Welcome Information

Thank you for choosing our practice to take care of your health care needs! We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Registration: All patients must complete a patient information form before seeing their provider.

Charges: Full payment is due at the time services are rendered unless other payment arrangements have been made. For patients without insurance, payment is due at the time of service for both sick and well visits. Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process**. In the event your health plan determines a service to be "non-covered", you will be responsible for all non-covered and allowable charges.** Delays in insurance processing occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering care. Whenever insurance denies payment for a service, it is your responsibility to cover the charges, therefore, it is important to review your benefits with your insurance provider.

FMLA/ Paperwork: Any patient that needs paperwork completed by *Methodist Medical Group may be* assessed a processing fee. This must be paid in full before the paperwork can be picked up or faxed. Please inquire with our staff regarding specific fees prior to submission of your form(s).

NSF/ Closed Accounts: There will be a $35.00 charge added for returned checks.
Clinical Fees: There may be a processing fee for controlled medication refills and an additional fee to re-write if the prescription is not filled within the 21 day deadline. The voided prescription must be returned before a new prescription is issued.

There is a $25.00 fee for medical records up to 25 pages. Additional pages are $0.50 per page. All Medical Records are processed by HealthMark and take seven business days to process.

Appointments/ No Show: We request 24 hour notice for appointment cancellations. Patients with three (3) missed appointments and/ or no shows annually will result in dismissal from the practice. If you no show to your appointment you may be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled visit.

Insurance: Insurance cards must be available prior to each visit. Please notify our office if there is a change in your insurance plans or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to the contracted insurance company for the member. Any dispute for unpaid charges form the insurance company will be billed to the member. All patients must have a valid insurance ID card in order to utilize benefits.

Medication Refills: All prescription refill requests should be called into your pharmacy at least five (5) working days before the last pill taken to allow adequate time for approval. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after office hours or on weekends.
Referrals: Allow 5 to 7 working days to process routine referrals.

Behavior: Physical and verbal abuse towards the office staff or other patients will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.

After Hours: Our phone message will provide patients with a number to call our answering service for urgent needs after hours. The answering service will notify the physician on call.

Feedback: We appreciate all feedback provided. You will be receiving a patient satisfaction survey from Press Ganey. Please take time to complete this and let us know how we are doing.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

Signature of Patient or Guardian

Patient Date of Birth

Relationship to Patient, if not signed by the Patient

Date

Methodist FAMILY HEALTH CENTERS

PATIENT INFORMATION

Name		Date of Birth	Sex
Address	City	State	Zip
Home Phone	Work	Cell	
Email Address		**Social Security Number**	
Preferred Pharmacy (Name / Address / Phone Number):			
Employer Name and Address:		Student Status: ○ Full Time ○ Part Time ○ N/A	
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify)*			
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide		Marital Status ○ Single ○ Married ○ Divorced ○ Widowed/Widower	
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):			Veteran ○ Yes ○ No

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

NAME	Date of Birth	Relationship to Patient	
Address	City	State	Zip
Phone Home/Cell	Work	**Social Security Number:**	

PRIMARY INSURANCE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number	Group Number		
Address	City	State	Zip
Name of Insured **Date of Birth**	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other		

SECONDARY INSURANCE IF APPLICABLE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number	Group Number		
Address	City	State	Zip
Name of Insured Date of Birth	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other		

HOW DID YOU HEAR ABOUT US?

○ Existing Patient (*Please Specify)* _____ ○ Family Referral(*Please Specify)* _____

○ Insurance ○ Billboard/Drive By ○ Employee ○ Direct Mail ○ Hospital Referred ○ Internet ○ Living Magazine ○ Other _____

Which lab is your insurance co. contracted with? ○ LabCorp ○ Quest ○ CPL ○ Other (please define): _____

Please note, that we may draw labs in the office; however, it is your responsibility to know which lab your insurance co. is contracted with. Please call your insurance co. prior to having blood work drawn to make sure that they will cover testing for the appropriate CPT codes. We are not responsible for third party bills related to services rendered.

I certify that I have carefully reviewed this document, understand and have filled out truthfully.

_____ _____

Signature of Patient or Guardian (Relationship to Patient, If not signed by the Patient) Date

Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other:

I authorize MMG and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contact Only: Name: _____ Relation: _____ Phone: _____

Communication for Appointment Reminders and Appointment Follow-Ups:

Methodist Medical Group (MMG) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives, If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MMG to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclosed based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give MMG your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MMG this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please initial all that apply*): ____ email address _____ phone number _____ text message[1] _____ secure patient portal to be used in the manner described above.
Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

____ (*initial*) I decline to give MMG consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be required to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____
Patient (Print Name) Date of Birth

_____ _____
Signature of Patient or Guardian Date

[1] Please note the text messaging service is a complimentary service provided by MTP, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.

