Ellner Bariatric

Ellner Bariatric
2878 Camino del Rio South, Suite 303
San Diego, CA 92108
Phone 619-286-7866

Email forms to: ellnerpreop@gmail.com
OR Fax to 619-286-7867

Website: www.EllnerBariatric.com

Requested Procedure:_____

Last name, First, Middle		Date of Birth / Sex	Marital Status M D S W
Street Address		Gender Preference (if different from above)	Cell Phone
City	State Zip code	Social Security #	FAX Number
Email Address(es):			
Driver's License# & State		Race/Ethnicity	Preferred Language
Emergency Contact:	Relationship	Cell Phone	Religious Preference
Street Address, City, State, ZIP		Home Phone	
Employer's Name		Occupation	
Employer's Street Address			
City	State Zip code	Work Phone	

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscriber's Name (if different than patient above) & DOB:	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? ☐ Former patient ☐ TV ☐ Newspaper ad ☐Internet ☐ Magazine ☐ Radio

website: www._____ ☐ Friend ☐ Physician's Name: _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Signature: _____ Date: _____

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PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

Name:		Date:	Age:
Occupation: (If retired or disabled, what *did* you do or what is your disability?)			
Weight (Required)	Height (Required)	BMI	Body Frame – Circle One
			Small Medium Large

WEIGHT HISTORY

*What is your highest weight in the last 5 years ?*_____ *What is your lowest weight in the last 5 years?* _____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

_____

_____

_____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program			Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes❑	No ❑				
Nutri-Systems	Yes❑	No ❑				
Weight Watchers	Yes❑	No ❑				
OptiFast	Yes❑	No ❑				
Medi Fast	Yes❑	No ❑				
Fen/Phen/Redux	Yes❑	No ❑				
Meridia	Yes❑	No ❑				
Lindora	Yes❑	No ❑				
T.O.P.S.	Yes❑	No ❑				
O.A.	Yes❑	No ❑				
Acupuncture	Yes❑	No ❑				
Metabolife	Yes❑	No ❑				
Atkins Diet	Yes❑	No ❑				
Pritikin Diet	Yes❑	No ❑				
Other:						

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List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1 Year_____ Weight at start_____ at delivery_____

Pregnancy #2 Year_____ Weight at start_____ at delivery_____

Pregnancy #3 Year_____ Weight at start_____ at delivery_____

Pregnancy #4 Year_____ Weight at start_____ at delivery_____

Food and Exercise History

What are your dietary pitfalls? (circle answers)

Snacking stress eating grazing all day love sweets eating large meals fast foods
Love salty love crunchy skipping meals restaurants boredom love carbs
Other _____

What do you typically eat for the following:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____

What do you do for exercise:

_____

Difficulty with exercise is due to (circle answers):

back pain lack of motivation shortness of breath joint discomfort
scheduling family embarrassment time
other: _____

WEIGHT RELATED ILLNESSES – ALL QUESTIONS MUST BE ANSWERED

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes❑ No ❑

If Yes: ♦Year Diagnosed _____

Do you have, or have you had:

❑ Angina
❑ M.I. (myocardial infarction, "heart attack"), stroke, mini-stroke (TIA)
❑CABG (coronary artery bypass graft)
❑ Abnormal EKG
❑ Stress test to rule out cardiac problems
❑ Palpitations, Fast Heartbeat (tachycardia), Slow Heartbeat (bradyarrhythmia)

