Johns Creek Surgery / Atlanta Bariatrics / The Vein Center at Johns Creek /Bodiatrics

Welcome to our office. In order to serve you properly we will need the following information.
All information will be kept strictly Confidential.

Patient Demographic Information

Patients Full Name:_____ Date of Birth: / / Sex: ___ Male ___ Female

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

(Email and Number used for Appointments reminder calls)

Email: _____ Primary Phone: _____ Secondary Phone:_____
Primary Care Physician: _____ Office Phone Number: _____
Referring Physician: _____ Office Phone Number: _____

Pharmacy: _____ Pharmacy Phone Number: _____

Marital Status: ____ Single ____ Married ____ Divorced ____Other

Person Responsible for Account:_____ Date of Birth: / /
Patients Employer: _____ Work Phone: _____
Address:_____ City: _____ State: _____ Zip: _____

Name of Souse/Parent: _____ Date of Birth: / /
Primary Phone: _____ Secondary Phone:_____
Emergency Contact: _____ Relationship to Patient: _____
Primary Phone: _____ Secondary Phone:_____

Insurance Information

Primary Insurance Company: _____ Phone Number: _____

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

Insured's Name: _____ Date of Birth: / /

Relationship to Patient: _____ Member ID # _____ Group # _____

Secondary Insurance Company: _____ Phone Number: _____

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

Insured's Name: _____ Date of Birth: / /

Relationship to Patient: _____ Member ID # _____ Group # _____

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 Johns Creek Surgery / Atlanta Bariatrics/ The Vein Center at Johns Creek/Bodiatrics will be covered by my insurance plan(s), and I understand that I am responsible for any balance. I authorize my insurance benefits to be paid directly to the physician. I also authorize Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek /Bodiatrics or my insurance company to release any information required to process my claims.

_____ _____
Patient / Responsible Party Signature Date

JOHNS CREEK SURGERY, PC / ATLANTA BARIATRICS / THE VEIN CENTER AT JOHNS CREEK /BODIATRICS

PATIENT QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Patient Name: _____ **Today's Date:** _____

Age: _____ **Date of Birth:**_____ **Occupation:** _____

Primary Care Physician: _____ **Referring Physician:** _____

What problem brought you here today? _____ **How long have you had this problem?**_____

What pharmacy do you use? _____

Check Yes if you ever had the following?

Yes		Yes		Yes	
☐	Heart Disease	☐	Ulcers	☐	High Blood Pressure
☐	Rheumatic Fever	☐	Liver Disease	☐	High Cholesterol/Lipids
☐	Mitral Valve Prolapse	☐	Thyroid/Endocrine Disease	☐	Arthritis/Joint Problems
☐	Artificial Heart Valve/Pacemaker	☐	Gallbladder Disease	☐	Gastroesophageal Reflux
☐	Stroke / Vascular Disease	☐	Asthma	☐	Sleep Apnea
☐	Blood Clots	☐	Seizures	☐	Diabetes (NIDDM)
☐	Cancer	☐	HIV / AIDS	☐	Depression
☐	Artificial Joints	☐	Hepatitis	☐	Bipolar Disorder
☐	Restless/pain or heaviness in the legs	☐	TB		
☐	Other Illness or Medical Problems: _____				

List any surgery you have had and when/where performed:

_____

_____

Have you taken cortisone/steroids in the past six months? _____ **If yes, what type?** _____

Are you taking any blood thinners (ie, Coumadin, Lovenox, etc.)? _____

List all medications **you are taking:**

Name	Dose	Frequency	Name	Dose	Frequency
_____			_____		
_____			_____		
_____			_____		

List any allergies**:** _____

Current/Previous tobacco use? _____ **How much per day?** _____
Do you drink alcohol? _____ **How much per day?** _____

Check Yes if you are currently having any of the following?

