

COMMUNITY BARIATRIC SURGEONS
Community Hospital North Bariatric Center of Excellence
7250 Clearvista Drive, Ste 100
Indianapolis, IN 46256
317-621-(LOSE)5673 - fax: 317-621-6040

PATIENT HEALTH QUESTIONNAIRE

Please MARK the name of the surgeon you are consulting with today:

_____ **RoseMarie Jones, MD** _____ **Scott Mimms, MD**

Reason for today's visit: _____ **Date:** _____

Who referred you to our office: _____

Last Name: _____ First _____ M.I. _____

Patient AGE _____ **Date of Birth:** ____/____/____ **SSN:** _____ - _____ - _____ **Male or Female**

Address: _____

City: _____ **State** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **Work:** _____

Email address: _____ **May we contact you at work?** Y or N

Marital Status: Single Married Widow Widower Separated Divorced

Race: Caucasian African American Hispanic Other

Referring Physician: _____ **Phone:** _____

Address: _____ **City** _____ **State** _____ **ZIP** _____

Primary Care Physician: _____ **Phone:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Employer: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Spouse/Next of Kin: _____ **Relationship:** _____

Phone: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

INSURANCE INFORMATION ~ Primary

Primary Insurance (If this is under workman's compensation, ask front desk for Work Comp Questionnaire)

Name: _____

Claims Address: _____

City: _____ **State** _____ **Zip** _____

Policy Holder:

Last Name: _____ **First** _____

Relationship: _____ **Policy Holder DOB:** _____ **Policy Holder Gender: M or F**

Policy Holder SSN: _____ **ID#** _____ **Group#:** _____

Phone Number: _____ **Effective Date:** _____

SECONDARY INSURANCE

Secondary Insurance (If this is under workman's compensation, ask front desk for Work Comp Questionnaire)

Name: _____

Claims Address: _____

City: _____ **State** _____ **Zip** _____

Policy Holder:

Last Name: _____ **First** _____

Relationship: _____ **Policy Holder DOB:** _____ **Policy Holder Gender: M or F**

Policy Holder SSN: _____ **ID#** _____ **Group#:** _____

Phone Number: _____ **Effective Date:** _____

Patient Name: _____ Date of Birth _____

Please list all providers involved in your care:

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

REVIEW OF SYSTEMS

Name:

Date of Birth:

General	Eyes	Ears/Nose/Throat
<input type="checkbox"/> Fever	<input type="checkbox"/> Blurring	<input type="checkbox"/> Earache
<input type="checkbox"/> Chills	<input type="checkbox"/> Double vision	<input type="checkbox"/> Ear discharge
<input type="checkbox"/> Sweats	<input type="checkbox"/> Irritation	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Discharge	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Vision loss	<input type="checkbox"/> Nasal Congestion
<input type="checkbox"/> Lack of energy	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Sore throat/ <input type="checkbox"/> Hoarseness
<input type="checkbox"/> No Issues	<input type="checkbox"/> No Issues	<input type="checkbox"/> No issues
Cardiovascular	Respiratory	Gastrointestinal
<input type="checkbox"/> Chest pains	<input type="checkbox"/> Cough	<input type="checkbox"/> Nausea/ <input type="checkbox"/> Vomiting
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Diarrhea/ <input type="checkbox"/> Constipation
<input type="checkbox"/> Fainting	<input type="checkbox"/> Excessive sputum	<input type="checkbox"/> Change in bowel habits
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Spitting up blood	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Dark stools
<input type="checkbox"/> Swelling in extremities	<input type="checkbox"/> No issues	<input type="checkbox"/> Bloody stool (bright red)
<input type="checkbox"/> No issues		<input type="checkbox"/> Jaundice
		<input type="checkbox"/> Heartburn
		<input type="checkbox"/> No issues
Genitourinary	Musculoskeletal	Skin
<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Back pain	<input type="checkbox"/> Rash
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Itching
<input type="checkbox"/> Pain upon urination	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Dryness
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Suspicious lesions
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> No issues
<input type="checkbox"/> Absence of menstruation	<input type="checkbox"/> Stiffness	
<input type="checkbox"/> Normal menstruation	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Abnormal vaginal bleeding	<input type="checkbox"/> No issues	
<input type="checkbox"/> Pelvic pain		
<input type="checkbox"/> No issues		
Neurologic	Psychiatric	Endocrine
<input type="checkbox"/> Transient paralysis	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Weakness	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Seizures	<input type="checkbox"/> Mental disturbance	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Fainting	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Weight change
<input type="checkbox"/> Tremors	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Increased appetite
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Paranoia	<input type="checkbox"/> No issues
<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	
Heme/Lymphatic	Allergic/Immunologic	
<input type="checkbox"/> Abnormal bruising	<input type="checkbox"/> Hives	
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hay fever	
<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Persistent infections	
<input type="checkbox"/> Deep vein thrombosis	<input type="checkbox"/> HIV exposure	
<input type="checkbox"/> No issues	<input type="checkbox"/> No issues	Rev: 1/17/2011

Name _____ AGE: _____ DOB _____

Do you smoke? _____ Yes _____ No Cigarettes Cigars _____ Amount per day (packs)

Do you use other smokeless tobacco products? _____ Yes _____ No _____ Amount per day

Do you drink alcohol? _____ Yes _____ No Type: _____

Average drinks per day: _____

Do you drink caffeinated drinks? _____ Yes _____ No Amount _____ Type _____

Do you use recreational drugs? _____ Yes _____ No Type: _____

FAMILY HISTORY

	FATHER	MOTHER	BROTHER	SISTER	PATERNAL FATHER	PATERNAL MOTHER	MATERNAL FATHER	MATERNAL MOTHER
BLEEDING PROBLEMS								
CANCER: TYPE								
DIABETES								
HEART DISEASE								
HIGH BLOOD PRESSURE								
STROKE								
OTHER								