Methodist
MEDICAL GROUP

Financial Policy

1. **Authorization to Release Information:**
I authorize **METHODIST MEDICAL GROUP** to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payer for the purpose of obtaining payment on account of (1) **METHODIST MEDICAL GROUP,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. **Assignment of Benefits:**
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

   If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

   I understand that I am responsible for providing **METHODIST MEDICAL GROUP** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **METHODIST MEDICAL GROUP**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

3. **Medicare / Medicaid Assignment of Benefits: (Do not complete unless you receive Medicare/Medicaid health care benefits)**
   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

      Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

      Initial _____

_____ _____
Signature of Patient or Guardian (and relationship if not patient) Date

_____ [ ] Patient under 18 years of age
Witness

_____ _____
Translator (Print Name) Translator (Signature)

Methodist
MEDICAL GROUP

Notice of Privacy Acknowledgement

Methodist Medical Group Notice of Privacy Practices provides information about how *Methodist Medical Group* may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is posted in the waiting room. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for **treatment, payment and health care operations**, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

This Privacy Acknowledgement does **not** give us consent to release records to anyone except to whom is mentioned. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

Signature of Patient or Guardian	Patient Date of Birth
Relationship to Patient, if not signed by the Patient	Date

Methodist MEDICAL GROUP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: ____ Social Security Number: _____

Account Number: _____ Date of Last Visit: _____

Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.
2. The following individual(s) or organizations are authorized to make the disclosure:

   Name: _____

   Address: _____

   Phone: _____ Fax: _____
3. The type and amount of information to be used or disclosed is as follows: (Please Check)

   ____Entire Health Record ____Operative Procedures ____Pathology Report ____Echocardiogram

   ____History & Physical ____X-ray/Imaging Reports ____X-ray Film ____Laboratory Reports

   ____Other (please describe) _____
4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and/or drug abuse.
5. This information may be disclosed to and used by the following individual(s) or organization(s) (*please include the name and address of the individual or organization*):
   Manuel Castro-Arreola, MD phone: 972-709-7110 fax: 972-709-7128
6. This information is being disclosed for the following purpose(s); _____
7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to MedHealth, 3400 W. Wheatland Rd, Suite 453, Dallas, TX 75237. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
   _____

This authorization will expire 12 months from the date of signing.

9. I understand that my treatment, payment, or eligibility to file to insurance company will not be conditional on the completion and signature of this form.
10. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
11. I understand that I will be given a copy of this authorization form after signing.

_____ _____

Signature of Patient/Responsible Party or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relation to Patient Date

_____ _____

Signature of Witness Date

Please check the appropriate boxes and add notes as needed (Please be specific):

Have you had Bariatric Surgery? □ Yes □ No

If so, which procedure? □ Lap Band □ Sleeve □ Gastric Bypass □ Revision □ Other: _____

Who was your surgeon? _____ What year did you have surgery? _____

My obesity started:

- □ In Childhood
- □ At Puberty
- □ An Adult
- □ After Pregnancy
- □ After a traumatic event

Please describe:

Height: _____ Birth Weight: _____ High School Weight: _____

Weight at Marriage:

Highest adult weight: Date:

Lowest adult weight: Date:

How many years at current weight:

Most weight loss on any program: _____ Program Type: _____

Age at which you first seriously dieted:

Taste preferences (Please check all that apply):

- □ Sweets
- □ Salty
- □ Fast food
- □ Comfort foods
- □ Other: _____

Eating Habits (Please check all that apply):

- □ Binge Eater
- □ Stress
- □ Boredom
- □ Loneliness
- □ Other: _____

Medically supervised weight loss attempts:

Diet Attempts:	Date:	Duration:	Max. Wt. Loss:	MD Supervised:

Medication History:

Medication Name:	Dosage:	Time Taken:

Please list any medications to which you are allergic:

1.
2.
3.

Allergic to latex? □ Yes □ No Allergic to food? □ Yes □ No, What foods?

Please list any vitamins and/or herbal supplements you are currently taking:

1.
2.
3.

