LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS

Surgical and Medical Weight Loss
3830 Washington Rd. Suite 17,
Martinez, GA 30907
(General Surgery Paperwork)

Have you ever been a patient in this office for any doctor: ❑ Yes ❑ No

Patient's Full Name: _____
(please print) (First) (Middle) (Last) (name called)

Mailing Address: _____
(Street/apt #) (City) (State) (Zip)

_____
(Date of Birth) (Age) (Sex) (Ethnicity)

_____
(Area Code) (Phone #) (Cell #) (Work #)

_____
(Social Security #) (Employer)

_____
(Email Address) (Pharmacy/Pharmacy Phone #)

_____
(Marital Status) (Spouse's Name)

_____
(Spouse's Date of Birth) (Spouse's SS#)

_____

Please state reason for seeing doctor today: _____

Dr. that referred you here: _____ **Primary Care Physician:** _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____ 2nd ph #: _____

Primary Insurance Co: _____ Insured: _____

Secondary Insurance Co: _____ Insured: _____

Payment Information: *You will receive statements for balances due which are payable upon receipt. We are happy to assist you with account issues. If your account becomes delinquent & is referred to a 3rd party for collections, you are responsible for all collection and/or attorney fees. Per your insurance contract, all co-pays are due at the time of office visits. Thank you for giving us the opportunity to serve you. Please refer to our payment policy for further information.*

HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this information. We are counting on you to provide accurate health history information.

Name:	Age:	DOB:
Current Height:	Current Weight:	

Allergies:

❑ Problems with anesthesia ❑ Latex or tape allergy

❑ Food; Please specify: _____

❑ Medication(s); Please specify: _____

History **(please do not write in this space):**

CURRENT MEDICATIONS

Medication		Strength/Dosage	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

PAST MEDICAL HISTORY

Past/Current Medical History (Check all that apply):	❑ Heart Attack	❑ Heart Failure/Heart Attack	❑ Atrial Fibrillation	❑ High Blood Pressure
	❑ Diabetes	❑ Elevated Cholesterol	❑ Cancer	❑Hepatitis/Liver Ds
	❑ Stroke	❑ COPD or Emphysema	❑ Kidney Failure	❑Reflux/Heartburn
	❑Blood Clots	❑Sleep Apnea	❑ Vascular Disease	❑ Hypothyroidism
	❑ Asthma	❑ Arthritis	❑ Thyroid problems	❑ Knee/Joint Pain
	❑ Depression/Anxiety	❑ HIV	❑ Cancer_____	

What age did you start your menstrual cycle? ____ How many children do you have?____ C-Sections?____ Breast Feed?_____

Please list any other medical conditions:

PAST SURGICAL HISTORY

Surgical History and type:	Date of Surgery:
❑None	
❑Chest Surgery	
❑ Abdominal Surgery	
❑Hernia Repair	
❑Breast Surgery	
❑Heart Surgery	
❑Hysterectomy	
❑Weight Loss Surgery	
❑Other	

FAMILY MEDICAL HISTORY

Do you have any siblings? ❑❑ Yes ❑❑ No If yes, How many sisters? _____ brothers? _____
half-sisters? _____ half-brothers? _____ stepsisters? _____ stepbrothers? _____
Your Birth Order/Position in family: _____

Family History:	Family Relationship:
❑Colon Cancer	
❑Breast Cancer	
❑High Blood Pressure	
❑ Diabetes	
❑Heart Attack	
❑Stroke	
❑ Aneurysms	
❑Gallbladder Disease	
❑ Obesity	❑ Mother ❑ Father ❑ Grandparent(s) ❑ Sibling(s)

SOCIAL HISTORY

Education:	Highest degree completed: ❑GED ❑High School ❑College ❑ Masters ❑PhD ❑MD ❑Other: _____
Occupation:	❑Employed Full Time ❑ Employed Part Time ❑ Disabled ❑ Unemployed ❑Full Time Student ❑Part Time Student Current Position: _____
Current Marital Status:	❑Married ❑Separated ❑Single ❑Widowed ❑Divorced ❑Partnered # number of times married _____
Pregnancies	Number of pregnancies _____ Number of miscarriages/abortions _____ /_____ Current ages of biological children _____ Number of males _____ Number of females _____ How many of your children are overweight or obese? _____ Current ages of step-children _____ How many of your step-children are overweight or obese? _____
Tobacco Use:	❑Never ❑Previously, but quit ❑ Currently (list packs/day and # of years) Year you quit_____
Substance Abuse:	❑Never ❑ Rarely (less than once a month) ❑ Occasionally (less than once a week) ❑ Moderately (one or more times weekly) ❑ Daily ❑I quit drinking (year_____) Quit due to a problem with alcohol? ❑ Yes ❑ No

