Texas
Laparoscopic
Consultants

Consent To Release Medical Information

I give authorization for the staff of Texas Laparoscopic Consultants, Dr. Yu, Dr. Scarborough, and Dr. Mehta to communicate medical information to the below listed persons. These communications include, but are not limited to: information about the procedure I am having, the scheduling of pre-operative testing, the outcome of my surgery and condition, information regarding any complications, and my post-operative care. Information discussed could also include any additional health conditions (such as psychiatric problems, substance abuse, and or HIV status) as related to my current condition and medical treatment.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Printed Name	Date
Signature	
Witness	Date

_____I DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION

Bariatric Patient History Questionnaire

Demographics: *Please fill out completely*

First Name:_____ Address:_____

Middle Name:_____ City, State Zip: _____

Last Name:_____ *Email Address:_____*

Do you consent for TLC to email you clinical information such as lab reports? Yes No _____**Initials**

Do you consent for TLC to send a text to your mobile phone about appointment notifications? Yes No _____**Initials**

Nickname / Preferred Name:_____ Cell Phone: _____Ok to leave voicemail? Y N

Maiden Name:_____ Home Phone: _____Ok to leave voicemail? Y N

Gender: Male Female Other Phone:_____Ok to leave voicemail? Y N

Date of Birth:_____ Social Security Number:_____

Marital Status: Single Married Partnered Separated Divorced Widowed

Ethnicity: African American Arabic Asian Caucasian Hispanic Native American Other

Highest Level of Education: HS/GED Associate Bachelor Master Professional Doctoral

Employment: Full-time Part-time Homemaker Student Retired Disabled Unemployed

If disabled, specify the year and the cause: Year:_____ Cause:_____

Patient Occupation (indicate if student):_____

Employer:_____ Years Employed:_____

Employer's Address: _____

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse employment: Full-time Part-time Homemaker Student Retired Disabled Unemployed

Spouse's occupation (indicate if student):_____

Spouse's Employer:_____ Years Employed:_____

Use spouse as an emergency contact? Yes No Phone:_____

Emergency Contact #1:

First Name:_____

Last Name:_____

Relation to you:_____

Phone:_____

Emergency Contact #2:

First Name:_____

Last Name:_____

Relation to you:_____

Phone:_____

Referral and Visit Information

Reason for Visit (i.e. why are you seeking weight loss surgery?):_____

_____

From what age have you been obese? _____

Which procedure are you seeking? Band Sleeve Gastric Bypass Duodenal Switch Revision

How did you hear about TLC Surgery? Internet/Facebook Magazine Newspaper Other Patient

Our Website Television Yellow Pages Physician or Hospital Referral: _____

Primary Care Physician Information

Name:_____

Phone:_____ Address:_____

Fax:_____ City, State Zip: _____

Do you consent for TLC to send medical records to your PCP? Yes No _____**Initials**

Specialist Physician Information: ***if you regularly see a specialist***

Name:_____ Type:_____

Phone:_____ Address:_____

Fax:_____ City, State Zip: _____

Primary Insurance Information: ***Please fill out completely***

Insurance Company:_____ Policy Number:_____

Full Name of Cardholder:_____ Group Number:_____

Cardholder's DOB:_____ Effective Date:_____

Cardholder's SS#:_____ Termination Date:_____

Cardholder's Employer:_____ Insured ID:_____

Notes:_____ Insurance Phone#:_____

Relationship to Cardholder: Self Spouse Child Other:_____

Is this plan: Cobra Medicare Medicaid Disability Workman's Comp None

Secondary Insurance Information: ***Please fill out completely***

Insurance Company:_____ Policy Number:_____

Full Name of Cardholder:_____ Group Number:_____

Cardholder's DOB:_____ Effective Date:_____

Cardholder's SS#:_____ Termination Date:_____

Cardholder's Employer:_____ Insured ID:_____

Notes:_____ Insurance Phone#:_____

Relationship to Cardholder: Self Spouse Child Other:_____

Is this plan: Cobra Medicare Medicaid Disability Workman's Comp None

Comorbidities / Problem List

***Please not that if you are not familiar with a listed condition, then it may not pertain to you.

Gastrointestinal

K21.9	Reflux	O Yes	O No
R12	Heartburn	O Yes	O No
K21.9	Have you ever taken any of these medications in the past 6 months:	O Tums O Alka Seltzer Heartburn O Zantac O Pepcid O Prilosec	O Nexium O Omeprazole O Mylanta O Pepto O Other gas/heartburn meds
K21.0	(Gas) Gastro-esophageal reflux	O Yes	O No

