you!