MD & Bryan Brewer, MD
7200 Highway 161, Suite 120
Irving, Texas 75039

PATIENT INFORMATION

Name: _____ **DOB:** _____/_____/_____ **Social Security:** _____
Last First MI

Address: _____
Street Apartment Number City State Zip

Cell Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ **Male** ☐ **Female**

Emergency Contact: _____ Phone Number **:** _____ Relationship: _____

How did you hear about New You Bariatrics? _____

I authorize New You Bariatrics to contact me by the following methods: (please check boxes)
☐ **cell phone** ☐ **text messaging** ☐ **home mail** ☐ **work phone** ☐ **Email**

DATE: _____ **SIGNATURE:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

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RELEASE OF INFORMATION TO OTHERS (HIPPA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize New You Bariatrics and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

□ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

□ **No information whatsoever**

To whom can we release information (please list names):

□ _____
Name Phone# Relationship to Patient

□ _____
Name Phone# Relationship to Patient

□ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

_____ _____
Signature of Patient/Guardian Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize New You Bariatrics to furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to New You Bariatrics.*

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to New You Bariatrics. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by New You Bariatrics.

The foregoing information is true and correct to the best of my knowledge. I authorize New You Bariatrics to provide medical treatment to me in the office or in the hospital.

_____ _____
Signature of Patient/Guardian Date

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PATIENT NAME: _____ DATE: _____

FINANCIAL POLICY

New You Bariatrics requires payment in full for any amounts that are the patient's responsibility at the time services are rendered. This includes co-pays, co-insurance, and/ or deductible amounts. Once your claim is processed by your insurance company, any additional amounts owed will be billed to you. If the patients estimated amount due results in an overpaid claim, then a refund will be processed once all claims are settled and there is no additional amounts owed by the patient.

You are responsible for knowing the specific rules of your insurance carrier. The staff at New You Bariatrics will do their best to provide the patient with *estimates* regarding any out of pocket costs, however, you the patient are responsible for understanding your insurance benefits and always have the right and responsibility to contact your insurance carrier regarding questions about your policy and coverage.

- The patient is responsible to pay any deductible and co-payment prior to or at the time services are rendered
- If your insurance carrier requires a referral, it is your responsibility to work with your primary care physician to obtain this referral prior to your scheduled appointment. If we do not have your referral number the day prior to your appointment, then you will be contacted to reschedule your appointment. If you are seeing our physician without a valid referral, then all charges will be responsibility of the patient.
- Our office NEVER guarantees that your insurance will pay, or that they will pay what they quoted our office. We will make every attempt at the beginning of your care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account
- Your insurance is a contract between you and the insurance company. We are not party to that contract. While we have an agreement with the plan to provide services, any questions regarding coverage must be resolved by you with your insurance company

Failure to provide your current insurance information prior to services being rendered may result in denial of your claim. We assist our patients in receiving reimbursement from your insurance company. However, please understand that you, the patient, have the final reasonability for your bill.

I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plans to New You Bariatrics.

I have read and understand New You Bariatrics' Financial Office Policy. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of my knowledge.

Any questions regarding insurance claims and bills received should be directed to Julie Suitor at phone number 214-373-3183 extension 105.

_____ _____

Signature of Patient/Guardian Date

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NO SHOWS AND CANCELLATIONS

Scheduled appointment times are reserved especially for you. If you need to cancel or reschedule an appointment, we require 24 hour notice. Please note that calls must be received during our regular business hours which are Monday through Friday, 9am to 4pm.

We allow a 15 minute grace period for all appointments. If you are more than 15 minutes late, you may be asked to reschedule your appointment.

Repeated "no show" appointments could result in dismissal from the practice.

As a courtesy to our scheduled patients, we do not accept "walk in" appointments.

I understand that the office will make every attempt to place a reminder call for scheduled appointments, however, whether or not a confirmation call is placed, I am still held responsible for remembering my appointment day and time.

