Bagshahi Bariatric and General Surgery

Welcome!

Thank you for choosing Bagshahi Bariatric and General Surgery for your surgical treatment. Enclosed you will find the new patient paperwork which we ask that you bring with you to your initial visit. We also ask that you please arrive 15 minutes early to allow adequate time to process your paperwork.

You will also need to bring:

- Photo ID
- Health insurance information, including a referral from your primary care provider (if required by your insurance carrier)
- Medical records, including your previous diet history (if available)
- All medications you are taking or a detailed list including over the counter medications, herbal products, and vitamins.
- Any operative (surgical) reports or pertinent imaging studies (UGI, EGD, CT)
- Method of payment for services rendered (i.e. copay, coinsurance, deductible), and/or payment in full for non-covered services.

If you have any questions or require additional information, please call 817-289-4200

Sincerely,

Dr. Hossein Bagshahi and Staff

Bagshahi Bariatric and General Surgery

***** MUST FILL OUT COMPLETELY ALL FIELDS ARE REQUIRED*****

Patient Registration Information (Please use full legal name, no nicknames)

Name: _____ **Date of Birth:** _____
Last Name First Name MI

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Driver License#:_____ **Social Security #:**_____ **Sex:** _____ M _____ F

Email Address: _____ **Name of Employer:** _____
(Confidential Medical Information will NOT be emailed)

PCP: _____ **Phone:** _____ **Referred By:** _____
Name of Primary Care Physician

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Other **Primary Language:** _____

Race/Ethnicity: ___ White/Caucasian ___ Hispanic ___ African American ___ Native American ___ Asian

___ Native Hawaiian ___ Chinese ___ Japanese ___ Filipino ___ Pacific Islander ___ Unknown ___ Other _____

Guarantor Information (List person or insured name responsible for bill)

Relationship of Guarantor to Patient: ___ Self ___ Spouse ___ Parent ___ Other _____

Name: _____ **Date of Birth:** _____
Last Name First Name MI

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Social Security #:**_____ **Sex:** _____ M _____ F

Name of Employer and Address: _____ **Work Phone:** _____

Primary Insurance Information

Insurance Name: _____ **Policy/ID #:**_____ **Group #**_____

Insured Name: _____ **Insured's DOB:** _____ **Insured SSN#:** _____

Claims Address & Phone #: _____

Secondary Insurance Information

Insurance Name: _____ **Policy/ID #:**_____ **Group #**_____

Insured Name: _____ **Insured's DOB:** _____ **Insured SSN#:** _____

Claims Address & Phone #: _____

By signing below, I am confirming that all information listed above is true to the best of my knowledge.

Signature: _____ **Date:** _____
(Patient or Responsible Party if a Patient is a Minor)

Bagshahi Bariatric and General Surgery

Medical Release of Information Form

Patient Name: _____ **DOB:** _____

Previous Name: _____ **Social Security #:** _____

Home Phone: _____ **Other Phone:** _____ **Sex:** _____

Address: _____ **City/State:** _____ **Zip:** _____

I request and authorize: _____
(Name of Physician and Clinic/Practice records are requested from)

This letter will authorize **Bagshahi Bariatric and General Surgery** to **OBTAIN** my medical records (as indicated by the check mark(s) below) or to otherwise obtain confidential information. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. At this time, I am requesting the following:

To release the medical record of the above-named patient to:

Bagshahi Bariatric and General Surgery
Hossein Bagshahi, MD and Jessica Roth FNP
1101 W Rosedale ST Suite 1
Fort Worth, Texas 76104

The reasons or purposes of this request for information are: **SPECIALIST**

This request and authorization applies to: ***(initial appropriate line)***

___ Health Care information relating to the following treatment, condition, or dates of treatment:
_____
This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, surgeries, etc.

___ All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. (Please circle all that apply)

___ All Health Care information **excluding** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. (Please circle all that apply)

___ I understand that I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____ _____
Signature of Patient or Legal Representative *Date*

_____ _____
Representative's Relationship to Patient *Representative's Printed Name*

_____
Patient or Representative's Phone Number

Unless otherwise revoke this authorization will never expire unless noted here Expiration date_____ I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Bagshahi Bariatric and General Surgery

Financial Responsibility Agreement

Patient Name: _____DOB: _____ MR#:_____

Notice: Our office does NOT treat work related injuries or file Workers Compensation claims or claims for visits related to motor vehicle accidents.

******Please read and initial each paragraph below******

____ I allow _____ to make payments on my behalf. I fully understand I'm responsible for all charges. _____ agrees to Pay for charges incurred on my behalf

_____ Signature of person agreeing to pay on patient's behalf.

____I understand that if my procedure is a "self-pay" procedure, costs related to medical care subsequent to the surgery, for any reason, may not be covered by my insurance and would be my responsibility or the person.