General

E11.9	Diabetes Mellitus (Type 2)	O Yes / Non Insulin or Insulin	O No
E10.9	Diabetes Mellitus (Type 1)	O Yes / Non Insulin or Insulin	O No
	Functional Health Status Prior to Surgery	O Independent O Partially Dependent O Totally Dependent	

Pulmonary

492	History of Chronic Obstructive Pulmonary Disease	O Yes	O No
Z99.81	Oxygen Dependent	O Yes	O No
I26.99	History of Pulmonary Embolism	O Yes	O No
G47.33	Obstructive Sleep Apnea (Require CPAP or BiPAP)	O Yes	O No

Musculoskeletal

R26.2	Is ambulation (walking) limited most or all of the time?	O Yes	O No

Cardiac

I25.2	History of Heart Attack	O Yes	O No
I10	Hypertension Requiring Medication	O Yes	O No
E78.5	Hyperlipidemia Requiring Medication	O Yes	O No

Vascular

453.4	Deep Vein Thrombosis Requiring Therapy	O Yes	O No
I87.2	Venous Insufficiency	O Yes	O No

Renal (Kidneys)

N19	Renal Failure (Required use of dialysis)	O Yes	O No
585	Chronic Renal Disease	O Yes	O No

Immune / Nutritional / Oncology / Other

Z92.25	Steroid / Immunosuppressant Use for Chronic Condition	O Yes	O No
	Therapeutic Anticoagulation	O Yes	O No

Social History: ***Please select all that apply***

Alcohol Use: Yes No Tobacco Use: Yes No Substance Abuse: Yes No

Drinks per week: _____ *Packs per week:* _____ *Uses per week:* _____ (RX or illegal)

Cans per week: _____

Surgical/ Hospitalization History: ***Please check or list all surgeries you have had***

		Month	Year
Gallbladder (Open)	☐		
Gallbladder (Laparoscopic)	☐		
Appendectomy	☐		
Hernia (Body Location: _____)	☐		
Hernia (Body Location: _____)	☐		
Hysterectomy (Uterus removed vaginally)	☐		
Hysterectomy (Uterus removed abdominally)	☐		
Ovary Surgery	☐		
Cesarean Section	☐		
Tubal Ligation:	☐		
Left Breast Biopsy	☐		
Right Breast Biopsy	☐		
Back	☐		
Right Knee	☐		
Left Knee	☐		
Tonsillectomy	☐		
Heart Surgery	☐		
Kidney Transplant	☐		
Liver Transplant	☐		
Pancreas Transplant	☐		
Other: _____	☐		
Other: _____	☐		

Previous Weight Loss Surgery

Procedure: _____ Doctor: _____ Date: _____ Weight: _____

Procedure: _____ Doctor: _____ Date: _____ Weight: _____

Procedure: _____ Doctor: _____ Date: _____ Weight: _____

Procedure: _____ Doctor: _____ Date: _____ Weight: _____

**If you have had multiple bands, please describe each procedure, including band removal and replacements.*

Family History: Please check all that apply

Obesity	☐	Kidney Disease	☐
Heart Disease	☐	Diabetes Mellitus	☐
High Blood Pressure	☐	Alcoholism	☐
Liver Problems	☐	Lung Problems	☐
Bleeding Disorder	☐	Gallstones	☐
Mental Illness	☐	Malignant hyperthermia	☐
Are you adopted?	☐	Cancer	☐

Please describe the person(s) and the type(s) of cancer present in your family:

Drug Allergies: ***Please list all DRUG allergies***

	Name of Medication	*Reaction it Causes*
1.		
2.		
3.		
4.		
5.		
6.		

