NEW LIFE
Surgical Associates

Name:_____DOB_____

Street Address: _____ APT/UNIT:_____

City:_____ State: _____Zip:_____

Home Phone:_____ Cell : _____

Email: _____ SSN:_____

Marital Status:_____ Race/ Ethnicity:_____

Occupation: _____ Employer: _____

Primary Care Doctor: _____ **Referring Doctor:** _____

Pharmacy: _____

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT?

Name: _____ Relationship:_____

Home phone: _____ Cell: _____

Insurance Information:

Primary:

Policy Holder:_____ Insurance Carrier: _____

Relation: _____ D.O.B: _____ SSN: _____

ID#:_____Group#_____

Secondary (If any)

Policy Holder:_____ Insurance Carrier: _____

Relation: _____ D.O.B: _____ SSN: _____

ID#:_____Group#_____

If Patient is a Minor, Please Complete:

Person Responsible or Guardian: _____D.O.B:_____

SSN:_____ Phone # (if different):_____

Signature:_____ Date:_____

New Life

Patient Name: _____ D.O.B:_____

Please indicate which illness you have been diagnosed or treated for:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Bleeding Disorders, explain:_____
  _____
- ☐ Heart issues, explain:_____
  _____
- ☐ Lung issues, explain:_____
  _____
- ☐ Other:_____
  _____

Past Surgical History:

1. _____
2. _____
3. _____
4. _____

Family History:

Father: Alive Deceased Age: ____

Health Problems: _____

Mother: Alive Deceased Age: ____

Health Problems: _____

Is there a family history of breast or ovarian cancer? _____

Current Medications:

Drug	Dosage	Frequency

Drug	Dosage	Frequency

Allergies and Adverse Reaction:

_____
_____
_____
_____

Marital Status: _____

Number of children: _____

Occupation: _____

Tobacco Use: _____ ___/cigarettes a day

How long ago did you stopped? _____

Drug use:_____

Alcohol Use: None Socially Occasionally Heavy

New Life

Patient Name: _____ D.O.B:_____

Years of Obesity? : _____ Highest weight in the last 5 years? : _____

Please indicate which **unsupervised** diets you have tried in the past:

☐ Atkins	☐ Slim Fast	☐ High Protein
☐ Pitkin	☐ South Beach Diet	☐ Zone Diet
☐ Body By Vi	☐ Cabbage Soup	☐ Vomiting
☐ Fasting	☐ Sugar busters Diet	☐ Binging/purging Diet
☐ Calorie Counting	☐ Herbal Life	☐ Low Fat
☐ Mayo Clinic	☐ Low Carbohydrate	☐ Other:_____

Please indicate which **supervised** diets you have tried in the past:

☐ Medically Supervised/HCG	☐ Opt fast/Medifast	☐ Adipex/Phentermine
☐ Weight Watchers	☐ Overeaters	☐ Blissful Wellness
☐ Jenny Craig	☐ Anonymous	☐ Nutri-system
☐ HMR	☐ TOPS	☐ Other:_____

Circle all that apply:

- General/Constitutional:
  Change in Appetite, Fever, Chills, Fatigue, Headache, Lightheadedness
- Ophthalmologic:
  Blurred Vision, Discharge, Itching and redness, Eye Pain
- ENT:
  Decreased Hearing
- Respiratory:
  Cough, Shortness of Breath at rest, Shortness of breath with exertion, Wheezing
- Cardiovascular:
  Chest pan at rest, Chest pain with exertion, Orthopnea, Palpitations
- Gastrointestinal:
  Abdominal pain, Diarrhea, Nausea
- Genitourinary:
  Blood in urine, Frequent urination, Painful urination
- Musculoskeletal:
  Painful joints, Swollen joints
- Peripheral Vascular:

Cold extremities, Pain/cramping in legs after exertion

- Skin:
  Rash, Skin lesion(s), Skin oozing
- Neurologic:
  Gait abnormality, Tingling/Numbness

New Life

This authorization form is for the release of Medical Information.

Patient Information

Name:_____ D.O.B:_____

Address: _____

SSN:_____ Phone:_____

I Hereby Authorize (Provider):

Name:_____

Address:_____

Phone:_____ Fax:_____

From:

Name: New Life Surgical Associates _____

Address: 8075 Gate Parkway West, Suite# 302, Jacksonville, Florida 32216

Phone: (904)399-4004 _____ Fax: (904)399-3489 _____

Record to be disclosed:

☐ Medical Noted/Summary ☐ Pathology ☐ History & Physical ☐ X-ray/EKG

☐ OP/Procedure Reports ☐ Recent Labs ☐ All Medical Record

Please send ONE progress note from each year this patient was seen showing their HIGHEST WEIGHT and DATE; EG: Progress sheet for years 2013 to current year.

Authorization and Signature

I hereby authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I also authorize the use of e-mail and texting as a means of communication. I understand my photograph will be taken for medical purposes only. I understand the treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not health plan of health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release New Life Surgical Associates from all liability arising from disclosure of my health information. **The release will expire in 1 year.**

By signing this agreement, I acknowledge that I have read, understand and agree with the above terms and conditions.

Date: _____

Patient/Guardian or legal representative Signature: _____

New Life

Payment Policy

All charges are due at time of service regardless of your insurance coverage or legal representation. If surgery is indicated we will work with you regarding your financial responsibility.

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.

Worker'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.

Interest and Fees

Balances not paid in full within 90 days are subject to interest at 18% APR. Balances that are turned over to collection agencies are assessed up to 50% 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 is 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.

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 be required at the time of scheduling. If you need to make payment arrangements please contact us at 904-399-4004.

Signature:_____ Date:_____

Our Privacy Responsibilities

New Life Bariatric Associates is required by law to:

- Maintain the privacy of your health information;
- Provide this notice that describes the ways we may use and share your health information and Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in New Life Bariatric Associates facilities. You may also request a copy of any notice from the New Life Bariatric Associates from the office manager.

Our Organization

- This notice describes the privacy practices of New Life Bariatric Associates. New Life Bariatric Associates includes physicians, employees and volunteers. This notice also describes the privacy practices of affiliated providers while they are performing services in behalf of New Life Bariatric Associates unless they provide you with a notice of their specific privacy practices. Affiliated providers are not employed by New Life Bariatric Associates but are authorized to provide services to patients. Affiliated providers may have different privacy practices from those described in this notice. For more information about the privacy practices of affiliated providers, please contact them directly.

Contact Us

- If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, contact: New Life Bariatric Associates at 904-399-4004.

If you would like to share you medical record, please list below the names, DOB, and phone number of the people authorized:

_____

_____

_____

I read and understand the information provided to me about HIPAA Privacy Regulations that are implemented at this office (HIPAA Regulations are posted in the waiting are of the office, if you would like a copy please ask the front office).

Name: _____ Date: _____

Signature: _____ Witness: _____