Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Registration Form

Date: _____

PATIENT INFORMATION

Name:_____

Home Address:_____

_____

City:_____ State:_____ Zip:_____

Employer:_____

Employer Phone:_____

Occupation:_____

City:_____ State:_____ Zip:_____

Emergency Contact Name:_____

Emergency Phone:_____

Social Security #:_____ Sex: ❍ M ❍ F

Age:_____ Date of Birth:_____ Marital Status:_____

Race: ❍ White ❍ Native Hawaiian/Other Pacific Island
❍ Asian ❍ American Indian or Alaska Native
❍ Unknown ❍ Black or African American

Hispanic Ethnicity: ❍ Yes ❍ No

Preferred Language: ❍ English ❍ Spanish

Home Phone:_____

Work Phone:_____

Cell Phone:_____

E-Mail Address:_____

INSURANCE INFORMATION (Subscriber is the individual under whose name the family or individual is insured.)

Primary Insurance:_____

Subscriber Name:_____

Subscriber Address:_____

City:_____ State:_____ Zip:_____

Subscriber DOB:_____

Subscriber Social Security #:_____

ID#:_____

Group#:_____

Claims Mailing Address:_____

City:_____ State:_____ Zip:_____

Insurer Website Address:_____

Relationship to Patient: ❍ Self ❍ Spouse ❍ Child

Secondary Insurance:_____

Subscriber Name:_____

Subscriber Address:_____

City:_____ State:_____ Zip:_____

Subscriber DOB:_____

Subscriber Social Security #:_____

ID#:_____

Group#:_____

Claims Mailing Address:_____

City:_____ State:_____ Zip:_____

Insurer Website Address:_____

Relationship to Patient: ❍ Self ❍ Spouse ❍ Child

Do you have an Advance Directive? ❍ Yes ❍ No

If yes, what type?

❍ Living Will ❍ Do Not Resucitate ❍ Assignment of Healthcare Power of Attorney ❍ Assiangment of Healthcare Surrogate

I grant permission to the employees of **Riverside Surgical and Weight Loss Center** to render care to me and expedite the orders of the physician and/or physician extender. I further authorize release of this information to other healthcare providers associated with my care.

Can medical information be left on your answering machine? ❍ Yes ❍ No

Patient Signature:_____ Date:_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Medical History Form I

Date:_____Patient Name:_____

Who referred you to our office? _____

Who is your primary care doctor? _____

PRESENT HISTORY (Please answer all the questions listed below)

State your reason for coming to see the doctor today (chief complaint):_____

_____

_____

_____

_____

Have you seen other doctors for this reason? Who? _____

_____

_____

How long have you been dealing with this problem? _____

_____

_____

_____

If applicable, have you experienced this problem before? _____

_____

_____

If applicable, describe the location(s) of any pain/discomfort:___

_____

_____

_____

If applicable, describe the quality of any pain/discomfort (sharp, aching, cramping, burning, etc.):_____

_____

_____

If applicable, please mark the severity of the pain/discomfort on a scale of 0 to 10.

0 1 2 3 4 5 6 7 8 9 10

no pain **severe pain**

If applicable, how often do you experience this problem? (Daily? Weekly?):_____

_____

_____

If applicable, are there any other symptoms or issues associated with this problem? (joint pain, walking etc.):_____

_____

_____

_____

If applicable, is there anything you can do to make this problem better?_____

_____

_____

If applicable, is there anything that exacerbates this problem?___

_____

_____

_____

If applicable, Is this problem related to any other problems or complaints that you are having?_____

_____

_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Medical History Form II

Patient Name:_____

SURGICAL HISTORY (Please list all surgical procedures you have had in the past)

1)_____

Year:_____ Surgeon:_____

2)_____

Year:_____ Surgeon:_____

3)_____

Year:_____ Surgeon:_____

4)_____

Year:_____ Surgeon:_____

5)_____

Year:_____ Surgeon:_____

FAMILY MEDICAL HISTORY (Please check [x] all medical conditions your blood relatives have, indicate relationship)