Skin Allergies: ***please circle all SKIN allergies***

	Circle all that apply	*Reaction it Causes*
1.	Latex	
2.	Iodine	
3.	Band-Aid Bandages or Adhesive	
4.	Other:	

Medications, Vitamins, & Minerals: ***Please check / list all medications that you currently use***

	Name	*Dosage*	*Frequency*	*Indication*
☐	Lisinopril			Hypertension
☐	Levothyroxine / Synthroid			Hypothyroidism
☐	Simvastatin / Zocor			High Cholesterol
☐	Amlodipine / Norvasc			Hypertension / Angina
☐	Metformin / Glucophage			Diabetes
☐	Hydrochlorothiazide			Hypertension

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

*Frequency:
QD: 1x daily BID: 2x daily TID: 3x daily QID: 4x daily QOD: 1x daily, every other day

Please list all *weight loss* medication you have taken:

_____

_____

Pharmacy Information:

Name: _____

Address: _____

Phone Number: _____

Review of Systems: *Check all the health problems you have had or are currently experiencing*

****Please note that if you are not familiar with a listed condition, then it may not pertain to you.*

Cardiovascular

- Heart Attack ☐
- Angina (chest pain with activity) ☐
- Rhythm disturbance/ palpitations ☐
- Congestive Heart Failure ☐
- High Blood Pressure ☐
- Ankle Swelling ☐
- Varicose Veins ☐
- Cramping in legs when walking ☐
- Phlebitis ☐
- Ankle/ leg ulcers ☐
- Heart bypass/valve replacement ☐
- Pacemaker ☐
- Clogged Heart Arteries ☐
- Rheumatic fever/ valve damage ☐
- Heart Murmur ☐
- Irregular heartbeat ☐
- Other: _____ ☐

Respiratory

- Asthma ☐
- Emphysema ☐
- Bronchitis ☐
- Pneumonia ☐
- Chronic Cough ☐
- Short of Breath ☐
- Use of CPAP or oxygen supplement ☐
- Tuberculosis ☐
- Pulmonary Embolism ☐
- Hypoventilation Syndrome ☐
- Cough up blood ☐
- Snoring ☐
- Awaken at Night ☐
- Daytime Drowsiness ☐
- Sleep Apnea ☐
- Lung Surgery ☐
- Lung Cancer ☐
- Other: _____ ☐

Endocrine

- Hypothyroid (low) ☐
- Hyperthyroid (high/ overactive) ☐
- Goiter ☐
- Parathyroid ☐
- Elevated Cholesterol ☐
- Elevated Triglycerides ☐
- Low Blood Sugar ☐
- Diabetes (Managed by diet pills) ☐
- Diabetes (Needing insulin shots) ☐
- "Prediabetes" w/ elevated blood sugar ☐
- Gout ☐
- Endocrine gland tumor ☐
- Cancer of endocrine gland ☐
- High Calcium level ☐
- Abnormal facial hair ☐
- Other: _____ ☐

Gastrointestinal

Heartburn	☐	Hiatal Hernia	☐
Abdominal Hernia	☐	Ulcers	☐
Diarrhea	☐	Blood in Stool	☐
Change in bowel habit	☐	Constipation	☐
Irritable Bowel	☐	Colitis	☐
Crohn's	☐	Hemorrhoids	☐
Fissure	☐	Rectal Bleeding	☐
Black, tarry stool	☐	Polyps	☐
Abdominal pain	☐	Enlarged Liver	☐
Cirrhosis/ hepatitis	☐	Gallbladder problems	☐
Jaundice	☐	Pancreatic disease	☐
Unusual vomiting	☐	Surgery	☐
Cancer	☐	Other: _____	☐

Bladder/ Kidney

Kidney Stones	☐	Blood in Urine	☐
Loss of bladder control (leakage)	☐	Kidney Failure	☐
For men: PSA in last year?	☐	Prostate Problems	☐
Trouble starting urine	☐	Burning on Urine	☐
Surgery	☐	Cancer	☐