____ I consent to treatment necessary to my care.

____ I understand that full payment is due at the time of service. This includes all Co-pays, Co-insurance, Deductible and Self Pay portions I owe that insurance will not cover.

____ I understand and agree that it is my responsibility to notify Bagshahi Bariatric and General Surgery of any changes to my demographics, insurance and/or billing information.

____ I understand and agree it is my responsibility to know if Bagshahi Bariatric and General Surgery is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me.

____ I understand and agree that my insurance (if provided) will be filed for services rendered, and Bagshahi Bariatric and General Surgery will provide medical information to the insurance company as required for payment of claims for services rendered. Any charge for out of network or non-covered services will be my responsibility.

____ I request that payment of authorized Medicare and other information benefits be made of my behalf to Dr. Bagshahi for any services furnished by Bagshahi Bariatric and General Surgery Fort Worth. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.

____I appoint Bagshahi Bariatric and General Surgery to act as my authorized representative in requesting an appeal from insurance plan regarding denial of services or denial of payment.

I have read and fully understand the above
Financial Responsibility Agreement

Signature: _____ Date: _____

(Please sign here- Patient or Responsible Party if Patient is a Minor)

Signature: _____ Date: _____

(Please print name of Patient or Responsible Party if different from Patient)

Patient Registration Form
Disclosures & Consents

Patient Name: _____DOB: _____ MR#:_____

ASSIGNMENT OF INSURANCE & BENEFITS:
I hereby authorize direct payment of insurance benefits to Bagshahi and General Surgery, or the physician individually for the services rendered to me or my dependents by the physician or those under his supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that is unable to collect from insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to *** or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the "HIPAA Notice of Privacy Practices". I hereby authorize, Bagshahi Bariatric and General Surgery, or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:
I certify that I understand the privacy risks of the mail, phone calls, text, and email. I hereby authorize Bagshahi Bariatric and General Surgery representative to mail, call, text, or e-mail with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying the office to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SEVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Dr. Bagshahi or those under his supervision.
I understand that if my procedure is a "self-pay" procedure, costs related to medical care subsequent to the surgery, for any reason, may not be covered by my insurance and would be my responsibility or the person.

DISCLAIMER FOR OUT OF NETWORK FILING AND REFERRALS:
Our company and companies/facilities that we may refer you to may not be participating with your Insurance Carrier(s). Your claims may be filed with your out of network benefits and processed by your carrier as out of network. Your carrier will send an explanation of your claim and they will make you responsible for the amount that they do not pay on the claim. Please contact your insurance carrier to make sure that your visit will be in-network. During the course of your physician/patient relationship with Dr. Bagshahi, Dr. Bagshahi may refer you to Baylor Medical Center of Trophy Club. The address of the Hospital is 2850 East Highway 114 Trophy Club, TX 76262. In connection with any referral to the Hospital, you are hereby advised that Dr. Bagshahi has an investment interest in the Hospital. This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Baylor Medical Center of Trophy Club. You will not be treated differently by your physician or Baylor Medical Center of Trophy Club if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

I have read and fully understand the above
Patient Registration Form Disclosures & Consents

Signature: _____ Date: _____
(Please sign here- Patient or Responsible Party if Patient is a Minor)

Signature: _____ Date: _____
(Please print name of Patient or Responsible Party if different from Patient)

Medication Prescription Refill Policy

Patient Name: _____DOB: _____ MR#:_____

At Bagshahi Bariatric and General Surgery, we are committed to assisting you with weight loss and surgery needs, which includes supplying necessary medications for you; however, we do have certain guidelines for refilling all medications prescribed by our physician.

- Vitamins and Supplements will be refilled by Dr. Bagshahi.
- Health maintenance medication refills must be refilled by your prescribing provider (i.e. PCP, Cardiologist, Pulmonologist). Please Discuss these medications with your prescribing provider prior to surgery. Some May need to be altered.
- If you are on an anticoagulant (i.e. Warfarin (Coumadin), Heparin) it is important that you contact your prescribing provider (i.e. PCP, Cardiologist, Pulmonologist) and develop a plan for post-operative anticoagulants regimen.
- You will only receive prescription narcotics from **one treating physician at a time**. If you are receiving narcotic medications from another physician, or if you are under contract with a pain management specialist, you should consult with your pain management physician to plan a post-operative pain control regimen. ***(Please refer to Dr. Bagshahi's Controlled Substance Agreement form on next page. THIS FORM MUST BE SIGNED)***
- Do not contact Dr. Bagshahi's office after normal business hours or on the weekends for a refill of medication. If you contact the answering services after hours for a refill the physician on-call will not be contacted with your request. ***Please do not be dishonest with the answering service!*** The medical providers do not have access to your medical records after business hours. It is important that you contact your pharmacy before you run out of medications.

