ADVANCED SURGICAL & BARIATRICS OF NJ, PA

LAST NAME:_____FIRST NAME : _____ M: _____

DATE OF BIRTH:_____ MARITAL STATUS: M____S___D____W____

SEX:___MALE___FEMALE ____OTHER

SS#:_____

HOME ADDRESS:

_____

Street Apt#/Bldg# City State Zip code

MAILING ADDRESS:

_____

Street Apt#/Bldg# City State Zip code

HOME PHONE:_____

WORK PHONE: _____

CELL PHONE: _____

Can we contact you via text message? YES_____ NO _____

E-MAIL ADDRESS:_____

Can we contact you via email? YES_____ NO _____

OCCUPATION: _____

EMPLOYER:_____

WORK ADDRESS:_____

ADVANCED SURGICAL & BARIATRICS OF NJ, PA

INSURANCE CARRIER: _____

INSURANCE ADDRESS:_____

INSURANCE PHONE:_____ EFFECTIVE DATE: _____

INSURED:_____INSURED'S DOB: _____

ID:_____ Group:_____Copay: _____

HEIGHT: _____ WEIGHT: _____ HOW LONG AT CURRENT WEIGHT?_____

GOAL WEIGHT: _____

ARE YOU A SMOKER? YES _____ NO _____ *IF YES, HOW MANY PER DAY?
_____

DO YOU DRINK? YES_____NO_____*IF YES, HOW OFTEN AND HOW MUCH?
_____

RACE: CAUCASIAN____AFRICAN AMERICAN_____ASIAN_____HISPANIC_____
OTHER_____

How Did you hear about us? _____

*THE INFORMATION YOU PROVIDE WILL HELP YOUR SURGEON PLAN YOUR TREATMANT AND INSURANCE APPROVAL PROCESS.

PRIMARY HEALTHCARE PROVIDER

ALL PATIENTS NEED TO HAVE A PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN'S NAME:
_____
ADDRESS:
_____

PHONE:_____
HOW LONG HAS HE/SHE BEEN YOUR PCP?
_____

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DO YOU HAVE OR HAVE YOU HAD	YES	NO	DON'T KNOW
DIABETES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HIGH TRIGLYCERIDES			
ANGINA/CORONARY ARTERY DISEASE			
HEART ATTACK			
HEART ARRHYTHMIA			
SLEEP APNEA			

PLEASE LIST ANY OTHER PHYSICIANS TREATING YOU:

_____

_____

_____

HAVE YOU EVER BEEN UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOLOGIST? YES_____NO_____

*IF YES, WITH WHOM AND WHEN?

_____

BEING OVERWEIGHT HAS AFFECTED YOU IN WHICH OF THE FOLLOWING WAYS:

- ❑ FAMILY LIFE
- ❑ SOCIAL LIFE
- ❑ EMOTIONALLY
- ❑ UNABLE TO FIND A JOB
- ❑ EXERCISE OR SPORTS

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATIONS	STRENGTH	REASON FOR MEDICATION	HOW OFTEN

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES_____NO _____

PLEASE LIST:

_____

_____

_____

DO YOU HAVE A LATEX ALLERGY? YES_____NO_____*IF YES, YOU WILL NEED TO SEE AN ALLERGIST TO CONFIRM THIS.

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REVIEW OF SYMPTOMS

SYMPTOM	NO	YES	DETAILS/COMMENTS
HIGH BLOOD PRESSURE READINGS			
ELEVATED BLOOD SUGAR READINGS			
FREQUENT OR SEVERE FATIGUE			
FREQUENT OR SEVERE WEAKNESS			
FEVER, CHILLS, OR NIGHT SWEATS			
FREQUENT OR SEVERE HEADACHES			
ANY HISTORY OF HEAD INJUURY WITH LOSS OF CONSCIOUSNESS			
EYEGLASSES OR CONTACT LENSES			
VISUAL PROLEMS THAT AREN'T CORRECTABLE			
HEARING PROBLEMS			
EAR PAIN			
CHRONIC SINUS CONGESTION			
FREQUENT BLOODY NOSE			
DENTAL PROBLEMS			
DENTURES			
WHEEZING			
COUGHING			
BREAST LUMPS, PAIN OR DISCHARGE			
HEART MURMUR			
CHEST PAIN WITH EXERCISE OR ACTIVITY			
HEART BURN			
REGURGITATION			
FREQUENT VOMITING			