❍ AIDS_____
❍ Alcoholism_____
❍ Arthritis_____
❍ Asthma_____
❍ Bleeding Disorders_____
❍ Breast Disease_____
❍ Cancer_____
❍ Clotting Disorders_____
❍ Colitis_____
❍ Crohn's_____
❍ Depression_____
❍ Diabetes_____
❍ Emphysema_____
❍ Heart Attack_____
❍ Heart Disease_____
❍ Hepatitis_____
❍ High Blood Pressure_____
❍ Kidney Disease_____
❍ Liver Disease_____
❍ Stroke_____
❍ Other _____

MEDICAL HISTORY (Please check [x] all medical conditions you have or have had in the past)

❍ AIDS
❍ Anemia
❍ Arthritis
❍ Breast Mass
❍ Bulimia
❍ Cancer
❍ Diabetes
❍ Emphysema
❍ Goiter
❍ Gout
❍ Hepatitis
❍ High Blood Pressure
❍ HIV Positive
❍ Liver Disease/Jaundice
❍ Multiple Sclerosis
❍ Pneumonia
❍ Psychiatric Care
❍ Rheumatic Fever
❍ Suicide Attempt
❍ Thyroid Problems
❍ Stomach Ulcers
❍ Venereal Disease
❍ Alcoholism
❍ Asthma
❍ Bleeding Disorder
❍ Bronchitis
❍ Clotting Disorder
❍ Chemical Dependency
❍ Deep Vein Thrombosis (DVT)
❍ Epilepsy
❍ Gonorrhea
❍ Heart Disease
❍ Herpes
❍ High Cholesterol
❍ Kidney Disease
❍ Migraines/Headaches
❍ Myocardial Infarction/Heart Attack
❍ Pacemaker
❍ Prostate Problems
❍ Pulmonary Embolism
❍ Reaction to Anesthesia
❍ Stroke
❍ Tuberculosis
❍ Vaginal Infections
❍ Latex Allergy

❍ Other_____

CURRENT MEDICATIONS (Please list all current medications with dosages or provide a list)

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

Drug Allergies (and reactions?):_____

_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Medical History Form III

Patient Name:_____

SOCIAL HISTORY (Please answer all the questions below)

Occupation:_____Marital Status:_____

Do you smoke?	❍ Yes	❍ No	If so, for how long?_____	Have you quit?	❍ Yes ❍ No
Do you or did you drink excessive alcohol?	❍ Yes	❍ No	If so, for how long?_____	Have you quit?	❍ Yes ❍ No
Do you use or have you used recreational drugs?	❍ Yes	❍ No	If so, for how long?_____	Have you quit?	❍ Yes ❍ No

REVIEW OF SYSTEMS (Please check [x] symptoms that you have had or may be experiencing)

General/Constitution
- ❍ Fever
- ❍ Fatigue
- ❍ Weakness
- ❍ Weight Gain/Loss ____
- ❍ Decreased Appetite

Eyes
- ❍ Pain
- ❍ Loss of Vision
- ❍ Double Vision
- ❍ Blurred Vision
- ❍ Flashing spots / light
- ❍ Glasses

Ears, Nose and Throat
- ❍ Loss of hearing
- ❍ Ringing in ears
- ❍ Nosebleeds
- ❍ Sinusitis
- ❍ Bleeding Gums
- ❍ Mouth Sores
- ❍ Frequent Sore Throat
- ❍ Hoarseness
- ❍ Constant Throat Clearing
- ❍ Difficulty Swallowing
- ❍ Ringing in ears
- ❍ Nosebleeds

Cardiovascular
- ❍ Chest Pain with Activity
- ❍ Shortness of breath at rest
- ❍ Shortness of breath with activity
- ❍ Chest pain at rest
- ❍ Leg Swelling
- ❍ Irregular Heart Beat
- ❍ Heart Palpitations

Respiratory
- ❍ Chronic Cough
- ❍ Coughing Up Blood
- ❍ Pneumonias
- ❍ Wheezing
- ❍ Asthma
- ❍ Night Sweats