Gynecologic *(for women only)*

Problems conceiving (infertility)	☐	Currently pregnant	☐
Uterine/ Ovarian Cancer	☐	Surgery	☐
Menstrual irregularity	☐	Menstrual pain	☐
Excessively heavy periods	☐	Abdominal pain	☐

Age started menses: _____ Date of last menstrual period: _____

Number of pregnancies: _____ Date of last pap smear: _____

Number of children: _____ Date of menopause onset: _____

Number of miscarriages or abortions: _____

Musculoskeletal

Arthritis	☐	Neck Pain	☐
Shoulder Pain	☐	Wrist Pain	☐
Back Pain	☐	Hip Pain	☐
Knee Pain	☐	Ankle Pain	☐
Foot Pain	☐	Heel Pain	☐
Ball of foot/toe pain	☐	plantar fasciitis	☐
Carpal tunnel syndrome	☐	Lupus	☐
Scleroderma	☐	Sciatica	☐
Autoimmune disease	☐	Muscle pain/spasm	☐
Fibromyalgia	☐	Broken Bones	☐
Joint replacement	☐	Nerve injury	☐
Muscular dystrophy	☐	Surgery	☐
Cancer	☐	Other: _____	☐

Head And Neck

Wear Contacts/ Glasses	☐	Vision Problems	☐
Hearing Problems	☐	Sinus Drainage	☐
Neck Lumps	☐	Swallowing Difficulty	☐
Dentures/ Partial	☐	Oral Sores	☐
Hoarseness	☐	Head/ Neck Surgery	☐
Cancer	☐	Other: _____	☐

Neurologic

Migraine Headaches	☐	Balance Disturbance	☐
Seizures or Convulsions	☐	Weakness	☐
Stroke	☐	Alzheimer's	☐
Pseudotumor cerebri	☐	Multiple Sclerosis	☐
Frequent severe headaches	☐	Knocked Unconscious	☐
Surgery	☐	Cancer	☐

Breast

Lumps	☐	Pain	☐
Fibrocystic disease	☐	Nipple discharge	☐
Surgery	☐	Cancer	☐

Skin

Rashes under skin folds	☐	Keloids (excessively raised scars)	☐
Poor wound healing	☐	Frequent skin infections	☐
Surgery	☐	Cancer	☐

Blood

Anemia (iron deficient)	☐	Anemia (vitamin B12 deficient)	☐
Exposed to HIV	☐	Diagnosed with HIV / AIDS	☐
Low platelets (thrombocytopenia)	☐	Received blood transfusion	☐
Hepatitis	☐	Abused intravenous drugs	☐
Lymphoma	☐	Swollen lymph nodes	☐
Superficial blood clot in leg	☐	Deep blood clot in leg	☐
Blood clot in lungs	☐	Bleeding disorder	☐
Would you accept a blood transfusion? Yes No		Blood thinning medicine use	☐

Psychiatric

Anxiety	☐	Depression	☐
Anorexia	☐	Bulimia	☐
Bipolar disorder	☐	Alcoholism	☐
Drug dependency	☐	Schizophrenia	☐
Other psychiatric problems	☐		

Hospitalization for psychiatric problems ☐

Have you ever been in a psychiatric hospital? ☐

Have you ever attempted suicide? ☐

Have you ever been physically abused? ☐

Have you ever seen a psychiatrist or counselor? ☐

Are you currently seeing a psychiatrist or counselor? ☐

Have you ever taken medications for psychiatric problems or for depression? ☐

Have you ever been in a chemical dependency program? ☐

Constitutional

Fevers	☐	Night Sweats	☐
Anemia	☐	Weight Loss	☐
Chronic Fatigue	☐	Hair Loss	☐

Thank you for filling out the questionnaire honestly and completely.

