VIRGINIA BARIATRIC
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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