Gastrointestinal
- ❍ Nausea
- ❍ Vomiting
- ❍ Vomiting Blood
- ❍ Heartburn
- ❍ Regurgitation
- ❍ Difficult Swallowing
- ❍ Pain with Swallowing
- ❍ Diarrhea
- ❍ Constipation
- ❍ Yellow Jaundice
- ❍ Stomach Pain
- ❍ Blood in Stools
- ❍ Black Tarry Stools
- ❍ Hemorrhoids
- ❍ Need for laxative/enema use

Genitourinary
- ❍ Difficult Urination
- ❍ Painful Urination
- ❍ Blood in Urine
- ❍ Frequent Urination
- ❍ Urgency
- ❍ Kidney Stones
- ❍ Frequent Night Urination
- ❍ Discharge from penis/vagina
- ❍ Erection difficulties
- ❍ Prostate troubles

Skin and Breast
- ❍ Hives
- ❍ Rashes
- ❍ Breast Mass
- ❍ Breast Pain
- ❍ Nipple Discharge

Neurological
- ❍ Headaches
- ❍ Dizziness
- ❍ Fainting
- ❍ Convulsions
- ❍ Arm / Leg Weakness
- ❍ Memory Loss
- ❍ Sensitivity of hands / feet

Psychiatric
- ❍ Depression
- ❍ Suicide Attempt
- ❍ Psych. Counseling
- ❍ Panic Attacks

Endocrine
- ❍ Heat/cold intolerance
- ❍ Flushing
- ❍ Increased Thirst
- ❍ Increased salt intake
- ❍ Finger nail changes

Hematologic
- ❍ Anemia
- ❍ Bleeding Tendency
- ❍ Clotting Tendency

Immunologic
- ❍ Rhinitis
- ❍ Skin Sensitivity
- ❍ Latex Allergy

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Weight History Form I

Date:_____Patient Name:_____Email Address:_____

WEIGHT INFORMATION

Height:_____feet, _____ inches.

Last Weight _____ lbs.

❍ Lap-Band ❍ Lap-gastric sleeve ❍_____

OFFICE USE ONLY

Today's Weight_____lbs. BMI _____

Ideal Body Weight:_____lbs. Excess Weight:_____lbs.

❍ Lap-Band ❍ Lap-gastric sleeve ❍ _____

PRIMARY CARE DOCTOR (Please fill in all blanks)

Name:_____Specialty:_____

Address: _____ City _____ State _____ Zip code_____

Phone:_____ How many times have you seen your primary care doctor in the last 5 years?_____

OBESITY CO-MORBIDITIES (The medical conditions listed below are associated with obesity, please check the ones you have.)

❍ High Blood Pressure
❍ Back Pain
❍ Asthma
❍ Drug Dependency
❍ Urinary Incontinence
❍ Diabetes
❍ Heartburn / Reflux
❍ Hip, Knee, Ankle/Joint Problems
❍ Psychiatric Problems
❍ Thyroid Disease
❍ High Cholesterol
❍ Gallbladder Disease
❍ Vein Clots/problems
❍ Liver Disease
❍ Infertility
❍ High Triglycerides
❍ Cancer
❍ Heart Disease
❍ Alcoholism

Do you have Sleep Apnea ❍ Yes ❍ No Are you currently using a CPAP or BiPAP machine? ❍ Yes ❍ No

How many times have you been admitted to the hospital in the last 5 years?_____

How many times have you been admitted to the Emergency Room in the last 5 years?_____

DIETING HISTORY – Last 5 years only (Must be filled out – list all diet and exercise attempts, use extra sheet if needed.)

