***LAPAROSCOPIC* & *ENDOSCOPIC SURGERY INSTITUTE, P.C.***

**PATIENT REGISTRATION**

**PATIENT NAME** (as it appears on insurance card):

First MI Last SS# \_

Home Address: City St Zip

Phone: Home Cell Work \_

E-Mail \_

**Date of Birth:**

**Sex:** o M o F **Marital Status:** o Single o Married o Divorced o Widowed o Separated

**Race: Ethnicity:**

* White o Black/African American o Asian o AmericanIndian/Alaska Native o Native Hawaiian/Pacific Islander o Declined
* Not Hispanic/Latino o Hispanic/Latino o Declined

**Preferred Language:**□English□ Spanish□Other \_

**Best Contact Method:**o Home o Cell o Work o E-Mail o Mail **Employment Status:**o Full-Time o Part-Time o Unemployed o Student o Disabled o Retired

**Preferred Pharmacy Phone: \_**

**Referring Physician Primary Care Physician \_**

**Fl NCIALLY B.ESPONSIBLE PARTY O Same as Patient Information** *(If different, please complete section below)*

Name:First

MI

Last

DOB: \_

Relationship: Spouse Parent Guardian Other (Please Specify):

Address: City St Zip \_

Phone: Home Cell Work. \_

Email Address Employer: \_

**INSURANCE INFORMAII.ON**

Primary Insurance: Member ID# Group# \_

Address: Phone: Policy Holder: \_

**EMERGENCY CONTACT**

Name: Relationship to Patient: \_

Phone: Home Cell Work.

 **ABOUT US**

* Friend/Family Member o Insurance Company o Walk-in o Web Search o Practice Website o Another Physician/Provider \_

□Other Advertisement: □Hospital/ ED: \_

The above information is true to the best of my knowledge. I understand that it is my responsibility as the patient to determine whether or not the services requested from LESI, P.C. will be covered by my insurance plan(s}, and I understand that I am financially responsible for any balance. I authorize my insurance benefits to be paid directly to the physician. I also authorize LESI, P.C. or my insurance company to release any information required to process my claims.

**Patient Signature \_ Date: \_**

LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, P.C. PERSONAL HISTORY FORM

Patient Name: \_ DOB: \_

Describe the reason(s) for your visit:

Patient Medical History (check all that apply):

□ Chronic Kidney Disease□GERD/Acid Reflux□Hepatitis B □ Hepatitis C (HCV)

□ Hernia O Liver Disease O Stomach/Intestinal Ulcers Anemia□Anxiety/Depression

□ Asthma □ Cancer: Type □ Congestive Heart Disease □ Gallstones

□ C0PD/Emphysema □ Coronary Artery Disease (CAD)□Diabetes□HIV/AIDS

□ Hyperlipidemia/High Cholesterol (HLD) □ Hypertension□ Hypothyroidism □ Migraines

□Obesity□Osteoporosis□Pancreatitis □Seizures□Stroke (CVA) □ Blood Clots

□Other:

**VACCINES:**

Have you ever had a Pneumococcal (Pneumonia) Vaccine?□Yes□No

Have you ever had any of the following vaccines?□Influenza (Flu) □ Hepatitis A□Hepatitis B □ Other

**SURGICAL HISTORY:**

0 Colon Surgery □ Gallbladder Surgery□Gastric Surgery□Liver Surgery□ Nissen Fundoplication

**0** Small Intestine Surgery□ Upper Endoscopy (EGD) □ Appendectomy **O** Brain Surgery

□ Breast Surgery □ CABG/Heart Surgery□Cosmetic Surgery□Fracture Surgery

□ Hernia Surgery□Joint Replacement□ Laparotomy □ Obesity Surgery Type:

□ Prostate Surgery □Spinal Surgery□Thyroidectomy **O** Transplant Surgery

**0** Heart Surgery **O** Other:

* Pacemaker

Family History:

Please list any family history of Illness:

**MEDICATIONS**

List Current Medications (including vitamins and herbal supplements):

Are you currently taking any blood thinners? □ Yes □ No If yes, which blood thinners are you taking: ALLERGIES:

List any medication allergies \_

* No known medication allergies

List any environmental or food allergies:

* No known environmental allergies □ No known food allergies

SOCIAL HISTORY

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) □ Never □ Former □ Current (Every Day) □ Current (Some Days)

I.V. or Recreational Drugs □ Never □ Former O Current (Every Day) □ Current (Some Days)

Tobacco (cigarettes, cigars, chewing tobacco, vape) □ Never □ Former □ Current (Every Day) □ Current (Some Days)

Patient Signature:



Date:

Laparoscopic & Endoscopic Surgery Institute, P.C.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, understand that as part of my health care, Laparoscopic& Endoscopic Surgery Institute, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

* *A* basis for planning my care and treatment,
* *A* means of communication among the many health professionals who contribute to my care,

o *A* source of information for applying my diagnosis and surgical information to my bill

0 *A* means by which a third-party payer can verify that services billed were actually provided, and

0 *A* tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *NoUce of lnformatjon Practkes* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent,

The right to object to the use of my health information for directory purposes, and

e The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Laparoscopic & Endoscopic Surgery Institute, P.C.is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Laparoscopic & Endoscopic Surgery Institute, P.C. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 the Code of Federal Regulations. Should Laparoscopic & Endoscopic Surgery Institute, P.C. change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I also give permission to watch the informed consent video and participate in the pre-operative training session in a group setting, if applicable.

