VIRGINIA BARIATRIC
171 Elden Street • Suite 3B • Herndon, VA 20170
Ph: (703) 709-9771 • Fax: (888) 519-0045
contact@virginiabariatric.com • www.virginiabariatric.com

PATIENT REGISTRATION

SEMINAR ATTENDED:_____ DO YOU HAVE A LIVING WILL? ☐YES ☐NO INITIALS: _____

PATIENT'S NAME : FIRST	M.I.	LAST	MALE OR FEMALE ☐M or ☐F	SOCIAL SECURITY #	DATE OF BIRTH

HOME ADDRESS	APT#	CITY	STATE	ZIP	HOME PHONE

EMPLOYER	ADDRESS	WORK PHONE

OCCUPATION	**REFERRED BY:**	CELL PHONE

COMMUNICATION CONSENT: Text: ☐ Yes ☐ No Phone: ☐ Yes ☐ No

EMAIL ADDRESS	PERSONAL PHYSICIAN: FIRST and LAST NAME	MARITAL STATUS ☐S ☐M ☐W ☐D

SPOUSE'S NAME	CELL PHONE	WORK PHONE	OCCUPATION

EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE

INSURANCE POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	FINANCIALLY RESPONSIBLE PERSON ☐PATIENT ☐SPOUSE ☐PARENT ☐OTHER

PHARMACY	ADDRESS	PHONE

POLICY PAYMENT

Professional services are charged to the Patient. The Practice will submit insurance claims on Patient's behalf, but Patient has final responsibility for all fees, regardless of insurance coverage. Payment is required when services are rendered unless other arrangements are agreed to in advance. If Patient's account goes to collections, Patient agrees to pay all fees and costs incurred by the Practice or its agents in the collection process.

I agree to pay a $50.00 fee for missed appointments without 24-hour advance notice; a $10 fee for copays not paid at the time of a visit; a $35 fee for record requests; and a 3% fee for credit transactions over $500. I certify that information I provided is accurate.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize VIRGINIA BARIATRIC SURGERY to furnish information to insurance carriers (including Medicare), and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I agree that I am responsible for any amount not covered by insurance(s).

PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") gives me certain privacy rights regarding my protected health information (PHI). I understand that this information will be used in:

- Treatment - Coordination of care and follow up among the healthcare providers who may be involved in that treatment directly and indirectly.
- Payment - Obtaining payment from third-party payers.
- Healthcare Operations - Administrative matters such as quality assessments and physician certifications.

I have received and/or previewed your Notice of Privacy Practices, with a complete description of uses and disclosures of my (or dependent's) PHI. I understand that the Practice has the right to change its Notice of Privacy Practices and that I may at any time request, in writing from Dr. Fitzer, a current copy of the Notice of Privacy Practices.

I understand that I may request in writing restrictions on how my protected health information is used. I also understand the Practice is not required to agree to any restrictions, but it is bound to abide by such restrictions to which it agreed.

Date Signature of Subscriber or Beneficiary

CONDITIONS OF REGISTRATION

THE PRACTICE

Virginia Bariatric Surgery Center, P.C., and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the healthcare provider rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures. **Patient is financially responsible for all covered and non-covered services.**

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare and Medicaid Services, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I, the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my spouse, my children, step-children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with participating insurance companies. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confirmation. I agree to pay a minimum $15.00 form fee. I agree to pay a $50.00 fee for missed appointments that are not cancelled at least 24 hours in advance, or if I arrive late for an appointment. I understand that prescription refills, forms, and missed appointment fees will be my financial responsibility and will not be sent to insurance. If my insurance requires or if I have not obtained the proper referral, I further agree that I am financially responsible for any incurred charges. Should any balance arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree to pay $600 if I cancel or reschedule already scheduled surgery within 3 weeks of confirmed surgery date, and I agree to pay $400 if I cancel or reschedule 4 to 6 weeks prior to already scheduled surgery. Service charges of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and service charge as an attorney fee, plus court costs and service charge in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed service charge, shall become an additional liability for which I (we) assume full responsibility.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic for the purpose of payment, treatment or operations.

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

I certify that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated in this document.

_____	_____	_____
Signature of Patient/Parent/Guardian/Guarantor	Print Name	Date

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MEDICAL RECORDS RELEASE

TO: _____
_____
_____

I hereby authorize you to release to:

Matthew A. Fitzer, M.D.
Virginia Bariatric Surgery, P.C.
171 Elden Street, Suite 3B
Herndon, VA 20170

☐ All Information

☐ Any information including the diagnosis and records of any treatment or examination rendered to me during the period:

From_____To _____

_____ _____
WITNESS PATIENT'S SIGNATURE

_____ _____
DATE PATIENT'S NAME (PRINT)

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Informed Consent for Telemedicine Services

Patient Name: Date of Birth: Date:

Introduction

Telemedicine involves the use of electronic communications to enable healthcare providers at a patient's location to interact with patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records
- Medical Images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data, and will include measures to safeguard the data and to ensure it is transmitted without corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain at a remote site while consulting from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow appropriate medical decision making by the providers;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that any information obtained in the use of telemedicine which identifies me will be disclosed to researchers only as authorized by law.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in a telemedicine interaction, and may receive copies for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to practitioners located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that those benefits cannot be guaranteed or assured.
7. I understand that the provider will bill services to my insurance company, and that I am liable for any fees or costs associated with this telemedicine visit.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Virginia Bariatric Surgery Center to use telemedicine in the performance of care.

Signature of Patient (or person authorized to sign): Date:

_____ _____