PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Patient's First Name:	MI:	Last Name:	DOB:	Social Security Number:

Address:	City:	State:	Zip:

Gender:
- ☐ Male
- ☐ Female

Ethnicity:
☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native American ☐ Pacific islander/Hawaiian ☐ Other:_____

Phone: (Select all phone numbers where messages can be left)
Home ☐ (_____)_____
Cell ☐ (_____)_____
Work ☐ (_____)_____

Email Address:_____

How did you hear about us? (Please check all that apply)
☐ Word of Mouth ☐ Hospital ☐ Internet ☐ Magazine ☐ Newspaper ☐ Website ☐ Physian Referral
☐ Radio ☐ Television ☐ Insurance ☐ Other _____

INSURANCE INFORMATION

Please select preferred payment method: ☐ Self Pay ☐ Insurance (Please complete supporting details below)

So that we can help you expedite the insurance process to determine your bariatric benefits, please provide us with a copy of your insurance card (front and back) and a valid photo id or complete the following information from your insurance card

Insurance Company Name: (as it appears on the card)	Customer Service Phone #: (on back of card) (_____)_____
Name on card:	Insured Date of Birth:

Relationship of Insured:	Social Security # of Insured:	Policy #:
Group #	Coverage Effective Date:	Insured Employer:

I am Interested in having:
☐ Gastric Bypass Surgery ☐ Adjustable Gastric Band Surgery ☐ Sleeve Gastrectomy ☐ Revision ☐ General

Primary Care Physician and/or Referring Physician:	Phone #: (_____)_____

AGREEMENT AND RELEASE

Your digital signature provides permission to U.S. Bariatric to release any information to determine insurance eligibility, benefits, Co-payments or any out-of-pocket expenses to U.S. Bariatric. Additionally, you are giving permission for any insurance company to inform U.S. Bariatric of the resonable and customer reimbursement for my surgical procedure. Your signature also provides permission to U.S. Bariatric to release information to other providers participating in your care.

_____ _____
Patient/Guardian Signature Date

OFFICE USE ONLY Verified Height: Verified Weight: BMI: Initials:

St. Augustine Office
U.S. Bariatric
300 Health Park Blvd., Suite 5002
St. Augustine, Florida 32086

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FAMILY

Patient Data

Patient's First Name: MI: Last Name:	DOB:	Social Security Number:

I, _____ authorize U.S. Bariatric to discuss my confidential information with:
(Print Name of Patient of Legal Representative)

Name of Person Granted Access to Information:	Relationship:

Home Number: (_____)_____	Cell Number: (_____)_____	Work Number: (_____)_____

Address:	City:	State:	Zip:

Name of Person Granted Access to Information:	Relationship:

Home Number: (_____)_____	Cell Number: (_____)_____	Work Number: (_____)_____

Address:	City:	State:	Zip:

Patient Rights

The time period during which release of information is authorized is fromthe signing date below until nine years afterward. Disclosures cannot be revoked, once made.
Additional exceptions to the right to revoke consent, if any, include: _____

_____

_____

All persons listed above may share information among and between themselves allowing U.S Bariatric to provide medical care and services. Upon my request, U.S. Bariatric will provide me with a copy of this form. I can change my mind at any time and revoke my authorization in writing.

Authorization

Please type or sign your name below to authorize:

_____ _____

Patient/Guardian Signature Date

St. Augustine Office
U.S. Bariatric
300 Health Park Blvd., Suite 5002
St. Augustine, Florida 32086

AUTHORIZATION FOR RELEASE OF INFORMATION TO U.S. BARIATRIC

Patient Data

Date:				
Patient's First Name:	MI:	Last Name:	DOB:	Social Security Number:
To *(List Physician/Medical Practice/Hospital Here)*:				
Phone Number: (_____)_____			Fax Number: (_____)_____	

Patient Data

By typing my name in the space below, I hereby authorize the above named physician, medical practice, or hospital to release my complete medical records to:

U.S. Bariatric St. Augustine

- ☐ Robert T. marema, M.D., F.A.C.S., FASMBS
- ☐ Christine M. Routhier, M.D., F.A.C.S.

_____ _____

Patient/Guardian Signature *Date*

_____ _____

Signature of Witness *Date*

St. Augustine Office
U.S. Bariatric
300 Health Park Blvd., Suite 5002
St. Augustine, Florida 32086

U.S. BARIATRIC

St Augustine
Flagler Hospital
300 Health Park Blvd
Suite 5002
St. Augustine, FL 32086
OFFICE: 904.819.5861
FAX: 904.819.5862

PROGRAM FEE AND OTHER OUT OF POCKET EXPENSES

Program Fee: You are required to pay a non-refundable program fee of $600. This fee covers pre-operative education and postoperative follow up programs and must be paid in full prior to surgery or at your initial consultation if you are joining our practice from another bariatric program. Insurance companies do not cover this program fee. This fee includes a variety of services offered to you as a valued member of the U.S. Bariatric family. This is a one-time fee, and is required to be paid in full at your pre-operative appointment or your initial consultation for transferring to our program. This fee includes a 30 day supply of Building Blocks vitamins that are given to you in your nutrition and exercise class. A great deal of planning and effort has gone into providing resources that offer you excellence in service and support while working toward your weight-loss goals. It may become necessary for you to seek consultation from an allied health professional not associated with U.S Bariatric in order for you to be as successful as possible. The support groups, resource meetings, material and programs offered by U.S. Bariatric and its affiliates do not guarantee continued success and based on demand and participation, these programs may be added, adjusted, or discontinued without notice.
U.S. Bariatric Education and Support: U.S. Bariatric provides a comprehensive educational program to assist in your postoperative weight-loss success. We offer professional supervises support groups, as well as exercise and spirituality based support. These groups and classes are beneficial for your recovery, overall well-being, and weight loss success. Our education and support will continue to be adjusted as we continue to listen to the needs of our patients.

Nutrition and Exercise Services: Our program is designed to allow you to learn new behaviors in your relationship with food and to provide you with a solid foundation for a new and healthy eating pattern and lifestyle. Once you have been approved for surgery, you will be required to attend a nutrition and exercise class. This appointment will last approximately two to three hours and is done by licensed professionals. After your surgery, regularly scheduled follow-up group sessions are available for nutritional and exercise guidance. If you would like an individual consultation with a nutritionist or exercise physiologist, an additional fee may apply.

Preoperative Consultation Fee:
Deductibles, Co-Payments, and Non-Covered Services
At the time of service, you are also financially responsible for any deductibles, co-payments, and/or non-covered services as required by your insurance provider.

I acknowledge that the purpose of my consultation is to evaluate me case and recommend further testing or intervention according to the opinion of our surgeons. If I should choose to proceed under the care of our surgeons after this initial consultation, I will be required to pay a program fee of six-hundred dollars ($600) prior to your next visit. These monies are not refundable under any circumstances and may not be applied to co-pays or any other fees you may incur while under our care.

_____ _____
Signature **Date**

_____ _____
Print Name **Date**

Our Mission
U.S. Bariatric is committed to restoring health in individuals suffering from morbid obesity and its devastating consequences by providinga devoted and exemplary program that portrays medical excellence and offers quality care, education, guidance, and support.

Core Values
Integrity

Benevolence

Continuing Eduction

Research

Honesty

Stewardship