Yes		Yes		Yes	
☐	Marked weight change	☐	Difficulty breathing when lying down	☐	Bleed/ bruise excessively
☐	Night sweats	☐	Coughing up blood	☐	Numbness/ tingling
☐	Vision changes	☐	Vomiting up blood	☐	Ankle swelling
☐	Frequent nosebleeds	☐	Persistent fever	☐	Chest pain
☐	Hoarseness	☐	Skin rash	☐	Abdominal pain
☐	Difficulty hearing	☐	Bloody urine	☐	Black, bloody, or pale stools

For women:
Are you pregnant? ___Yes ___No Last menstrual period: _____

_____ _____

The above is true and correct to the best of my belief. Patient's Signature Date

Johns Creek Surgery / Atlanta Bariatrics / The Vein Center at Johns Creek/ Bodiatrics
HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 106 and 164)

I hereby give my consent for Johns Creek Surgery, P.C./Atlanta Bariatrics/The Vein Center at Johns Creek/ Boidatrics to use and disclose protected health information (PHI) about me to carry out Treatment, Payment, or healthcare Operations (TPO). Johns Creek Surgery, P.C./Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics' Notice of Privacy Practices provided a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/ Bodiatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to:

Johns Creek Surgery, P.C.
Attn: Privacy Officer
6920 McGinnis Ferry Road
Suite 340
Suwanee, GA 30024

Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics Notice of Privacy Policy can be found on our websites, Patient Portal and in our lobby.

With this consent, Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, including laboratory results among others.

With this consent, Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek / Bodiatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/ Bodiatrics may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient Printed Name

Johns Creek Surgery / Atlanta Bariatrics / The Vein Center at Johns Creek /Bodiatrics

Financial and Practice Policies

REFERRALS

I understand that it is my responsibility to obtain a referral prior to being seen by Johns Creek Surgery PC if my insurance company requires one. I understand that it is my responsibility to find out from my insurance company if a referral is needed for my plan. I understand that I am responsible for payment if my insurance company denies my claim because I did not obtain a referral.

MEDICAID

I understand that Johns Creek Surgery PC does not accept Medicaid for any bariatric services including surgery, gastric band fills or dietitian services.

DIETITIAN APPOINTMENTS

I understand that Johns Creek Surgery PC will not bill my insurance company for dietitian services. I may request an itemized statement to submit to my insurance company for reimbursement.

CO-PAYMENTS

I understand that my co-payment is due at each office visit unless I am in a surgical global period. I understand that Johns Creek Surgery PC does not bill or waive co-payments

APPOINTMENTS AND CANCELLATIONS

Providing complete and thorough medical care to our patients is our number one goal. Our providers and staff members work very hard to maintain this goal and we ask that patients make every effort to adhere to the appointment time that has been reserved for you. We kindly ask that you give us 24 hours' notice in the event that you are unable to keep your appointment in order for us to schedule and care for other patients.

PRESCRIPTIONS REFILL POLICY

Providing patients with the highest standard of car requires that patients also take part in the process of monitoring their conditions. It is imperative that patients return for follow up visits in order to monitor certain conditions and also to allow us to closely watch areas that are of concern. In the event that you have received a prescription medication follow up visit in order to refill your prescription medication.

- We do not refill oral medications over the phone
- We will not refill any prescription issued by another provider without an evaluation by one of our providers.

 Initial: _____

INSURANCE

In order for our office to maintain accurate billing, we do require that an image of all of your insurance cards be on file in our system. It is imperative that you, as the insured, be aware of exactly how your policy (ies) has been written within your insurance company and how your individual benefits apply. Most insurance plans require a separate deductible for surgical procedures and you will be required to pay this deductible at the time of services. I understand that Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics will assist me with coverage issues, benefits and eligibility and precertification, if needed.

I have provided Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics with all of my insurance cards, including those insurance cards wherein Johns Creek Surgery/Atlanta Bariatrics/The Vein Center at Johns Creek/Bodiatrics may be a non-participating provider.

If your insurance company has not paid our office within 45 days, you will be billed from our office and we will ask that you contact your insurance carrier directly to help expedite your claim.

I understand that any contract for insurance coverage that I have is between my insurance company and me. I understand that Johns Creek Surgery, PC will assist me with coverage issues, benefits and eligibility and pre-certification, if needed, however, I am ultimately responsible for payment for all services rendered to me.

I understand that if I change my insurance company, plan or coverage while undergoing bariatric surgery, Johns Creek Surgery PC may not bill or accept my insurance. I agree to notify Johns Creek Surgery immediately of such changes. I understand that I may revert to a self-pay status and be responsible for all charges in the event of an insurance change.

TELEHEALTH SERVICES

By consenting to have a Telehealth Visit, you agree that you have read, understand, and agree with these terms. I also confirm by selecting YES below that:
I have been told the name and credentials of my telemedicine provider, I have been able to ask questions about telemedicine sessions, all of my questions have been answered, I understand no guarantees have been made about success or outcome, and I agree to take part in a telemedicine session.

Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see him or her in person. The doctor uses the Internet or other technology to:
give you advice, give you an exam, or do a procedure through online communications.
Telemedicine can also be used to: get prescription refills, book an appointment, or
let your doctor talk with other providers about your health problem or treatment.
Telemedicine is more than a phone call, an email, a fax, or an online questionnaire. Sometimes you may need to come to a healthcare facility to use their equipment (TV screen, camera, or Internet). A provider may use need to use technology tools or medical devices to check on your health remotely. If you agree, part of your health record may be sent to the telemedicine provider before your session. You and your healthcare team must decide if your health problem can be helped with telemedicine. The team and others involved in your care (e.g., medical home or hospital teams) will make a plan for your care using telemedicine. This will also include a plan in case you have an emergency during the telemedicine session. If the patient is a minor child, the telemedicine provider will explain to the parent how a telemedicine exam is different from an in-person exam. He or she will also explain if a complete exam of the child is possible.

 Initial: _____

Your Telemedicine Session. During your telemedicine session: The provider and the staff will introduce themselves. When starting a session, you may be asked to confirm the state you are in and the state where you live. The provider may talk to you about your health history, exams, x-rays, and other tests. Other providers may take part in this discussion. A visual and/or partial physical exam may take place. This may happen by video, audio, and/or or with other technology tools. A nurse or other healthcare staff may be in the room with you to help with the exam. Non-medical staff may be in the room to help with the technology. Video and/or photo records may be taken, and audio recordings may be made. A report of the session will be placed in your medical record. You can get a copy from your provider.

All laws about the privacy of your health information and medical records apply to telemedicine. These laws also apply to the video, photo, and audio files that are made and stored. Risks and Common Problems. Many patients like telemedicine because they do not have to spend time and money on travel to see a certain healthcare provider in person. Also, they can see a provider who they might not be able to see otherwise. Technology can make getting health care easy, but there can also be problems: If there is an equipment or Internet problem, your diagnosis or treatment could be delayed. Records or images that are taken and sent may be poor quality. This can delay or cause problems with your diagnosis or treatment. The records sent for review before the session may not be complete. If this happens, then it may be hard for the telemedicine provider to use his or her best judgment about your health problem. For instance, you could react to a drug or have an allergic response if the provider does not have all of the facts about your health. There could be problems with Internet security and privacy. For instance, hackers may access or view your health information. If this happens, then your medical records may not stay private.
If there is a technology problem, the information from your session may be lost. This
would be outside the control of your doctor and the telemedicine provider. Without a hands-on exam, it may be hard to diagnosis your problem. More Facts. A main goal of telemedicine is to make sure that you get good, personal health care, even though you are not seeing a provider in person. Some states may require you to have a face to face visit first and a yearly visit with your doctor before telemedicine treatment can happen. Telemedicine providers must follow the same rules for prescribing drugs just as they would for an office visit. Before your session, you will learn about which drugs telemedicine providers can and cannot prescribe. Having a telemedicine session is your choice. Even if you have agreed to the session, you can stop your medical records from being sent - if this has not happened yet. You can stop the session at any time. You can limit the physical exam. You will be told about all staff who will take part in the session. You can ask that any of these people leave the room to stop them from seeing or hearing the session. It is up to you to make sure the setting for your session is private. It should only include people who you are willing to share health information with. Your telemedicine provider can ask that people with you leave the room to make sure your session is private. Your session may end before all problems are known or treated. It is up to you to get more care if your health problem does not go away. You will be told how long it might take to respond to your emails, phone calls, or other types of messages. Before your session, you may want to ask how much of the cost will be covered by your insurance and how much you may owe

 Initial: _____

OUR PRACTICE IS NOW PARTICIPATING IN THE EMORY HEALTH INFORMATION EXCHANGE (HIE)

When it comes to your health care, it is important for all members of your care delivery team to have details about your current and past medical information. This is why Emory Healthcare has made it

easy for you to get this information to your providers through the Emory Health Information Exchange (HIE), an electronic network that allows approved providers within the Emory HIE network to securely share and view your health information. The Emory HIE has several significant benefits, such as: improves access to existing information required for diagnosis by ensuring that all members of your care team have a more complete picture of your health information (this is especially imperative during emergency treatment when time is most critical), enhanced coordination among your care team, easier for you to share information. With the Emory HIE, your providers have access to your medical information and can get to work on your current health questions and concerns, and reduced duplicate medical procedures