2. High Cholesterol Yes❑ No ❑ High Triglycerides Yes❑ No ❑

If Yes: ♦Year Diagnosed _____

♦ List medications _____

3. High Blood Pressure Yes❑ No ❑

If Yes: ♦Year Diagnosed _____

♦ List medications _____

4. Diabetes Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

♦ Gestational: Yes❑ No ❑

♦ Neuropathy: Yes❑ No ❑

♦ Controlled with: ❑ Diet

❑ Oral Medication (list) _____

♦ Last fasting blood sugar: _____

5. Asthma Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

♦ ER visits/last 2 yrs: _____

♦ Hospitalizations last 2 years: _____

♦ Steroids last 2 years: Yes❑ No ❑

6. Shortness of breath Yes❑ No ❑

If Yes, : ♦Can walk _____blocks

♦ Stairs: _____flights

7. Trouble Sleeping? Yes❑ No ❑

♦ Morning headaches Yes❑ No ❑

♦ Grinding of teeth/jaw Yes❑ No ❑

♦ Restless sleep Yes❑ No ❑

♦ Snoring Yes❑ No ❑

♦ Awakenings at night Yes❑ No ❑

♦ Observed apneas Yes❑ No ❑

♦ Arm/Leg Twitching (PLM 's) Yes❑ No ❑

♦ Excessive Daytime Fatigue/sleepiness Yes❑ No ❑

8. Sleep Apnea Syndrome Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

♦ Last sleep study: _____month/year

♦ CPAP used: Yes❑ No ❑

9. Heartburn/esophagitis/hiatus hernia? Yes❑ No ❑

If Yes: ♦Year Diagnosed: _____

♦ Upper GI series? Yes❑ No ❑

♦ Endoscopy? Yes❑ No ❑

♦ Medications: _____

♦ Frequency of use: _____

10. Belching up acid or sour fluid. Yes❑ No ❑
11. Coughing or choking at night? Yes❑ No ❑

12. Gallbladder disease? Yes❑ No ❑

If Yes: How was it Diagnosed? ❑ Ultrasound ❑ Physical Exam ❑ (Gallbladder removed)

13. Leakage of urine with laughing/coughing/sneezing? Yes❑ No ❑

If Yes: ♦Wear pads frequently? Yes❑ No ❑

15. Low back strain/Pain/Sciatica? Yes❑ No ❑

If Yes: ♦Seen by Chiropractor? Yes❑ No ❑
♦ Orthopedic Surgeon? Yes❑ No ❑
♦ Seen by Family Doctor? Yes❑ No ❑
♦ Medications taken: _____

16. Pain in Hips/Knees/Ankles/Feet? Yes❑ No ❑

If Yes: ♦Seen by Chiropractor? Yes❑ No ❑
♦ Orthopedic Surgeon? Yes❑ No ❑
♦ Seen by Family Doctor? Yes❑ No ❑
♦ Medications taken _____

17. Weight related injuries and trauma: _____

_____

18. Venous Stasis Disease? Yes❑ No ❑

If Yes: ♦Do you have Edema? Yes❑ No ❑ (edema is swelling in the lower legs or feet)
♦ Scaly & Thick Skin? Yes❑ No ❑
♦ Leg Ulcers? Yes❑ No ❑

19. Gout? Yes❑ No ❑

If Yes: ♦Gouty Arthritis? Yes❑ No ❑
Using Medication? _____

OTHER PAST MEDICAL HISTORY

Female Patients:

Number of pregnancies: _____ Age at first period: _____
Number of live births: _____ Date of last period: _____
Miscarriages/abortions: _____
Obstetric complications: _____

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Do you presently use:

Birth control pills Yes❑ No ❑ List type: _____

Estrogens Yes❑ No ❑ List type: _____

Other Contraceptive method: _____

*When was your last mammogram? Date*_____ *Results*_____

Please identify which of the following childhood illnesses you have experienced:

❑ Measles ❑ Mumps ❑ Chickenpox ❑ Obesity

❑ Rheumatic fever ❑ Heart murmur ❑ Asthma ❑ Tonsillectomy

Have you had:

❑ Hepatitis ❑ Blood Transfusion ❑ AIDS/HIV Exposure

❑ Colitis ❑ Kidney Disease ❑ Bleeding Abnormality

❑ Thyroid Problems ❑ Cancer, type: _____

Would you accept a blood transfusion in an emergency situation? ❑ Yes ❑ No

Please list below all serious illnesses and hospitalizations you have experienced in adulthood.
If you do not have any, please write in: N/A

Major Illness Date Treatment

_____

_____

_____

_____

_____

Major Surgery Date

_____

_____

_____

_____

_____

_____

Allergies: *If you do not have any, please check here* ❑ N/A

Allergic to any medications? Yes❑ No ❑ If yes, please list medication and reaction:

_____

_____

_____

Allergic to: Surgical tape: Yes❑ No ❑ Latex: Yes❑ No ❑ Iodine: Yes❑ No ❑

Other Allergies:

_____

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Please list ALL medications you currently use, including vitamins and supplements.
If you do not take ANY medications, vitamins or supplements, please check here ❑ N/A

Medication	Dose	Frequency

Do you use THC/Hookah/E cigs/Vape: Yes❑ No ❑ Frequency/Type: _____
Do you currently use tobacco: Yes❑ No ❑ Frequency/Type: _____
Are you willing to quit? Yes❑ No ❑
Have you previously used the above? Yes❑ No ❑ For how many Years? _____
How many packs a day? _____
Do you drink alcohol: Yes❑ No ❑ Frequency: _____
Drug Use (social): Yes❑ No ❑ Frequency: _____ Type: _____
Any history of substance abuse: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

❑ Obesity
❑ Diabetes
❑ High Blood Pressure
❑Heart Disease
❑ High Blood Cholesterol
❑ Lung disease, Asthma or Emphysema
❑Kidney Disease
❑ Bleeding tendency or Blood Disorder
❑ Breast Cancer
❑ Colon Cancer

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SYSTEM REVIEW – THIS PAGE CANNOT BE LEFT INCOMPLETE.

