

914 S BROAD ST
THOMASVILLE, GEORGIA 31792
PHONE: (229) 785-2400
FAX: (229) 502-9793

STERLING CENTER BARIATRICS

4 LIVE OAK COURT
MOULTRIE, GEORGIA 31768
PHONE: (229) 785-2400
FAX: (229) 502-9793

Date ____/____/____ Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Patient _____
Last First Middle Initial Preferred Name

Email _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ DOB ____/____/____ Single Married Widowed Separated Divorced

Social Security # _____ Ethnicity: Caucasian African American Asian Hispanic Other

Who Referred You: _____ Primary Language _____

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ Full-time Part-time City _____ State _____ Zip _____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birth date ____/____/____ SSN _____ Last First Middle Initial Employers Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ Full-time Part-time
PATIENT INSURANCE PRIMARY	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have. Insurance Company Name _____ Policy/Group # _____ Effective Date ____/____/____ Name of Insured _____ ID # _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have. Insurance Company Name _____ Policy/Group # _____ Effective Date ____/____/____ Name of Insured _____ DOB ____/____/____ ID # _____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of auto accident, work-related injury or other personal injury someone else might be legally liable for? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials _____ If you answered yes, please fill out accidents specific form, available at the front desk. Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in case of emergency (Name and Phone#) _____ Attorney _____ Phone _____ Address _____

PERSONAL HISTORY

Patient Name	Date of Birth	Age	Today's Date
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Did a physician send you to our office? YES NO

If yes, Who?

Are you currently having any pain? YES NO

Where?

If so, how severe is your pain? 10 being the worst. (Please circle one) 1 2 3 4 5 6 7 8 9 10

Who is your primary care physician?

Reason for today's visit

Are you R or L hand dominate?

Occupation	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <i>(Please ✓ one of the above)</i>	How many children do you have?
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Do you smoke? Formerly Currently Never Heavy Light # of years _____ (Quit, when? _____)

Alcohol Consumption: Formerly Currently Never Heavy Light

Do you use drugs Formerly Currently Never Heavy Light

FAMILY HISTORY (Has any of your immediate relatives ever had any of the following)

	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Mini Stroke	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Date of Last Menstrual Period: _____ (If applicable)

PAST MEDICAL HISTORY (Do you have or have you had any of the following)

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vasc Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Barrett's	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux Disease	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Mini Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's/UC	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Others _____		
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone (s)	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

PAST SURGICAL HISTORY

	DATE		DATE
<input type="checkbox"/> Heart Angioplasty	_____	<input type="checkbox"/> Organ Transplant	_____
<input type="checkbox"/> Heart Bypass/Valve	_____	<input type="checkbox"/> What Organ (s)	_____
<input type="checkbox"/> Hernia Repair	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Gallbladder Removed	_____	<input type="checkbox"/> Appendectomy	_____
<input type="checkbox"/> Neck Surgery	_____	<input type="checkbox"/> Abdominal Surgery	_____
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> Cardiac Pacemaker	_____
<input type="checkbox"/> Bladder Surgery	_____	<input type="checkbox"/> Joint Replacement	_____
<input type="checkbox"/> Kidney surgery	_____		<i>Name Joint</i>
<input type="checkbox"/> Prostate Surgery	_____	Other _____	_____
<input type="checkbox"/> Cancer Surgery	_____	_____	_____
<input type="checkbox"/> Cancer location	_____	_____	_____

REVIEW OF SYSTEMS (Do you have now or have you ever had any problems related to the following body systems)