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SYMPTOM	NO	YES	DETAILS/COMMENTS
HISTORY OF HIV INFECTION			
HISTORY OF LIVER PROBLEMS			
HISTORY OF HEPATITIS (STATE TYPE)			
USE OF BIRTH CONTROL			
INFERTILITY			
ANEMIA			
ANY HISTORY OF BLOOD TRANSFUSION			
BLEEDING TENDENCY			
CONVULSION SEIZURES			
PARALYSIS			
NUMBNESS OR TINGLING			
DEPRESSION			
ANXIETY			
DRUG OR ALCOHOL ABUSE			
CHRONIC SKIN RASH OR HIVES			
CHRONIC SKIN INFECTIONS OF LOWER LEGS			
CHRONIC SKIN INFECTIONS UNDER BREASTS			
CHRONIC SKIN INFECTIONS UNDER ABDOMINAL SKIN CREASE			
VARICOSE VEINS OF LEGS			
MIGRAINES			
FIBROMYALGIA			
LUPUS			
RHEUMATOID ARTHRITIS			
GOUT			
OTHER:			
OTHER:			
OTHER:			

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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

SYMPTOM	TREATMENT	DETAILS/COMMENTS
GASTRO ESOPHAGEAL REFLUX DISEASE		Endoscopy? ___Y ____N
GASTROINTESTINAL ISSUES		Colonoscopy? ___Y ___N
BREATHING ISSUES		
JOINT PAIN OR PROBLEMS		
FEVER, CHILLS, OR NIGHT SWEATS		
SHORTNESS OF BREATH (IF SO SPECIFY AFTER HOW MANY FLIGHTS OF STAIRS)		____Y_____N _____#flights of stairs

LIST ANY MAJOR ILLNESSES

ILLNESS	DATE	TREATMENT	OUTCOME

LIST ANY MAJOR SURGERIES INCLUDING MINOR PROCEDURES

SURGERY	DATE	REASON

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FAMILY HISTORY OF OBESITY:

MOTHER, FATHER, SIBLINGS	AGE NOW OR AT DEATH	CAUSE OF DEATH	WEIGHT: THIN, NORMAL, SLIGHTLY OVERWEIGHT, OVERWEIGHT OR OBESE	HEALTH PROBLEMS (please describe)

WHAT OTHER FAMILY MEMBERS ARE OBESE?

_____

_____

SURGICAL WEIGHT LOSS:

HAVE YOU EVER HAD ANY TYPE OF WEIGHT LOSS SURGERY IN THE PAST?
YES_____NO_____

IF YES, COMPLETE THE FOLLOWING:

SURGEONS NAME:_____

ADDRESS:_____

PHONE NUMBER:_____

DATE OF SURGERY:_____

TYPE OF SURGERY:_____

ADVANCED SURGICAL & BARIATRICS OF NJ, PA

COMPREHENSIVE DIETARY HISTORY

HEIGHT: _____ WEIGHT: _____

PLEASE COMPLETE THIS INFORMATION AND BE AS SPECIFIC AS POSSIBLE.

THIS WILL BE SENT TO YOUR INSURANCE COMPANY AS PART OF THE

DETERMINATION PROCESS.

DIET PROGRAMS

DIET TYPE	DATE (START-END)	WEIGHT LOST	WEIGHT REGAINED

PRINT FIRST NAME **PRINT LAST NAME**

SIGNATURE **DATE**

(By signing this document, you are confirming that this medical information is accurate and can be used to for your care at this practice)

Authorization to Obtain or Disclose Health Care Information
Patient Name:_____ **Date of Birth:** _____
Previous Name: _____

My Authorization:
You may disclose the following health care information (check all that apply)
_____ All health care information in medical record
_____ Health care information in medical record
_____ Health care information in my medical record relating to the following treatment:
_____
_____ Health care information in my medical record for the date (s): _____
_____ Other (e.g., X-days, bills) specify date (s): _____