Pharmacy Name: _____

Location: _____

Phone: _____ Zip Code if known: _____

Communication Disclosure:

I, the undersigned, hereby authorized Community Bariatric Surgeons. to **discuss my medical condition and financial matters pertaining to my care with:**

(name) _____ (relationship) _____

(name) _____ (relationship) _____

(name) _____ (relationship) _____

Patient's Signature: _____ Date: _____

Community Bariatric Surgeons
Community Bariatric Center Services
Sleep Disorder Screening Questionnaire

Today's Date: _____

Surgeon: _____

Last Name (Printed) _____ First Name (Printed) _____

DOB _____ Age _____ Sex _____ Height _____ Weight _____

Home Address: _____ City/State _____ Zip _____

Home Phone: _____ Alternate Phone: _____

1. Have you ever been diagnosed with a sleep disorder? Y N
2. Are you currently on a CPAP/BIPAP machine? Y N
If yes, what are your pressure settings? _____
If yes, what type of mask do you wear? _____
3. Do you snore? Y N
4. Do others say you stop breathing while you are sleeping? Y N
5. Do you have trouble staying awake when you need or want to be awake? Y N
6. Do you fall asleep during any of the following?

Watching TV?	Never	Rarely	Sometimes	Frequently
While at work?	Never	Rarely	Sometimes	Frequently
At Movies, Church?	Never	Rarely	Sometimes	Frequently

7. Have you ever fallen asleep while driving? Y N
8. Do you fall asleep frequently while reading books or newspapers? Y N
9. Do you have trouble getting to sleep or staying asleep when you want to sleep? Y N
10. Do you still feel tired after eight hours of sleep? Y N
11. Do you frequently get less than seven hours of sleep in a 24 hour period? Y N
12. Do you ever have a crawling leg feeling or restless legs during sitting/lying? Y N
13. Have you ever noticed jerking movements of your legs during sleep hours? Y N
14. How much of the following caffeine sources do you consume each day:
Coffee _____ Soft Drinks _____ Tea _____ Other _____
15. Do you believe you have any other sleep related problems? Y N
Please describe _____

Patients Primary Care Physician Information: Physician Name _____
Physician Address _____

For Office Use Only

Indicates a sleep study is recommended prior to surgery: Y N

Date faxed to scheduling: _____

Staff Member: _____

Fax Report to 317-621-6040 Mail Report to: 7250 Clearvista Dr. #100 Indianapolis, IN 46256

PATIENT FINANCIAL POLICY
Community Bariatric Surgeons

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION: A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:

Primary Insurance: We will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected**. If necessary, we can set up a payment schedule. Payment arrangements will be made with a signed Payment Agreement and the approval of the Office Manager.

Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible party on the registration form.

WORKERS' COMPENSATION: Workers' compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a workers' compensation form must be completed.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA and MasterCard. VISA and MasterCard payments can also be accepted by phone or fax.

PAST DUE ACCOUNTS: Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement.

Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice.

In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

A patient may remit in full for all outstanding charges owed on account including amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. Consecutive missed appointments without notice will be documented and may result in discharge from the practice.

ACCOUNT CONSULTATION: Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance please ask to speak with the Office Manager.

MEDICAL RECORDS: If you need us to transfer your records to another physician, please contact the office. They will provide you with the HIPAA compliant documents.

ACKNOWLEDGMENT OF RECEIPT: I have received a copy of the financial policy.

_____ / /
Patient/Guarantor Signature Date

MEDICARE/MEDIGAP AUTHORIZATION: I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to _____ (*name of practice/provider*) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap insurer) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

_____ / /
Patient/Medicare Beneficiary Signature Date

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES:

This is to acknowledge my receipt of this facility's Notice of Privacy Practices.

_____ / /
Patient/Guarantor Signature Date

Consent to Treatment
Insurance Authorization and Assignment of Benefits

“By signing this form, I authorize the physicians, agents, and employees of Community Bariatric Surgeons to provide medical and surgical care and services, including, but not limited to, diagnostic tests, examinations, and other medical and surgical procedures, in the course of my medical care, and I agree to comply with the plan of care/services to which I have consented.”

I authorize Community Bariatric Surgeons to release information and submit insurance claim forms on my behalf for all services furnished on an inpatient or outpatient basis. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries, or carriers, any information needed for submitting claims.

I hereby assign, transfer and convey to Community Bariatric Surgeons all medical, surgical and related benefits, including major medical benefits payable under my insurance policy or by any other third party payors, to be applied to charges for services performed by Community Bariatric Surgeons and I request that all payment of benefits be made directly to Community Bariatric Surgeons.

I agree to provide current and complete information so that charges may be billed to my insurance company or other third party payor.

I accept full financial responsibility if I fail to notify Community Bariatric Surgeons of pre-certification requirements that result in the denial of charges by the insurance company and if I fail to notify of changes in insurance coverage. It is my responsibility to obtain a referral from my Primary Care Physician and to determine if my surgeon is in my network and a preferred provider.

I understand that I am responsible for any remaining balance after insurance or other third party payor reimbursement, including any deductible or co-insurance. I understand that I will be responsible for any charges not covered by insurance or other third party payor, or in the event that there is not insurance or other third party payor coverage. I hereby guarantee payment in full of my account within thirty (30) days of the performance of services or in accordance with the written financial arrangements made at the time such services were performed. All accounts not paid in accordance with the above statement will be outsourced for collection.

This authorization will remain in effect until revoked in writing. A photocopy of my signature shall be valid as the original.

Signature: _____ Date: _____

If patient is a minor, signature of parent/legal guardian:

Signature: _____ Date: _____

Rev: 10-20-2011