I fully understand and accept the terms of this consent

Patient's Signature Date

FOR OFFICE USE ONLY

( ) Consent received & filed by ;o"-'nL, \_

( ) Consent refused by patient, and treatment/refused as permitted

**Laparoscopic & Endoscopic Surgery Institute, PC**

I The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby assigns and conveys directly to Laparoscopic & Endoscopic Surgery Institute, PC (the "Provider"), the right to pursue payment for benefits and take any necessary steps, including pursing administrative appeals and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, MedRevenue Solutions, LLC and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder.

I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and the provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for all professional services from the 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. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as:*"The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,"* and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to,any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against c:my unexp.ected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary ao<:J,cfpricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative, and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health insurance or plan.

I hereby authorize the Provider, MedRevenue Solutions, LLC, its attorneys or other designated business associate0 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; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 §

U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) 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. I authorize Provider or MedRevenue Solutions, LLC, its attorneys, or designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, take legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. I understand that I will be held financially responsible for all fees

accumulated for collection agency fees. administrative fees, attorney fees and court costs incurred by the provider ,listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocatiOn of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

Patient/Guardian/Insured Signature Employer Group Name Covering Benefits Date

**Laparoscopic** &. **Endoscopic Surgery Institute, PC Financial Agreement/Procedure Guidehnes**

Welcome to Laparoscopic & Endoscopic Surgery Institute, PC. Please take a few minutes to review the following information concerning our billing and payment procedures for services rendered by our office. We have provided thi information to you because ultimately you are responsible for all charges, knowledge of your insurance policy benefits, and payments for services received. Our financial coordinator is available to assist you with any questions or concerns you may have regarding billing and payments.

It is the responsibility of the patient to provide Laparoscopic & Endoscopic Surgery Institute, PC with the most up-to­ date insurance information. If our providers do not participate with your particular insurance plan or provider network, payment of your insurance claim will be based on your out of network benefits and insurance allowable. Due to our out of network status, some insurance companies may mail their payment directly to the insured. Unless you paid for your surgery in full upfront, this money is not yours to keep and should be forwarded to Laparoscopic & Endoscopic Surgery Institute, PC within 10 days of receipt. Failure to comply with this policy will result in your account being placed with an outside collection agency for collection. Please contact our financial coordinator if you have any questions or concerns.

I understand that I am financially responsible for any amount NOT covered by my in urance company and agree to make payment in full to Laparoscopic & Endoscopic Surgery Institute, PC.

Co-Payments are the responsibility of the patient and are due at the time of your pre-operative/post-operative appointment.

I understand that I am responsible for any future surgical or diagnostic procedures due to complications or non-related medical conditions. I also understand that if I require disability or FMLA forms to be completed that I will be required to pay a$35.00 fee. Payment is due prior to completion of the forms. I understand that I will be charged a rate of $90.00 for any non-emergency phone consultation after regular business hours and weekends. I understand that I will be charged a

**$25.00** fee for any missed appointment that is not canceled 24hrs in advance.

I also understand that I will be placed in collections for unpaid balances and all future medical care will be suspended. I understand that if I have been required to pay a surgical deposit, this fee may be non-refundable if I later decide to cancel my surgery. For your convenience, we accept cash, money order, certified bank/cashier's check, Visa, MC,

Di cover, or American Express. No personal checks are accepted. Self-Pay patients must provide their surgery fees in full at the time of their pre-operative appointment.

I understand that my physician may refer me to Atlanta General and Bariatric Surgery Center\_for o,utpatient surgery. I understand that the Doctor has a financial interest in this surgery center and that has been disclosed to

**me.**

I understand that this release includes all confidential information in my medical record, including information related to psychiatric care, drug and/or alcohol abuse and HIV/AIDS. I authorize medical information to be released via mail, fax, electronic data, and or by telephone as requested. I understand that this authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I authorize all insurance benefits for services rendered by Laparoscopic & Endoscopic Surgery Institute, PC and/or its associates to be paid directly to Laparoscopic & Endoscopic Surgery Institute, PC.

I have read and agree to the above financial agreement/procedure guidelines for Laparoscopic &: Endoscopic Surgery Institute, PC

Patient or Responsible Party Signature Witness

Print Name Date