Family Medical Leave Act / Short Term Disability / Medical Records Policy

At Bagshahi Bariatric and General Surgery, we are happy to assist you with the completion of any FMLA/STD forms required for leave of absence related to surgery and/or post-surgical complications, as well as the release of medical records to various other physicians involved in your care; however, we do have certain guidelines for completing the required forms for FMLA and/or STD and sending requesting medical records.

- If you require leave of absence documentation for your employer for upcoming surgery, it is your responsibility to provide our office with the necessary paperwork and contact information of whom to return it to prior to your scheduled surgery (preferably prior to your pre-op appointment).
- You must allow 7 business days for completion of FMLA/STD forms and requests for medical records upon receipt of the required forms by our office. It is your responsibility to provide the necessary forms in advance.
- There will be a $25 fee due prior to your FMLA/STD being completed and processed. Also, an additional fee of $35 must be paid for any secondary request for completion.
- If you require a release to return to work, please contact our office via phone during normal business hours and provide the necessary contact information needed to forward your release to your employer.
- There will be a $50 fee due prior to releasing your medical records to yourself; however, there is no charge to release medical records to another physician for continuation of care. We must receive a signed request to release medical records. (A verbal request will not be honored.) You may contact our office to obtain this form.

I have read and fully understand the above
Policies regarding Medication Refills and FMLA/STD/Medical Records

Signature: _____ Date: _____
(Patient or Responsible Party if a Patient is a Minor)

Controlled Substance Agreement

Patient Name: _____DOB: _____ MR#:_____

Controlled substances have the potential to be addictive and must be taken exactly as prescribed.

I, _____, understand that if I am prescribed a controlled substance I must adhere to the following restrictions. **Failure to conform to any of the below listed restrictions may result in being dismissed as a patient of Dr. Bagshahi/Bagshahi Bariatric and General Surgery and being reported to the police.**

****Please read and initial each line below****

1. _____I will not use alcohol/illegal drugs while being prescribed medication(s).
2. _____I will not take any other prescribed medications without first notifying **Dr. Bagshahi.**
3. _____I will notify **Dr. Bagshahi** immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms & urgent care centers). **Failure to do so is a *crime.* Obtaining or attempting to obtain drugs by fraud and or deceit and will be reported to the police.**
4. _____I will submit to random urine and/or serum drug screens as ordered.
5. _____I will purchase all of my medication at _____ pharmacy and authorize **Dr. Bagshahi** to communicate with my pharmacist.
6. _____I authorize **Dr. Bagshahi** to communicate with all physicians that I have seen.
7. _____I understand that it is illegal to share this medication.
8. _____I agree to keep my medication locked in order to prevent loss or theft.
9. _____I understand that I will be taken off this medication if there is evidence of addiction and or abuse.
10. _____I understand that this medication may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment.
11. _____I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. _____I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications.
13. _____I authorize this office to release a copy (or original) of this controlled substance agreement to the police if I violate any of the listed terms or at their request.
14. _____ (Y or N) Have you received ***any*** prescription medications from ***any*** other physician in the past thirty days? If yes, please list physician and medication on back.
15. _____ I understand I may be called **at any time** to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be **responsible for any costs that may be incurred.**
16. _____ I waive my right of privacy and authorize **Dr. Bagshahi** to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances). No refills will be authorized on weekends, holidays, after office hours or by producing a police report. Lost/stolen medications will not be replaced.

I have read and fully understand the above
Policies regarding Controlled Substance Agreement

Signature: _____ Date: _____
(Patient or Responsible Party if a Patient is a Minor)

Physician Signature: _____ Date: _____

This was obtained from The National Association of Drug Diversion Investigators.

Appointment No Show / Cancellation Policy

Patient Name: _____DOB: _____ MR#:_____

At Bagshahi Bariatric and General Surgery we are happy to help you with your weight loss and medical needs. That includes being able to provide you an appointment when needed. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family; however, when you do not call to cancel an appointment (otherwise known as a "NO SHOW"), you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. In an effort to combat this issue, please read and acknowledge the following policy:

- If your EGD appointment is missed or cancelled without providing a 72-hour notice, your account will be charged with a $100.00 "NO SHOW/Cancellation" fee (this will not be covered by your insurance company). This will not go towards the cost of your EGD.
- If your Office Visit is missed without providing a 24-hour notice your account will be charged $50.00 "NO Show" fee this is not covered by your insurance company)
- If you cancel your Surgery with less than 72 hours' notice, there will be a $750.00 Cancellation Fee charged to your account. (this is not covered by insurance)
- You can be dismissed from the practice if you are repeatedly a **NO SHOW** or **CANCEL** your scheduled appointments without providing sufficient notice.

I have read and understand the above policy on missing scheduled appointments without providing a 24-hour notification.

Signature: _____ Date: _____
(Patient or Responsible Party if a Patient is a Minor)