REVIEW OF SYSTEMS

Check the boxes that apply to YOU.	
Constitutional:	❑Weight gain ❑Weight Loss
Eyes:	❑ Double vision ❑Blurred vision
Cardiovascular:	❑ Heart attack or chest pain ❑ Pain in legs with walking
ENT:	❑ Hearing Loss ❑Sore throat
Respiratory:	❑ Excessive shortness of breath ❑Chronic/Persistent cough
Gastrointestinal:	❑ Recent blood in stool ❑Heart Burn
Genitourinary:	❑ Difficulty with urination ❑ Incontinence
Musculoskeletal:	❑ Leg cramps ❑Joint pain
Skin/Breast:	❑ Breast mass ❑ Nipple discharge
Neurological:	❑ Seizures ❑ Stroke
Psychiatric:	❑ Depression ❑ Anxiety Disorder ❑ Bipolar Disorder ❑ Other: _____
Endocrine:	❑ Hot/Cold episodes ❑ History of thyroid disease
Hematology/Lymphatic	❑ Abnormal bleeding ❑ History of blood clots

Please list any other symptoms/problems you are having:

_____

_____

The above is true and correct to the best of my knowledge (Please sign)

Signature_____ Date_____

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS
General and Bariatric Surgery /Medical Weight Loss
(here after referred to as Live Healthy MD)

PATIENT ACKNOWLEDGMENT FORM

Patient's Name:_____SSN:_____DOB:_____

I understand that the patient's health information is private and confidential. I understand that Live Healthy MD works very hard to protect the patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Live Healthy MD may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that the nutritionist(s) and mental health practitioner(s) who contract with Live Healthy MD and the program director will have access to my medical file. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Live Healthy MD has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and contains a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

Live Healthy MD may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Midtown Surgical Specialists/Live Healthy MD will provide me with the most current "Notice of Privacy Practices".

Live Healthy MD has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgments/authorizations; reasonable time frames for requests, charges for copies and non-routine information needs; etc. I will assist Live Healthy MD by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Live Healthy MD "Notice of Privacy Practices".

Signature:_____Date: _____

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, person representative, etc.)

PATIENT ACKNOWLEDGMENT FORM CONTINUED

With this consent, Live Healthy MD/Midtown Surgical Specialists may call my home or other alternative location and leave a message, to include return call messages, on voice mail or with any person who answers in reference to any items that assist the practice in carrying out treatment, payment, and operations such as appointment reminders, insurance items and calls pertaining to my clinical care, including test results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Live Healthy MD to release my protected health information to my family members both verbally and written, and to mail prescription, disability forms, etc. to me or my family members as needed.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

The above information on all of these pages has been completed by me and is true and correct to the best of my knowledge.

Signature:_____ Date: _____

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, person representative, etc.)

Printed name of Patient and/or Personal Representative: _____

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS
General and Bariatric Surgery /Medical Weight Loss

Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of service your appointment may be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account to include deductibles. We appreciate payment in full by the billing due date. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through the use of:
    a. Recurring payment with a credit/debit card
    b. Establishing monthly payment contract with our office
    c. Extension of a line of credit through a medical services credit company
3. Statements will be mailed to you monthly for our outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia. Monthly finances charges may be applied to all outstanding balances over 30 days.
4. **Prior to elective surgery we will confirm benefits, and calculate balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We expect payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing concerns after the rendered services.**
5. **Questions or concerns regarding your bills should be addressed directly with the midtown billing staff and not your physician at (706) 738-3359.**
6. We take pride in our relationship with you and appreciate you giving us the unique opportunity to care for you and your family. We understand that medical care can be costly. We are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter. We cannot help you if we do not know what the problem is regarding making payment.
7. I give my permission for the staff and physicians at Midtown Surgical and Live Healthy MD to contact me with automated reminders by the above methods. I understand that patient specific medical information will not be left, but information about appointment dates, times, doctors and locations and instructions will be communicated. We cannot guarantee that someone else other than the intended patient will not receive the call/message.

_____ _____ _____

PRINTED NAME SIGNATURE DATE

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS

SURGICAL AND MEDICAL WEIGHT LOSS

Automated Message Consent

In our office we have an automated system that will allow us to communicate with you better. The system will allow us to send you automated appointment reminders and other messages by:

1. Voice message (land and cell lines): **Home #**_____

   Cell #_____

   Work #_____

2. Text message (must have text capability) Cell #:_____

3. Email address: _____

1. Can we contact you by this system (we will not leave medically sensitive information):

❑ YES ❑ No

2. If YES, then please answer the following questions:

   1. How do you want to be contacted:

   ❑ Voice ❑ Text ❑ Both

   2. If voice message, then what number do you prefer us to call:

   ❑ Home ❑ Cell ❑ Work

   3. When do you want to get these messages

   ❑ Morning ❑ Afternoon ❑ Evening

Signature:_____ Date:_____