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information. Circle the specific symptoms, not just the categories in bold.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze – decreased sex drive

♦ Men: discharge from penis – loss of erection – painful erection
♦ Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods – lack of orgasm

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – x-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling
OTHER: _____

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Your primary care physician's information is required. If you need any of this information, please give their office a call.

Primary Care Physician Name	Address/Location	Main Phone Number	Fax Number (please call their office for this)

Personal Physicians

Please list all the physicians under whom you receive medical care.

	Name	Address/Location	Telephone	Fax
Cardiologist				
Endocrinologist				
Orthopedist				
Psychiatrist				
Psychologist				
Therapist				
Nephrologist				
Other (Specify)				

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Patient Name	Date of Birth
Address	Social Security Number
City, State, Zip	Phone #

I authorize (name of your doctor/facility) _____ to release copies of my medical records, created during the course of my diagnosis and treatment at your facility, and for continued patient care, to:

Ellner Bariatric
2878 Camino del Rio South Suite 303
San Diego, CA 92108
Phone: 619-286-7866 | Fax: 619-286-7867

Approximate Dates of Service for requested Medical Records: _____

I understand the information is released for continued patient care and may not be provided in whole or in part to any other agency, organization or person. I hereby waive my/his/her rights to the privileges of confidentiality with respect to any HIV test result or mental health information or drug/alcohol information that may be contained in the medical record. The Healthcare provider, its employees and officers and attending physicians are released from legal responsibility or liability for the release of information to the extent stated and authorized herein. Records may be faxed to expedite continuing care. This authorization is valid for 180 days from date of signature unless revoked in writing earlier by the patient.

Signature of Patient	Date

Signature of Parent/Guardian/Legal Representative

Relationship to the Patient

This fax contains CONFIDENTIAL INFORMATION and is only for the individual or entity named in this document. Otherwise, you are hereby notified that disclosure, copying, distribution or other action to the content for this fax is strictly prohibited. If this is received in error, please contact sender immediately.

Ellner Bariatric

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name (please print) Date of Birth

Both before and after surgery we will need to contact you regarding test results, insurance information, referrals, etc. We will need your authorization to convey this protected health information in a way that is most convenient for you.

Designated method of contacting the patient (check all that apply):

❑ OK to leave detailed messages on HOME answering machine (_____) _____

❑ OK to leave detailed messages on MOBILE voicemail (_____) _____

❑ Leave call back messages only on this phone number (_____) _____

❑ Send detailed messages via primary e-mail address: _____

❑ Send detailed messages via secondary e-mail address: _____

❑ Please check if your e-mail is confidential and should NOT be used. A fax number will be required as an alternate method of sending documents. Fax Number: (_____) _____

_____ _____

Signature Date

Ellner Bariatric

2878 Camino Del Rio South, Suite 303 *(619) 286-7866 phone*
San Diego, CA 92108 *(619) 286-7867 fax*

Appt Cancellation and Late Payment Policy

In consideration of the great number of patients desiring appointments, there will be a $75 fee charged to anyone cancelling an appointment within 24 business hours (M-F 8am-5pm) of the scheduled time. Payment will be required before another appointment will be scheduled. Thank you for your cooperation

_____(Initial)

Email Communication with Patients

Our patients communicate a great deal with the office and most find that email is the most efficient method. Because of patient privacy laws, we need your permission to correspond via email. Please read the following carefully.

I authorize Ellner Bariatric to use unsecured email for communicating with me regarding my medical condition. I understand that commonly used email does not protect my personal information from possibly being available on the internet. Unencrypted email is not HIPAA (Patient Privacy) compliant. With my signature below, I permit the use of such email correspondence with Ellner Bariatric.

_____(Initial)

Policy Regarding Pets

At Ellner Bariatric, we love pets of all shapes and sizes. However, in order to maintain a clean environment for our patients with fresh surgical incisions, as well as a clean area for sterile dressings, we cannot allow pets of any kind in the office. This includes service and support animals. If your disability requires that you have personal assistance, we ask that you make arrangements to bring a caregiver to your appointment(s), so you will be comfortable while still maintaining the safety of others. We greatly appreciate your assistance in maintaining a clean, infection free environment.

