New Life
Center For Bariatric Surgery

PREMIER
Surgical

Patient's Name _____ Date of Birth _____

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore, you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

Insurance Information

Participating Insurance Companies - For those companies we participate with, Premier will file your claim for you and accept assignment for payment directly to us. Please provide us with current and valid insurance cards.

Non-Participating Insurance Companies – In those cases where we are non-par, Premier will file your insurance claim for you but will not accept assignment, meaning payment will be made directly to you. You are responsible for payment of your account in full so please plan to direct any payments to us.

Referrals and Authorizations – It is your responsibility to understand your benefit design and obtain all required referrals and authorization approvals from your insurance company. Failure to do so will result in reduced benefits and higher patient responsibility for you.

Other Payment Information

Office Visits – All co-pays, deductibles or co-insurance are due at the time of service.

Surgery – If surgery is required, you will be responsible for all or a portion of the fee, payable in the form of a deposit at the time of scheduling. If you are having non-urgent or elective surgery, 100% of the estimated patient responsibility portion will be due prior to scheduling the service. If you have a life threatening illness and need urgent or emergency care, we will not delay your surgery; however, non-urgent or elective surgeries may be delayed pending payment of your portion of the estimated fees. If you do not have insurance and need to discuss a payment plan, please notify us before we schedule your surgery.

Work's Compensation – You must contact your employer and their worker's compensation insurance company and be assigned a case worker before we will be able to treat you for a worker's compensation injury.

Payment Options / Billing Questions – Payment options include cash, check, MasterCard, and Visa. For billing questions or credit care payments, you may reach us at 865-306-5700. Payments may be mailed to Premier Surgical Associates, PO BOX 52948, Knoxville, TN 37950-2948

Interest and Fees – Balances not paid in full within 30 days are subject to interest at 18% APR. Balances that are turned over to collection agencies are assessed a 30% collection fee.

Returned Checks – If your check is returned for non-sufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment if your acknowledgement and acceptance of this policy and its terms and conditions. A $25.00 charge will be added to your account for each returned check. Additionally, you will not be able to schedule any follow-up appointments until the fee is paid in full.

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Missed Appointment Fees – In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit, ultrasound or other diagnostic test appointment. A minimum of 30 and up to 90 minutes is set aside for each appointment and your communication and compliance is much appreciated by your physician and supporting staff.

Please be aware that if 24 hour notice is not received a fee of $25 may be charged to your account which must be settled before another appointment is scheduled.

Please call us if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

Self-Pay Accounts – For patients who have no insurance plan, payment is expected at the time of service for all services including surgeries. If a procedure or surgery is scheduled, a deposit of at least $150 will re required at the time of scheduling. If you need to make payment arrangements please contact us at 865-306-5700.

Collection Accounts - A collection fee of 30%will be added to all accounts that are turned over to collection agencies.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGED

I have been given an opportunity to review, ask questions about and understand Premier Surgical Associates'' Notice of Privacy Practices for Protected Health Information (Notice).

FINANCIAL RESPONSIBILITY

I understand and commit to the following:

1. I have received a copy of Premier's financial policies and have read and understand these policies.
2. I will pay my co-pay, deductible and co-insurance at the time of service.
3. I will provide the most current insurance information and immediately notify Premier of changes.
4. If surgery is required, all or a portion of my financial responsibility must be paid prior to surgery.
5. I will follow my insurance company's requirements for referrals and pre-authorizations and I understand that if I fail to do so, my insurance benefits will be reduced and I will be responsible for all denied balances.
6. I understand that I am responsible for all balances.
7. If I have no insurance, I have informed Premier and I am responsible for 100% of all balances.
8. A collection fee of 30% will be added to all my accounts that are turned over to collection agencies.

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits – including Medicare, and any other government sponsored program, private insurance, and any other health plans – be made to **Premier Surgical Associates, PLLC** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **Premier Surgical Associates, PLLC** to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from mu insurance companies. I authorize my insurance companies to give **Premier Surgical Associates, PLLC** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____ **Date** _____

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PATIENT INFORMATION FORM (PLEASE PRINT)

Patient Name (First, Middle, Last) _____

Preferred Name (What you go by) _____

Social Security Number _____ Date of Birth _____

Sex (circle one): Male Female Martial Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Race (circle one): Caucasian/White, Latino/Hispanic, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Not Reported/Refused

Ethnicity (circle one): Caucasian/White, Latino/Hispanic, Black or African American, Other, Not Reported/Refused

Language (circle one): English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-Time Student, Part-Time Student

Patient Mailing Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____
(By including your cell phone number, you have given Premier consent to call your cell phone for appointment reminders using our automated system)

E-Mail _____

Employer _____ Occupation _____

Referring Physician (please include phone number) _____

Other *Current* Healthcare Providers (please provide first and last name and phone number):

Primary Care _____ Cardiology _____

Pulmonary _____ Endocrinology _____

Nephrology _____ Dialysis Center _____

Other: _____

MEDICAL RECORDS RELEASE

I hereby authorize Premier Surgical Associate, PLLC to release any information in my chart to any medical practitioner, doctor, hospital, medical institution to who I may be referred to assist with my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, medical institution assist in my care.