Diet Program (Drugs/Exercise/Diet Programs)	**Supervised** (By a M.D., Dietitian, etc.)	**Is Documentation Available?**	**Year**	**Duration**	**Start/End Weight (lbs.)**
❍ Weight Watchers	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
❍ Meridia	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
❍ Fen-Phen	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
❍ Nutri-System	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
❍ Exercise	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
❍ Over-the-Counter Drugs	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
_____	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
_____	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
_____	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___
_____	❍ Yes ❍ No	❍ Yes ❍ No	_____	___ yrs. ___ Mos.	___ / ___

Other:_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Weight History Form II

Patient Name:_____

DOCTOR LIST (Please list all doctors who have assisted you with weight loss or are involved in your medical care)

	Doctor Name	Type of Doctor (reason seen)	Office Telephone	Office Address
1.	Dr._____	_____	_____	_____
2.	Dr._____	_____	_____	_____
3.	Dr._____	_____	_____	_____
4.	Dr._____	_____	_____	_____

SLEEP APNEA SCREEN (Please respond to the questions below with a [x])

❍ Yes ❍ No Do you snore?
❍ Yes ❍ No Do you make choking sounds while asleep?
❍ Yes ❍ No Do you stop breathing while asleep?
❍ Yes ❍ No Do you fall asleep at inappropriate times, such as driving?
❍ Yes ❍ No Do you sleep better in one position vs. another?
❍ Yes ❍ No Do you get better sleep in a Lazy Boy™ /recliner chair?

PROCEDURE BEING CONSIDERED ([x])

(All procedures are performed laparoscopically.)
❍ Laparoscopic Sleeve Gastrectomy
❍ Adjustable Lap Band
❍ Band over Bypass
❍ Bypass
❍ Other_____

OBESITY FAMILY HISTORY (Please be as accurate as possible [x])

Age or time period when you first started dieting/weight control:
❍ Preschool ❍ Kindergarten ❍ Grade School ❍ High School ❍ College ❍ Adult Age_____

Identify family members with morbid obesity:

❍ Mother	❍ Father	❍ Sister	❍ Brother	❍ Daughter	❍ Son
❍ Maternal:	❍ Grandfather	❍ Grandmother	❍ Aunt	❍ Uncle	
❍ Paternal:	❍ Grandfather	❍ Grandmother	❍ Aunt	❍ Uncle	

How many of these family members have had weight loss surgery?_____

Did any of the family members identified above have any of the medical conditions listed below?

❍ High Blood Pressure	❍ Diabetes	❍ High Cholesterol	❍ High Triglycerides	❍ Sleep Apnea
❍ Heartburn/Reflux	❍ Back Pain	❍ Hip, Knee, Ankle Joint Problems	❍ Vein Clots / Problems	❍ Heart Disease
❍ Depression	❍ Liver Disease	❍ Psychiatric Problems	❍ Alcoholism	❍ Drug Dependency
❍ Urinary Incontinence	❍ Infertility	❍ Gallbladder disease	❍ Cancer	

IMPORTANT REMINDERS

Did you check if your insurance company covers weight loss surgery? ❍ Yes ❍ No _____
What type of provider does your insurance company consider us as: ❍ in network ❍ out of network ❍ non-participating ❍ preferred
Do you have a copy of your insurance pre-certification criteria for weight loss surgery? ❍ Yes ❍ No _____
Can you document consecutive 6 months of a supervised diet/exercise program? ❍ Yes ❍ No _____
Have you attended our Weight Loss Surgery Seminar? ❍ Yes date: _____ ❍ No
Do you intend to attend our Weight Loss Surgery Seminar? ❍ Yes ❍ No _____
Have you read the educational information provided on our website? ❍ Yes ❍ No _____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Patient Weight History Form III

Patient Name:_____

In order to obtain pre-certification for your weight loss surgery operation the surgeon has to submit a Letter of Medical Necessity. The Letter of Medical Necessity is a letter written by a doctor to your medical insurance company requesting permission for a weight loss surgery operation. Often your personal answers below help the doctor in writing a stronger letter on your behalf.