Please list all previous surgeries and hospitalizations:

Surgery:	Hospitalization:	Date:	Reason:	Provider Name:

Patient Name: DOB:

Methodist
CHARLTON BARIATRICS

Please check if you have any of the following conditions/symptoms:

☐ **Heart Disease**	☐ **Lung Disease**	☐ **Endocrine**	☐ **Neurology Stroke**
☐ Angina	☐ Asthma	☐ Diabetes How long? Last BS?	☐ Epilepsy
☐ Bypass	☐ Sleep Apnea	☐ Thyroid	☐ Hematology Anemia
☐ Palpitations	☐ Use CPAP / BiPAP	☐ Cushing	☐ Bleeding Problems
☐ Chest Pain	☐ Obesity / hypoventilation	☐ Cholesterol	☐ Skin Rash / Dermatitis
☐ Bad Circulation	☐ Shortness of breath – Walking How many blocks?	☐ **Musculoskeletal**	☐ Other:
☐ Varicose Veins	☐ Shortness of breath - Stair Climbing. How many flights?	☐ Joint Pain	
☐ Heart Attack	☐ **Gastroenterology**	☐ Low Back Pain	
☐ Valve Disease	☐ Heartburn / GERD	☐ Hip Pain	
☐ Stress Test	☐ Ulcers	☐ Ankles Pain	
☐ High Blood Pressure	☐ Fatty Liver	☐ Knee Pain	
☐ Swollen Legs	☐ Gallbladder Disease	☐ Injury related to Weight	
☐ Blood Clots Lungs	☐ Colitis	☐ **Psychological**	
☐ Blood Clots Legs	☐ Constipation	☐ Depression	
☐ **Urinary**	☐ Hiatal Hernia	☐ Bipolar	
☐ Kidney Stones	☐ Hernia	☐ Bulimia	
☐ Infections	☐ Blood in Stool	☐ Anxiety	
☐ Leakage of Urine	☐ Abdominal Pain	☐ Tuberculosis	
☐ Blood in Urine	☐ **Anesthesia Problems**		

Women only:

Date of last menstrual period:

Are your menstrual periods regular? ☐ Yes ☐ No

Are you using birth control? ☐ Yes ☐ No if yes, what type?

Number of pregnancies: Number of live births: Abortions? ☐ Yes ☐ No

Pregnancies:	**Year:**	**Weight at start:**	**Weight at delivery:**
Pregnancy #1			
Pregnancy #2			
Pregnancy #3			
Pregnancy #4			
Pregnancy #5			

Any problems during or after pregnancy? ☐ Yes ☐ No if so, please explain:

Patient Name: DOB:

Habits:

Are you a smoker? □ Yes □ No If so, how many packs/day?

Have you ever been a smoker? □ Yes □ No Age started? Age Quit?

Do you consume alcohol? □ Yes □ No Drinks/day?

Do you use recreational drugs? □ Yes □ No Type/frequency?

Comments:

Family History:

Please check which, if any, of your family members had any of the following conditions.

Conditions:	**Relative: Mother, Father, Sibling, Grandparent, Aunt, Uncle**
□ Anemia	
□ Sleep Apnea	
□ Kidney Disease	
□ Diabetes	
□ Gout	
□ High Blood Pressure	
□ Bleeding Problems	
□ Stroke	
□ Obesity	
□ Cancer	
□ Gallstones	
□ Heart Disease	
□ Blood Clots	
□ Obesity Related Conditions	
□ Other:	

Exercise:

Please describe your exercise routine. Include type of exercise, frequency and physical limitations.

Type of exercise:	Frequency:	Physical limitations:

Please write any other concerns that you have regarding your health or bariatric surgery:

Motivation to get surgery for weight control:

Describe your goals as you achieve weight loss:

Methodist
CHARLTON BARIATRICS

Sleep Apnea Questionnaire:

Patient Name: _____

Height: _____ Weight: _____

Age: _____ Male / Female: _____

STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel **TIRED**, fatigued, or sleepy during daytime?	YES	NO
Has anyone **OBSERVED** you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood **PRESSURE**?	YES	NO

BANG		
BMI more than 35kg/m2?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference > 16 inches (40cm)?	YES	NO
GENDER: Male?	YES	NO

TOTAL SCORE		

High risk of OSA: YES 5 – 8

Intermediate risk of OSA: YES 3 – 4

Low risk of OSA: YES 0 – 2

List of Providers:

Do you have a primary care physician? If so, please list below along with any other specialist you've seen.

Provider Name:	Specialty:	Phone Number:	Fax Number:	Address:

Travel Exposure:

Traveled outside the country in that last month?

□ Yes □ No

Have you been in contact with anyone who has traveled outside the country in the last month?

□ Yes □ No

If yes, have you had the following symptoms?

□Cough □ Rash □ Fever higher than 101.5F

□ Vomiting □ Diarrhea □Trouble Breathing

How did you hear about US?

□ Family/Friend □ Internet □ Newsletter □ E-Mail

□ Physician Referral - Physician Name: _____Office Number: _____

□ Other:_____

Illness:

In the past two weeks, have you experienced the following?

□ Flu □ Hepatitis □ Fever □ Cough □ Runny Nose □ Sore Throat/Strep □ Pertussis

Preferred Laboratory:

□ Labcorp □ Quest □ CPL (Clinical Pathology Laboratories) □ PCP