BARIATRIC PATIENT HISTORY

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.

Date:_______________ Name:________________________________ D.O.B.:____________

Age:________ Sex: M F

Please check any medical conditions which you have or have had:

___ Heart Disease ___Irregular Heart Beat ___Cancer: Type_____________
___ Hypothyroidism ___Venous Stasis Ulcer ___ Arthritis
___Lymphedema ___Phlebitis ___Deep Venous Thrombosis
___Incontinence ___Pacemaker ___Asthma
___Stroke ___Other:__________________
___Reflux Disease ___**# of medications used** ___Other:__________________
___ High Blood Pressure ___**# of medications used**
___ Diabetes ___**insulin** ___**non-insulin**
___Sleep Apnea **requiring CPAP/BIPAP**
___High Cholesterol **requiring medication**
___Kidney Disease **Do you currently require dialysis? Y N**

Please list any past surgical procedures:

1.____Date__________
2.____Date__________
3.____Date__________
4.____Date__________
5.____Date__________

Allergies:

______________________________Type of Reaction______________________________
______________________________Type of Reaction______________________________
______________________________Type of Reaction______________________________

Latex Allergy ___yes ___ no
Bloodless Patient ___yes ___ no

Medications:

________________________ ___________________________ _____________________
________________________ ___________________________ _____________________
________________________ ___________________________ _____________________

Please check the following medications which you take on a regular basis.

___ **Aspirin** ___ **Coumadin** ___ **Plavix**

Diet History:

___Weight Watchers ___ South Beach Diet ___Atkins

___LA Weight Loss ___ Liquid Diet ___Nutrisystem

___Exercise ___ Hypnosis ___Behavioral Modification

___Acupuncture ___ Medically Supervised Diet

___Meridia ___Xenical ___Phen/Phen or Redux

Other:________________________________

Other:________________________________

Social History:

Do you currently smoke cigarettes?__yes __no # of packs per day___ Date Quit_____

Did you smoke in the past?__yes __no # of packs per day___ Date Quit_____

Do you drink alcohol on a regular basis? ___yes ___no # of drinks per day ____

Do you use recreational drugs? ___yes ___no

Family History:

____

____

____

Patient Signature______________________________ **Date:**________

The above is true and correct to the best of my belief.

Nurse Signature_________________________________**Date:**________

I have reviewed the above information with the patient.

Patient Information

Please answer all questions fully

Date:______________________________

Account Number:_______________________

IBRAHIM M. IBRAHIM, MD FACS

JEFFREY W. STRAIN MD, FACS

CELINES MORALES-RIBEIRO, MD

201-227-5533

Patient

Name(Last, First,)	Social Security #	Age	Birth date	Sex M F	Home Phone
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Responsible Party

Name(Last, First,)	Social Security #	Age	Birth date	Sex M F	Home Phone
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Primary Doctor	Referring Doctor	Referring doctor address	Phone	Fax

Insurance Information

Primary Insurance Company	Policy #		Group #	Co-pay
Subscriber's Name	Birth date		Social Security #	Relationship to Patient
Subscriber's Address	City	State	Zip Code	Phone #
Secondary Insurance Company	Policy #		Group #	Co-pay
Subscriber's Name	Birth date		Social Security #	Relationship to Patient
Subscriber's Address	City	State	Zip Code	Phone #

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature:____ Date: ______________________
(Signature of insured or authorized person, patient or parent if minor)

IBRAHIM M. IBRAHIM, MD, FACS
JEFFREY W. STRAIN, MD, FACS
CELINES MORALES-RIBEIRO, MD

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand an comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards, ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with any government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way comprises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in <u>your</u> best interest.

We also want you to know that we support your full access to your personal records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request
Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: ____

Signature:___________________________________Date__________________

If minor, signature of parent or guardian:__________________________________

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits and Claims

I hereby assign and transfer to Dr.Ibrahim, Dr. Strain and Dr. Morales all benefits payable by my insurance company for services performed by Dr. Ibrahim, Dr. Strain and Dr. Morales

I hereby authorize Dr. Ibrahim, Dr. Strain and Dr. Morales to submit a claim to my insurance carrier or intermediary for all services rendered by Dr. Ibrahim, Dr. Strain and Dr. Morales as well to exercise any appeals and other rights under my policy on my behalf.

I direct my insurance carrier, or its intermediaries, to issue a payment check directly to Dr. Ibrahim, Dr. Strain and Dr. Morales

If my insurance company will not directly pay Dr. Ibrahim, Dr. Strain or Dr. Morales. I authorize and direct that the insurance company send all checks and copies of Explanation of Benefits form in connection with the services of Dr. Ibrahim, Dr. Strain and Dr. Morales to:

Bergen Laparoscopy & Bariatric Associates, LLC
97 Engle Street
Englewood, New Jersey 07631

Financial Responsibility

I understand and agree that I am responsible for all charges incurred in connection with the receipt of services and care from Dr. Ibrahim, Dr. Strain and Dr. Morales and promise to pay promptly to Dr. Ibrahim, Dr. Strain and Dr. Morales the amount of such charges.

I hereby authorize Dr. Ibrahim, Dr. Strain and Dr. Morales to release all information necessary regarding services rendered to my insurance company and referring physician.

I understand that regardless of my assignment benefits, I am responsible for the total charges of services rendered not covered by the insurance company. I understand that co-payments or deductibles are due in full at the time of service.

I agree to cooperate, aid and assist Dr. Ibrahim, Dr. Strain and Dr. Morales in procuring all possible insurance benefits.

Patient Receipt of Check

In the event that I receive direct payment of any amounts due for services rendered by Dr. Ibrahim, Dr. Strain or Dr. Morales. I agree to forward immediately to Dr. Ibrahim, Dr. Strain and Dr. Morales any checks payable to me for services rendered by Dr. Ibrahim, Dr. Strain or Dr. Morales endorsed to the order of Dr. Ibrahim, Dr. Strain and Dr. Morales Strain as well as any Explanation of Benefits (EOB) to the extent not sent directly to Dr. Ibrahim, Dr. Strain and Dr. Morales. I agree to notify Dr. Ibrahim, Dr. Strain and Dr. Morales upon receipt such check and to endorse the check "Payable to the Order of Dr. Ibrahim or Dr. Strain", and immediately mail the check and EOB form to Dr. Ibrahim, Dr. Strain or Dr. Morales keeping copies of the check and EOB for my records.

Failure to Comply

I understand that failure to comply with my responsibilities under this form will result in my account remaining active. I guarantee payment of all said charges incurred including any interest that might accrue. In the further event that the account must be placed with an attorney, collection agency fees and cost incurred in collection.

The undersigned had read and understand the above terms.

____

(Please Sign)

Date: ______________________

(Patient)