WHAT ARE YOUR EXPECTATIONS FROM WEIGHT LOSS SURGERY? (Please write legibly)

_____

_____

_____

_____

_____

_____

DOES YOUR EXCESS WEIGHT PLACE LIMITATIONS ON YOUR DAILY ACTIVITIES SUCH AS WALKING, TYING SHOES, OR MAINTAINING PERSONAL HYGIENE? (Please write legibly)

_____

_____

_____

_____

_____

_____

_____

WHICH SURGERY DO YOU PREFER AND WHY? (Please write legibly)

_____

_____

_____

_____

_____

_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to Me by my healthcare provider or employee of **Riverside Surgical & Weight Loss Center, LLC**

Do we have your permission to: (Please check all that apply)

Call you at home? _____ YES _____ NO
E-Mail you? _____ YES _____ NO

If yes, can we leave the following information on your home answering machine or voicemail:

Appointment Information _____ YES _____ NO

Billing Information _____ YES _____ NO

Medical Information _____ YES _____ NO

Can we call you at work? _____ YES _____ NO

If yes, can we leave the following information on your work answering machine or voicemail:

Appointment Information _____ YES _____ NO

Billing Information _____ YES _____ NO

Medical Information _____ YES _____ NO

I give my permission to share the following information with the person(s) named below:

1. Name_____ Relationship_____

   Appt ___ YES ___ NO Billing ___ YES ___ NO Medical ___YES ___ NO

2. Name_____ Relationship_____

   Appt ___ YES ___ NO Billing ___ YES ___ NO Medical ___ YES ___ NO

3. Name_____ Relationship_____

   Appt ___ YES ___ NO Billing ___ YES ___ NO Medical ___ YES ___ NO

4. Name_____ Relationship_____

   Appt ___ YES ___ NO Billing ___ YES ___ NO Medical ___ YES ___ NO

Patient Name_____ DOB_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

PA Associates "LLC".

PA Associates "LLC".
110 Orlando Blvd.
Indialantic, Florida. 32903
Phone: 321-506-6781 Fax: 321-914-0283
E-Mail: pa_associates@yahoo.com

Consent For Surgical Assistant

I understand that my physician requires a surgical assistant for my scheduled procedure. My surgeon has requested Anthony A. Moore PA-C of P.A. Associates "LLC." as that assistant.

I understand that I am responsible for the assistant fee, and that a separate claim will be made to my insurance company by PA Associates "LLC."

I understand that the fee for this service will be a percentage of the surgeon fee, and that the amount for which I am responsible (including the insurance payment) will not exceed $500.

I understand that I am responsible for any co-payment, deductible and charges not covered as determined by my insurance policy.

I understand that PA Associates may not be an in network provider, and the amount of the fee covered by my insurance will be affected by this.

Print Name:_____

Sign Name:_____

Date:_____

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

FINANCIAL POLICY

MEDICARE: This office is a participating provider with traditional Medicare. Your claims will be filed and you will not be held responsible for any services approved by Medicare other than your co-pay, deductible and non-covered services.

SECONDARY INSURANCE: This office will file your secondary insurance as a courtesy. *Patients are responsible for communicating with their insurance carriers regarding disputes, non-payment and timely physician reimbursement.* In the even your secondary has not paid within 45 days, payment for services become patient responsibility.

WAIVER OF CO-PAYMENT: The office of the Inspector General strictly prohibits waiver of co-payments. Although this provider accepts assignment that does not mean that there is no payment due after Medicare. Many secondary carriers do not pay the full twenty percent of co-payment, therefore, any balance remaining after your secondary carrier pays are your responsibility.

MANAGED CARE CONTRACTS: Due to the vast number of managed care contracts, you are responsible for ensuring services will be covered under your managed care contract. **Co-payment is due at the time of visit.**

PROFESSIONAL COURTESY: **The Office of the Inspector General strictly prohibits professional courtesy.**

I understand that my insurance coverage is a contract between my insurance company and me and I am solely responsible for any non-covered service or balances. I also understand that full payment is required upon receipt of my statement. If I am unable to pay in full, I agree it is my responsibility to contact the office to set up a payment plan. I understand that I am responsible for resolving any disputes regarding reimbursement not made by my carrier. I understand that even though my carrier may indicate services are above usual and customary, I am still responsible for payment to my physician. I understand that I am responsible for informing this office of any address change, insurance change or name change. I understand that if I receive a payment from my carrier that I will immediately forward the payment to the billing office. I authorize the above physician to release any information acquired in the course of my examination or treatment in order to file my insurance. I authorize payment for all services to be made to my physician. ***I have read the above Financial Policy and understand my responsibility as a patient. I have requested clarification of any part of this financial agreement that I do not understand.***