	YES	NO		YES	NO		YES	NO
CONSTITUTIONAL			GASTROINTESTINAL Con't			PSYCHIATRIC		
Good general health lately	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Appetite/Wt Change	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Weakness/Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss or confusion	<input type="checkbox"/>	<input type="checkbox"/>
Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Burning /Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
EYES			Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	Central Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Vision Change	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Control Problems	<input type="checkbox"/>	<input type="checkbox"/>	Glandular or hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Contacts/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Change of force of strain when urinating	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease or injury	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence or dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Recent Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Possible Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain/swelling/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL			Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
ENT			Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Change in hat or glove size	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness or swelling	<input type="checkbox"/>	<input type="checkbox"/>	Slow to heal after cuts	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>	Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>	Easily bruise or bleed	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sore	<input type="checkbox"/>	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>	Petechiae	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath or bad taste	<input type="checkbox"/>	<input type="checkbox"/>	Decreased range of motion	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands/nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat or voice change	<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Wrist/Hip/Foot pain	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC		
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<i>History of skin reaction or other adverse reactions to:</i>		
CARDIOVASCULAR			GENITOREPRODUCTIVE			Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Sexual Drive	<input type="checkbox"/>	<input type="checkbox"/>	Morphine, Demerol		
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Sudden heart beat changes	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Novocain or other anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	SKIN			Aspirin or other pain remedies	<input type="checkbox"/>	<input type="checkbox"/>
Light Headedness	<input type="checkbox"/>	<input type="checkbox"/>	Skin sores or ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus antitoxin or other serums	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin thickening	<input type="checkbox"/>	<input type="checkbox"/>	Iodine, mentholated		
Swelling in limbs/Ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	or other antiseptic	<input type="checkbox"/>	<input type="checkbox"/>
Orthostatic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs/medications	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Change in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>	Known food allergies	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Breast problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cough / Asthma /Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL			_____		
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or recurring headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____		
GASTROINTESTINAL			Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>				_____		

PATIENT AGREEMENT AND OFFICE POLICIES

CREDIT POLICY

Charges for medical services in the office are due and payable at the time services are rendered.

EMERGENCIES:

There is always a physician on call for emergency care. If you have an emergency, please call the office at 229-289-1517 during office hours before driving to the emergency room. Your call will alert the office to your problem and will minimize delays in the hospital emergency room.

PRESCRIPTION REFILLS:

Prescription changes or refills are made during office hours to allow time to locate and evaluate your records. Please have your pharmacy send a refill request. No refills are available at night or on the weekends.

INSURANCE

If you have health insurance, our office will gladly file your claim for you, however, it should be understood that YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR DOCTOR'S BILL IS AN AGREEMENT BETWEEN YOU AND YOUR PHYSICIAN. You are responsible for your bill regardless of the status of your insurance claim. Insurance companies, according to their contracts, have a schedule of fees, which they will pay. Your doctor's fees may be more or less than the schedule of your insurance company. YOU ARE DIRECTLY RESPONSIBLE FOR YOUR ACCOUNT IRRESPECTIVE OF YOUR INSURANCE SCHEDULE.

INSURANCE APPEALS:

Should your insurance disallow or deny any part of your claim our office will appeal the decision at the patient's request. There will be a charge for this appeal based on the amount of time involved with gathering data, copying records, follow-up phone calls, etc. *Note: The patient will remain responsible for the balance of the account regardless of the appeals process. If the insurance carrier makes additional payment after the appeal that portion of the patient's payment will be refunded.

RETURNED CHECK:

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month. If unusual circumstances should make it impossible to meet your obligation, please talk to our financial representative. She will be glad to assist you with arrangements for making payments. If you have any questions about the above information, please call 229-289-1517 we will be glad to assist you.

MISSED APPOINTMENTS:

Please notify our office at least 24 hours in advance of any appointment you are unable to keep. This allows us to see other patients who are waiting to be seen. Our policy is after 3 missed appointments you will be discharged from the practice.

LATE ARRIVAL:

Patients arriving more than 15 minutes after appointment time will be asked to reschedule. This will assure that the physician has enough time to give to the late patient without taking away time from the other scheduled patients.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned and hereby assign and convey directly to Sterling Center Bariatrics all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim I hereby authorize and plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I certify that I have accurately answered the above questions to the best of my knowledge. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician any monies due. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature of Insured / Guardian

_____/_____/_____
Date

GENERAL HEALTH OVERVIEW

Patient Name _____ Date of Birth _____ Today's Date _____

Your overall general health is very important. Please answer the following questions so that we might know what additional services you might need now or in the future.