You may use or disclose health care information re: testing, diagnosis, and treatment for (check all that apply):
_____ HIV (AIDS Virus) _____Sexually transmitted diseases (STD)
_____ Psychiatric disorders/mental health _____Drug and/or alcohol use

You may disclose this health care information to:
Name: Advanced Surgical and Bariatrics of NJ, PA
Address: 49 Veronica Avenue, Suite 202 Somerset, NJ 08873

Reason (s) for this authorization (check all that apply):
_____ at my request
_____ other (specify): _____
_____ on (date):_____when following even occurs: _____
_____ in 90 days from the date signed (if disclose is to a financial institution or an employer of the patient for purposes other than payment.

My Rights
I understand I do not have to sign this authorization in order to get health benefits, treatments, payment enrollment). However, I do have to sign an authorization form

- To take part in research study or
- To receive healthcare when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Advanced Surgical and Bariatrics of NJ, PA based upon this authorization I will need to write a letter to Advanced Surgical and Bariatrics of NJ, PA. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized Signature Date Time

Printed Name if signed on behalf of the patient Relationship

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

OUR PLEDGE REGARDING MEDICAL INFORMATION:

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and service you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we used and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information

OUR LEGAL DUTY

Law Requires Us to:

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- Follow the terms of the current the notice

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time provided that the changes are permitted by law
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep including information previously created or received before the changes

NOTICE OF CHANGE TO PRIVACY PRACTICES: Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon requests

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION: The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use and disclose information for any purpose not listed below, without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to your doctors, nurses, technicians, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party-payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, payment and health care operations, we may use and disclose medical information for the following purpose

Facility Directory: Unless you notify us that you object to the following medical information about you will be placed in our facility directories: your name, your location in our facility; your condition described in general terms.

Notification: We may use and disclose medical information to notify or help notify; a family member, your personal representative, or another person who is responsible for your care. We will share information about your location, general condition, or death. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays or medical information about you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy medical information

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a Coroner, medical examiner, funeral director, or an organ procurement organization

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court of administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: as required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration. We may also, when we are authorized by to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped legal custody.

Workers Compensation: We may disclose health information when authorize or necessary to comply with laws relating to workers compensation or other similar programs.

YOUR INDIVIDUAL RIGHTS:

You Have a Right to:

1. **Look at or get copies of certain parts of your medical information. You must make your request in writing**
2. **Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).**
3. **Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing od that information.**

Financial Counseling Acknowledgment

Initials

_____ I acknowledge full financial responsibility for services rendered by Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates LLC and Advanced Surgical & Endoscopy of NJ LLC. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates LLC and Advanced Surgical & Endoscopy of NJ LLC. In the event that my insurance company sends payment directly to me it is my responsibility to bring those checks to the office pertaining to services rendered by Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates LLC and Advanced Surgical & Endoscopy of NJ LLC.

_____ I understand that Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates, LLC and Advanced Surgical & Endoscopy of NJ, LLC, will verify my health benefits through my insurance as a courtesy to me. I further understand that it is my responsibility to ensure services are covered and/or what my exact benefits are. Financial counselors are available to assist me in this process and I acknowledge receipt of being provided with a financial counselor to explain my benefits and patient responsibility to me. I understand that I am ultimately responsible for payment of all services rendered. I understand that any co-pays, deductibles, or any other payments of outstanding balances are due prior to services being rendered. I understand that it is my responsibility to update Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates, LLC and Advanced Surgical & Endoscopy of NJ LLC, of any insurance changes.

_____ I understand that health insurance is a contract between me and the insurance company and/or my employer, not Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates LLC and Advanced Surgical & Endoscopy of NJ LLC. If there are any disputes of benefit coverage, I understand that I need to contact insurance company.

_____I have read and fully understand the above financial responsibility I wish to receive financial counseling regarding my benefits and patient responsibility for services rendered by Advanced Surgical and Bariatrics of NJ, PA, Bariatric Surgical Associates LLC and Advanced Surgical & Endoscopy of NJ LLC.

_____ I wish to decline financial counseling I have read and fully understand the above financial responsibility.

_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

_____ _____

Print name of Patient/Parent/Legal Guardian **Date**