PATIENT OR GUARDIAN:_____**DATE:**_____

Revised 8.30.09

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Sebastian HMA Medical Group

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____Fax Number: _____

❍ ACCESS REQUEST TO COPY/INSPECT

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure: _____
Name of Facility

_____
Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service:_____

❍ Complete Medical Record

❍ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

❍ History & Physical (H&P)
❍ Discharge Summary
❍ Operative Report
❍ Consultation Reports
❍ X-ray and imaging reports
❍ Progress Notes
❍ Laboratory Test Results
❍ Immunization Record

❍ Other- list specific Items: _____

BEHAVIORAL HEALTH REPORTS:

❍ Social History
❍ Client Data Form
❍ Referral/Treatment Form
❍ Admission Evaluation
❍ Notification of Admission
❍ Treatment Plan
❍ Academic History
❍ Aftercare Instructions
❍ Psychological Evaluation

❍ Other – list specific items: _____

3. I understand that the information in my 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 health services, and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Sebastian HMA Medical Group

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.
5. This information may be disclosed to and used by the following individual/organization:

Name: _____

Address: _____

For the purpose of:

❍ Further Medical Care
❍ Insurance Eligibility/Benefits
❍ Inspection/Copying of my records
❍ Legal Investigation or Action
❍ Personal
❍ Changing Physicians
❍ Other (please specify): _____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.
8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.
9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires within 90 days, unless otherwise specified.

_____ _____

Signature of Patient — Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____

Name of Patient (Please Print)

Patient is: ❍ Minor ❍ Incompetent ❍ Disabled ❍ Deceased

Legal Authority: ❍ Custodial Parent ❍ Legal Guardian ❍ Executor of Estate of Deceased
❍ Power of Attorney for Health Care ❍ Authorized Legal Personal Representative

_____ _____

Signature of Witness — Date

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Sebastian HMA Medical Group

General Consent to Treat/Patient Authorization/ Acknowledgement of Benefits Release

The following are the conditions for services provided by **RIVERSIDE SURGICAL AND WEIGHT LOSS CENTER** for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by **RIVERSIDE SURGICAL AND WEIGHT LOSS CENTER** and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and **RIVERSIDE SURGICAL AND WEIGHT LOSS CENTER**. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that **RIVERSIDE SURGICAL AND WEIGHT LOSS CENTER** can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may b e used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time.

_____ _____

Date Signature of Patient/(Parent, Guardian or Legally Authorized Representative)

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Sebastian HMA
Agreement of Financial Responsibility

Patient:_____

Date of Service:_____

The following items have been discussed with me:

_____1. I acknowledge that I have not supplied the clinic verifiable third party insurance coverage (including auto, workers compensation, commercial, Medicare or Medicaid).

_____2. I have been asked to make a deposit of $50.00 towards my treatment/services.

_____3. I understand if I have no insurance coverage I will be given a discount of 20% off of total charges if full payment is made today. This applies to general surgery patients only. The charges for bariatric surgery are already a discounted price for patients who do not have insurance.

_____4. I understand that if I do not provide verifiable third party insurance, establish an acceptable payment arrangement or pay my balance in full, my account will be referred to a National Collection Agency within 21 days.

Any questions regarding this bill should be made to the clinic office staff

_____Monday-Friday _____ am –_____pm.

_____ _____

Patient / Guarantor Date

_____ _____

Witness Date

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

Health Management™ PHYSICIAN NETWORK

e-Prescribing/Medication History Download Consent Form

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in and e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – providers the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that CLINIC NAME can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to CLINIC NAME to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction

_____ _____

Print Patient Name DOB

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient

Riverside Surgical & Weight Loss Center, LLC

Patrick W. Domkowski, MD, PhD, FACS
Jason M. Radecke, MD, MS
Barbara Allen, ARNP-BC
General and Bariatric Surgery

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total Score	

SCORE RESULTS:

1 — 6	Congratulations, you are getting enough sleep!
7 — 8	Your score is average
9 and up	Very sleepy and should seek medical advice

Print Patient Name _____ Date _____