Participation in the Emory HIE is your choice. If you choose to opt out and not participate in the HIE, your health information will not be shared among health care providers through the HIE. Instead, your providers will continue to share information via previously established methods, such as phone, fax, mail or through an existing electronic medical record. This also means that opting out of the HIE does not affect the sharing of information by providers using the same electronic medical record. It applies only to the HIE. You can opt out by letting our front office staff know, and they will provide you with the Emory HIE Opt-Out Form.

SURGERY CENTER REFERRAL

I understand that my physician may refer me to Atlanta General and Bariatric Surgery center for outpatient surgery. I understand that the Doctor has a financial interest in this surgery center and acknowledge that this information has been disclosed to me.

My signature below states that I have read, understand, and agree with these policies.

_____ _____

Patients / Legal Guardian Signature Date

_____

Print Patients Name

Johns Creek Surgery / Atlanta Bariatrics / The Vein Center at Johns Creek / Bodiatrics

By signing this, I confirm that I have been offered a copy of Johns Creek Surgery, P.C.'s *Notice of Privacy Practices*. I understand that it is my responsibility as a patient to read the information contained in the document.

I understand that I will need to provide a security access code to Johns Creek Surgery, PC in order for Johns Creek Surgery PC to speak to someone on my behalf about my medical condition, appointment reminders or billing issues. My security access code is:

_____ Mother's maiden name –OR –

_____ last 4 digits of my social security number

I understand that anyone calling on my behalf will need to know my security code before any information including appointment reminders can be discussed with them.

I understand that no information will be released to anyone who cannot provide the security access code that I have designated.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature of JCS employee Date

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as correspondence to the individual's office instead of their home.

___ Home Telephone

____ Ok to leave a message with details
____ Leave message with call-back number only

____ Written Communication

____ Ok to mail to my home address
____ Ok to mail to my work/office address
____ Ok to fax to this number _____

____ Work Telephone

____ OK to leave a message with details
____ Leave message with call-back number only

_____ I give authorization for CSCD to leave message in my absence with _____
_____(indicate relation to patient) for matters regarding:

____ Cell Telephone

____ OK to leave a message with details
____ Leave message with call-back number only

____ my appointment reminders
____ my account such as billing and amount due
____ my treatment/test results

Surgical Assistant Service – Patient Disclosure Form

For your surgery your surgeon may request the services of a Surgical Assistant. There is a separate fee for these services and they will not be included in either your surgeon's fee or the hospital charges.

The surgical assistant service will file a claim on your behalf with your insurance for these surgical assistant services and although your surgeon may participate in your insurance network, the surgical assistant may or may not be eligible for reimbursement under your insurance plan. **If your insurance denies payment you will not be responsible for these charges as long as you have filled out your Surgical Assist demographics.**

Regarding the above and all other information contained in this form, I (the undersigned) acknowledge, understand, and agree as follows:

* I am the patient who will receive the surgery (or such patient's personal representative). I have read and understand this surgical assistant service policy and all information contained in this form. I have had the full opportunity to ask any questions that I may have regarding this surgical assistant financial policy. All questions have been answered to my full satisfaction.

Initial: _____

* I authorize the payment of insurance benefits to be made on my behalf to the surgical assistant service designated for my surgery. I hereby authorize any and all release of any medical records or medical information in order to process the claim for services rendered.

Initial: _____

* I understand that my insurance benefits may not cover these surgical assisting services **and I will not be personally responsible for any charges incurred that are non-covered or deemed medically not necessary, or denied by my insurance carrier as long as I have filled out the necessary Surgical Assist demographics.**

Initial: _____

***The Insurance Company may send you a check to pay for the Surgical Assistant. The Surgical Assistant Practice will also receive this EOB stating that the payment was sent to you to cover these services. The Surgical Assistant practice will invoice you for the same amount of the check you received from the insurance company, and you will be responsible for payment of this invoice.**

Initial:_____

Patient (or Personal Representative):_____

Representative relationship to patient: _____

Print Patient's Name: _____ Date: _____

Surgeon: _____