Heartburn/Reflux/Gerd Symptoms

Check all that apply:

- ☐ Chest Pain/Discomfort
- ☐ Long term Cough, Sore Throat
- ☐ Difficulty Swallowing
- ☐ Bad Breath/Dental Erosion
- ☐ Stomach Fullness or Bloating/Gas
- ☐ Upper Abdominal Discomfort
- ☐ Asthma/Shortness of Breath
- ☐ Sudden Saliva
- ☐ Burping
- ☐ Burning Back of Throat
- ☐ Feeling of Lump in Throat
- ☐ Regurgitation
- ☐ Nausea After Eating

OTHER SYMPTOMS?

Check the foods or beverages that worsen your Heartburn/Reflex/Gerd Symptoms:

- ☐ Spicy Foods
- ☐ Citrus Fruits
- ☐ Milk
- ☐ High-Fat Foods
- ☐ Chocolate
- ☐ Caffeine
- ☐ Salty Foods
- ☐ Sodas and Carbonated Beverages
- ☐ Alcohol

Have you made any diet modifications?

- ☐ Yes, I have reduced or completely eliminated above listed food from diet.
- ☐ No.

Has your diet modification been effective?

- ☐ Yes.
- ☐ Somewhat, but still requires medication.
- ☐ Not at all.

Other methods attempted to improve Heartburn/Reflux/Gerd Symptoms:

- ☐ Changing Position in Bed
- ☐ Avoid Tight Clothing
- ☐ Sleeps in a Reclined Position
- ☐ Weight Loss
- ☐ New Bed/or Adjustable Mattres

OTHER METHODS?

How often do you use the following medications:

	1-4 Times a Week	Daily	A Few Times a Day
Alkas-Seltzer	☐	☐	☐
Pepcid	☐	☐	☐
Zantac	☐	☐	☐
Tagamet	☐	☐	☐
Maalox	☐	☐	☐
Mylanta	☐	☐	☐
Pepto-Bismol	☐	☐	☐
Rolaids	☐	☐	☐
Tums	☐	☐	☐

How long have you been on the following medications:

	0-6 Months	6 Months to 1 Year	Over 1 Year
Dexilant	☐	☐	☐
Nexium	☐	☐	☐
Prevacid	☐	☐	☐
Prilosec, Zegerid	☐	☐	☐
Protonix	☐	☐	☐
Aciphex	☐	☐	☐
Reglan	☐	☐	☐

TEXAS LAPAROSCOPIC CONSULTANTS, LLP
MEDICAL SERVICES FINANCIAL AGREEMENT

Texas Laparoscopic Consultants

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. If you do not wish to have your insurance carrier billed for services rendered you will be responsible for the total charges for treatment. By initialing you accept complete financial responsibility for services rendered at the time of service unless other arrangements have been established. This will remain in effect unless you complete a new agreement.

If you do wish to have your insurance carrier billed for services rendered we are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.
We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

I authorize payment of medical benefits to the undersigned physician for services rendered. I also authorize the release of any medical or other information necessary to process claims for services provided to me. I also request payment of government benefits to the party who accepts assignment.

Payment for Services

Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, and Discover. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

Physician Disclosure of Financial Interest

Ownership interests in the following entities reflect our commitment to providing the highest standard of patient care in the office, laboratory and surgery settings and enhances our ability to direct the manner in which your care is delivered (Victory Medical Center Houston, Gala Histology Laboratory, United Pathology Associates). The entities listed above are not contracted with insurance companies and will be considered "out of network" when claims are processed. If you obtain services from these entities, and the service is covered under your benefit plan, the costs of the service will be covered under the "out of network" portion of your benefit plan. If your benefit plan does not have out of network benefits, it is possible that you may not have coverage for the service and will be required to pay the costs yourself. Further, your physician may receive a benefit from the referral. If you have any concerns regarding your referral to any of the above-indicated entities, please do not hesitate to contact our office to request additional information, including an alternative referral. Please be aware of your right to request a referral to an alternative facility.

For Private Pay Patients

We, the staff at Texas Laparoscopic Consultants, are accepting you as a private pay patient and will not retro file a claim to your private insurance or Medicaid for services rendered. You will be responsible for paying for any service you receive. **X_____ (Please initial)**

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.
Sincerely, Terry Scarborough, M.D. and Sherman Yu, M.D.