Patient's Signature _____ **Date** _____

Patient's Name _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Contact Name (First, Middle, Last) _____

Sex (circle one): M F Patient Relationship to Contact (circle one): Child, Wife, Husband, Parent, Grandparent, Other

Language (circle one): English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other

Home Phone _____ Work Phone _____ Cell Phone _____

Contact is a Parent/Guardian (circle one): Yes No
If patient is under the age of 18, Emergency Contact should be a Parent or Guardian unless patient is an Emancipated Minor

PHARMACY

Preferred Pharmacy _____ Phone No. _____

Pharmacy Address _____

City, State, Zip _____

CONSENTS

Do you have any of the following (please circle all that apply):
Living Will, Do Not Resuscitate (DNR), Power of Attorney, End of Life Decision, No Cardio-Pulmonary Resuscitation (CPR)

PHONE MESSAGES

Please check yes or no:

___ Yes ___ No Premier may leave messages on my answering machine at HOME.

___ Yes ___ No Premier may leave messages on my CELL PHONE VOICEMAIL.

___ Yes ___ No Premier may leave messages with my EMPLOYER/WORK.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with an individual, if I am unavailable at the number provided by me.

Patient's Signature _____ **Date** _____

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Patient's Name _____ Date of Birth _____

INSURANCE INFORMATION

PRIMARY Insurance Company _____

Group No. _____ Member ID _____

Primary Insurance Subscriber (circle one): Patient Other Sex (circle one): Male Female

Subscribers Name (First, Middle, Last) _____

Subscriber's Social Security Number _____ Date of Birth _____

Marital Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student

Subscribers Employer _____

Subscribers address (if different from patient) _____

City, State, Zip _____

Subscribers Home Phone _____ Work Phone _____ Cell Phone _____

Patient Relationship to Subscriber (circle one): Self, Child, Wife, Husband, Parent, Other

SECONDARY Insurance Company _____

Group No. _____ Member ID _____

Primary Insurance Subscriber (circle one): Patient Other Sex (circle one): Male Female

Subscribers Name (First, Middle, Last) _____

Subscriber's Social Security Number _____ Date of Birth _____

Marital Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student

Subscribers Employer _____

Subscribers address (if different from patient) _____

City, State, Zip _____

Subscribers Home Phone _____ Work Phone _____ Cell Phone _____

Patient Relationship to Subscriber (circle one): Self, Child, Wife, Husband, Parent, Other

Patient's Name _____ Date of Birth _____

WORKERS COMPENSATION or AUTO INSURANCE INFORMATION

Your Supervisor _____ Supervisor's Phone No. _____

Workers Compensation or Auto Insurance Phone No. _____

Claims Address _____

City, State, Zip _____

Adjusters Name _____ Adjusters Phone No. _____

Claim No. _____ Approval No. _____

Date of Injury _____ Did injury occur at work (circle one): Yes No Auto Accident (circle one); Yes No

Briefly describe injury or accident: _____
_____
_____
_____

FOR MEDICARE SUPPLEMENT POLICIES ONLY
ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

Name _____ Medicare Number _____

Medigap Policy Name _____ Medigap Policy Number _____

I request that payment of the authorized Medigap benefits be made on my behalf to Premier Surgical Associates, PLLC for services furnished to me by them. I authorize any holder of medical information about me to release it to:

Name of Policy _____

any information needed to determine these benefits or the benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____ **Date** _____

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PATIENT MEDICAL RECORD RELEASE AUTHORIZATION

Date: _____ Patient Date of Birth: _____

Patient Name: _____

I hereby authorize the release of my personal health information to the following relatives or individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

For the purpose of you treatment and our payment and operations we will disclose your protected health information to physicians, other medical professionals, hospitals and insurance companies, Otherwise it is our policy to release such information only to the patient unless otherwise specified to do so by you in writing. **This authorization will not expire unless revoked by you by giving us written notice of such revocation.** Information disclosed under this authorization may be disclosed again by the person or organization to which it is given and is no longer protected by federal privacy regulations.

I hereby authorized New Life Bariatric/Premier Surgical to release my protected health information to the individuals listed above.

I hereby authorize New life Center for Bariatric Surgery to release the contact and identifying information for the purpose of Bari Life Bariatric Supplements marketing to me their products and supplements.

Patient's Signature _____ **Date** _____