SIGNATURE:_____ **DATE:** _____

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PATIENT NAME: _____ DATE: _____

PHARMACY & PCP INFORMATION

PHARMACY NAME: _____ PHONE #: _____

PHARMACY ADDRESS: _____ CITY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

How did you hear about New You Bariatrics? _____

□ **No Known Drug Allergies**

MEDICATION ALLERGIES

□ **No Other Allergies (latex, contrast or adhesives)**

□ **Yes I have known Drug Allergies (Please list name and symptoms)**

1._____ _____

2. _____ _____

3. _____ _____

LIST ALL CURRENT MEDICATIONS YOU ARE TAKING

NAME: *Example: Benadryl*	**DOSE** *40 mg*	**FREQUENCY** *one tab a day*	**REASON PRESCRIBED:** *Allergies*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

I understand that prescription refills should be handled at the time of the office visit whenever possible. It is my responsibility to know when my prescription is about to run out. Medication refills are only handled during regular business hours and will not be addressed after business hours or on weekends.

SIGNATURE:_____ **DATE:** _____

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PATIENT NAME: _____ DATE: _____

Have you ever been diagnosed with any of the following medical conditions? Circle all that apply.

PAST MEDICAL HISTORY

Diabetes	Osteoarthritis	HIV/AIDS/Hepatitis	Stomach Ulcer
High Blood Pressure	Kidney Disease	Blood clots in legs/ lungs	Liver Disease
High Cholesterol	Anemia	Thyroid Disease	Tuberculosis
Elevated Triglycerides	Hiatal Hernia	Esophagitis	Sleep Apnea
Congestive Heart Failure	Angina	Asthma	Heart Disease
Acid Reflux/ Heartburn	Lupus	Depression/ Anxiety	Crohn's Disease
Heart Attack	Stroke	Coronary Bypass Surgery	
Year:_____	Year:_____	Year: _____	

List all other medical conditions, illness or important information not previously mentioned:

_____

_____

Family History: Has any blood relative ever had any of the following? Circle all that apply.

Obesity	Arthritis	Depression	High Blood Pressure	Heart Disease
Diabetes	Stroke	Cancer	Kidney Disease	Seizures

List all other medical conditions, illness or important information not previously mentioned:

_____

List all previous diet and exercise programs you have tried and the months/years you tried them:

_____

PRIOR SURGERIES

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

PRIOR HOSPITALIZATIONS

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

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PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, services as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health records is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health records to a third party. A reasonable copying/ labor charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request.

I CONSENT TO THE FOLLOWING:

1. ***Receiving text messages from New You Bariatrics***
   Initial here if you consent: _____

2. ***Receiving email communication from New You Bariatrics and their staff. I understand that my email may be shared with a third party vendor for the practice's marketing purposes.***
   Initial here if you consent: _____

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NEW YOU BARIATRICS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

THIS 8 PAGE DOCUMENT IS AVAILABLE FOR REVIEW AT ANY TIME. YOU MAY REQUEST TO REVIEW IT AT ANY TIME.

EFFECTIVE 11/06/2018

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2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health records to a third party. A reasonable copying/ labor charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request.

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By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

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Consent to be Photographed, Filmed, Videotaped and/or Interviewed and Release of Liability

I, the undersigned, hereby consent to be photographed, filmed, videotaped and/or interviewed while a patient, employee, physician or visitor of New You Bariatric Center (NYBC), Dr. Charlotte Hodges, Dr. Bryan Brewer or an event sponsored by NYBC, Dr. Charlotte Hodges, Dr. Bryan Brewer or its respective member organizations.

I agree that NYBC, Dr. Charlotte Hodges, Dr. Bryan Brewer or any other companies may use or permit other persons to use the negatives, prints or video prepared from my photographs, words or written materials reflecting my interview for any purposes and in such manner as they may choose, including but not limited to use in informational or promotional materials about any NYBC, Dr. Charlotte Hodges, Dr. Bryan Brewer entity, including

- News Coverage by television, newspaper, radio, internet or other media
- Video News Releases
- Advertorials and Marketing Materials
- Internal and external communication, including newsletters and video productions
- Social Media

I understand that I will not be paid or reimbursed in any way for current or future use of my likeness, words or ideas. I hereby give up any right to inspect or approve the finished product or products that may be used in connection therewith or the use to which it may be applied.

I hereby release and agree to indemnify and hold harmless NYBC, Charlotte Hodges, MD, Dr. Bryan Brewer, its affiliates and trustees, officers, employees, agents, patients, representatives, and medical staff from any injury and/or damages sustained as a result of such photographing, filming, videotaping and/or interviewing, including but not limited to, claims for personal injury, property damage, invasion of privacy and/or breach of confidentiality.

I have read and understand this consent prior to signing.

Signature _____ Date _____

Please Print:

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Email Address _____