My signature below constitutes acknowledgement and acceptance of these policies.

_____	_____	_____	_____
Patient or Guarantor Signature:	**Date**	**Patients Name (Please Print)**	**Date**

Consent to Treatment

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other relationship _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing. I understand that medical students, under supervision, may be involved in my care.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

Assignment of Benefits

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other relationship _____

I acknowledge full responsibility for the payment of services received and agree to pay them in full at the time of service unless other arrangements have been made. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Texas Laparoscopic Consultants will assist I billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable amount of time.

I authorize Texas Laparoscopic Consultants to bill my insurance or third-party payer and receive payment directly from them for services rendered. I also authorize Texas Laparoscopic Consultants to release information as required to my insurance or third party payer (including my employer's worker's compensation carrier) for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

My signature signifies acceptance of all terms in this Assignment of Benefits.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

Authorization for Designated Representative

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other relationship _____

I hereby authorize Texas Laparoscopic Consultants to act as my Designated Representative in all matters concerning submission and appeals of insurance claims and decisions on my behalf. I understand this information is privileged and will only be released as specified in this authorization, or as required or permitted by law.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

HIPAA Consent Form

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other relationship _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. The back of this form outlines some of those policies and requests your consent regarding how we may convey information to you and others so as to serve you better. The practice's complete Notice of Privacy Practices (NPP), which we have either given to you before or with this form, is posted in the office and available upon request. You should review the NPP prior to signing this consent.

My signature signifies acceptance of all terms in the HIPAA Information and Consent Form.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information and potentially anonymous usage in this publication. You have the right to revoke this consent in writhing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Texas Laparoscopic Consultants

Non-Covered Services Waiver

Date:_____

Patients Name:_____ **ID#**_____

Service Description

Date of Service: _____

Procedure: Bariatric Products (vitamins, supplements, etc)

Procedure: Psychological Consultation

Procedure: Nutrition Classes/consults

Procedure: _____

Procedure: _____

Procedure: _____

Approximate cost: _____

Provider name: _____

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the _____ Insurance Program and therefore all cost associated with these services are not an allowable expense under my insurance.

By signing the NON-COVERED WAIVER, I am hereby agreeing in advance in writing, to accept the full financial responsibility for all cost associated with the non-covered medical services, described in the document under "SERVICE DESCRIPTION" and performed by the named provider.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Texas
Laparoscopic
Consultants

Terry Scarborough, M.D
Sherman Yu, M.D
Sheilendra Mehta, M.D
1200 Binz Street, Suite 950
Houston, TX 77004
Ph: 713-493-7700
Fx: 281-971-4065

Surgery Cancellation/Reschedule Policy

Texas Laparoscopic Consultants is privileged to provide treatment for our patients. Our staff accommodates the needs of patients to schedule surgery in a timely manner. This requires careful planning and coordination among our office, the surgical facilities, and other medical specialists who may be involved in your care such as the anesthesiologist and surgical technicians. The cancellation/rescheduling of a scheduled surgery/endoscopic procedure results in failure to serve other patients as well as disruption in schedules for other healthcare professionals and the operating room.

Therefore, we respectfully request your cooperation and understanding of the surgery/procedure scheduling process and our cancellation policy.

Cancellations or rescheduling of any general or bariatric surgical procedures made within **10 business days** of the scheduled date, will be assessed a **$200 administrative fee**. Cancellations or rescheduling of any EGD or colonoscopy procedure made within **5 business days** of the scheduled date, will be assessed a **$100 administrative fee**. This fee is not billable to insurance or reimbursable, and must be paid before we can schedule any further appointments or procedures.

This fee also applies if you reschedule your procedure more than once (regardless of the 5 or 10 day notice).

_____(*Initial*) If you are requesting a refund of your surgery deposit and are within the 5 or 10 day period, you will receive your refund less the cancellation fee.

By signing below, you are acknowledging that you have read and understand our cancellation policy.

Name: _____ DOB: _____

Signature: _____ Date: _____