ALL PATIENTS COMPLETE THIS PORTION

COMMENTS

Yes No

- Have you had a colonoscopy in the last 10 years?
- Do you currently use any type of tobacco (cigarettes, pipe, chewing, etc.)
- Do you have any moles, lesions, or skin tags for us to look at today?
- Have you had a screening "lipid" blood test in the last 5 years?

MALE PATIENTS ONLY

- Have you had a prostate exam in the last 12 months?
- Have you had a blood test for prostate cancer in the last 12 months?

FEMALE PATIENTS ONLY

- Do you do monthly self-breast exams?
- Have you had a breast exam by a physician in the last 12 months?
- Is there a possibility that you are pregnant?
- Do you have a history of sexually transmitted disease (including HIV) infection?
- Have you had a mammogram in the last 12 months?
- Have you had a bone density test (DEXA) in the last 24 months?

What are three questions you'd like to ask your doctor about today's visit?

1. _____
2. _____
3. _____

Patient's Signature: _____ Date _____

STERLING CENTER

BARIATRICS

Acknowledgment of Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice

I understand that the providers of Sterling Center Bariatrics are part of an organized healthcare arrangement. These providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organizations notice of privacy that describes how my health information is used and shared. I understand Sterling Center Bariatrics have the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Official at 229-289-1517.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient: _____

Internal Use:

Written Acknowledgment was not obtained based on the following circumstance:

- Patient Refused to sign**
- Emergency Situation**
- Unable to communicate with Patient**
- Other:** _____

Signature of Office Representative

Date

Contact Authorization

I authorize staff of Sterling Center Bariatrics to contact me regarding appointment reminders, payment and lab/test results using the following methods I have checked below:

- Telephone (_____)_____/_____, (_____)_____/_____
- If I am not available, I authorize representatives of Sterling Center Bariatrics to leave a message on the answering machine or voice mail at the telephone numbers listed above.
- I authorized representatives of Sterling Center Bariatrics to leave messages concerning the aforementioned items with the following individual (s) _____
- U.S. Mail
- Other:

Patient/Authorized Representative Signature

Date

Consultation/Referral Form

Patient Name: _____ Race: _____ DOB: _____

SS#: ____/____/____ Telephone: _____ Cell: _____ Work: _____

Mailing Address: _____

Primary Insurance: _____ Policy#: _____

Auth # for Medicaid/Wellcare/Tricare: _____ Email: _____

Patient's Diagnosis/Conditions/Signs/Symptoms: _____

How long has patient had this problem: _____

Is this visit covered by workers' compensation? _____

If so, Claim #: _____

Insurance Co. Name: _____ Case-worker: _____ Phone#: _____

Also, written authorization of workers' compensation for specified service will be required.

Referring Physician: _____ Phone #: _____ NPI: _____

Referring Physician Fax#: _____

- Requesting a Consultation: Requesting provider is asking for the opinion, advice, recommendation, suggestion, direction, or counsel, in evaluating or treating this patient. The requesting provider understands that consulting physician may initiate diagnostic services and treatment at the time of the initial appointment. Requesting provider will receive a written report outlining the consultants' opinion and advice regarding this patient.
- Requesting a Referral: Referring provider is sending patient to Sterling Center Bariatrics for treatment only and is not seeking the opinion and/or advice of the consulting physician. Referring provider will not receive a written report pertaining to this patient's care.

**Attention: Non-English speaking patients are responsible for bringing a translator.*

Please keep this document in your chart as a part of your Plan of Care. Please fax insurance cards and all records including office notes, labs, x-rays, or other diagnostic studies at time consult is requested. Patient should arrive 30 minutes early to fill out new patient information or they may come by the office to pick it up.