_____(Initial)

Receipts for Services

If you require receipts for services/vitamins for taxes, HSA reimbursement or any other purpose, please alert our staff at the time of the transaction and a receipt will be provided at the time. Do not lose your receipts, as it is a very time-consuming process to track down old receipts and reconcile them at a later date. If you require copies of old receipts, you will be charged a minimum fee of $35 and it may take 2-3 weeks to obtain them, as some are sent off-site for secure storage. Keep track of all of your receipts so you don't incur extra costs.
_____(Initial)

I understand and will comply with the above policies.

_____	_____	_____
Printed Name	Date	Signature

Ellner Bariatric

HIPPA Notice of Privacy Practices

Effective on/or before May 21, 2012.

Ellner Bariatric, Inc / Julie Ellner M.D.
2878 Camino del Rio S #303, San Diego, CA 92108

Phone: (619) 286-7866
Fax: (619) 286-7867

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following the records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare to rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I_____acknowledge that I have received a copy of the "Notice of Privacy Practices" per HIPPA.
(Patient's Name)
This notice describes how Dr. Ellner and her staff may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)

2878 Camino del Rio South #303
San Diego, CA 92108
Phone: (619) 286-7866
Fax: (619) 286-7867

Ellner Bariatric

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Name

_____

Address

_____

City, State, Zip Code

The medical information/records will be used for the following purpose: _____

This authorization is:

❑ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

❑ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____(initial)

HIV Diagnosis/Treatment _____(initial)

Psychiatric/Mental Health _____(initial)

Genetic Information _____(initial)

Tests for Antibodies to HIV _____(initial)

DURATION This authorization shall be effective immediately and remain in effect until _____

Date (10 years from today)

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient *or legal/personal representative*

Relationship *if other than patient*

_____ _____

Patient's Name (PRINT)

Date

_____ _____

Patient's Social Security Number

Patient's Date of Birth

_____ _____

Witness name

Witness signature

Rev Oct 2013

Ellner Bariatric

Private Contract for Emergency and Scheduled Telephone Consultations

This letter serves as a private contract between Ellner Bariatric, Inc, NPI/TAX ID: 202538774, and the patient as follows:

MEMBER (PATIENT) NAME: _____

SUBSCRIBER ID/GROUP NO.: _____ **DOB:** _____

Due to recent changes in telemedicine coverage due to COVID-19, coverage may be offered and is subject to change by the insurance companies with no notice. If a patient has telemedicine coverage which can be used, insurance will be billed.

By signing this contract, the beneficiary indicates an understanding that Ellner Bariatric **will not bill insurance for services such as late cancellations, missed appointments, and missing post-op follow-up forms**.

Emergency Telephone Consultations: 99441 - $50, 99442 - $75, 99443 - $100
This contract is entered into willingly by the surgeon and the insurance beneficiary. All questions that I, the patient, have are answered and I understand that I am entering into this contract willingly and with the knowledge that I am solely responsible for payment for listed services from Ellner Bariatric. I have provided my credit card information below for this purpose and instruct Ellner Bariatric to charge this card for services unless I provide alternative method of payment ahead of time. I understand that these rates represent substantial discounts, given as a courtesy to patients who provide pre-authorization to use their credit card. I understand that if I decline to provide such authorization, full rates will apply, and I will be charged $250 for each telephone emergency consultation.

For Post-Op Patients: The beneficiary indicates an understanding that they will be responsible for a $25 fee if they fail to submit their Post-Op follow-up form before their scheduled appointment time.

_____ _____ _____
Credit Card Number (VISA, MC, Discover, AMEX) Expiration Date CVC

_____ _____
Billing Street Address City, State, Zip

_____ _____ _____
Patient Signature Date Surgeon Signature & Date

OR

I decline to provide my credit card for pre-authorization and I understand that I will be charged in full for each telephone consultation.

_____ _____
Patient Signature Date

Appt Cancellation and Late Payment Policy

In consideration of the great number of patients desiring appointments, there will be a $75 fee charged to anyone cancelling an appointment within 24 hours of the scheduled time. Payment will be required before another appointment will be scheduled. There will be a late fee of $50 assessed to the above card for failure to pay any billing invoice within 60 days of receipt.Thank you for your cooperation.

I have read and understand the above policy.

_____ _____
Patient Signature Date