Whole Health Weight Loss Institute

Scott Perryman, MD, FACS, FASMBS

Patient Information

Patient FIRST Name: ______________________________

Middle Initial: ______________________________

Patient LAST Name: ______________________________

Date of Birth: ______________________________

Address (Street, Zip): ______________________________

Sex: ______________________________

Phone — Cell: ______________________________

Ethnicity: ______________________________

Phone — Home: ______________________________

Race: ______________________________

Email Address: ______________________________

SSN: ______________________________

Pharmacy Name: ______________________________

Pharmacy Phone: ______________________________

Referring Physician: ______________________________

How did you hear about us? ______________________________

Emergency Contact Information

Name: ______________________________

Relationship: ______________________________

Phone Number: ______________________________

Insurance Information

Please provide your insurance card to the receptionist. If the person responsible for the bill is NOT the same as the person listed above, please complete the fields below.

Full Name: ______________________________

Date of Birth: ______________________________

Insurance Company: ______________________________

SSN: ______________________________

Subscriber ID #: ______________________________

Group #: ______________________________

Relationship to Patient: ______________________________

Signature and Authorization

I verify that the above information is true to the best of my knowledge. I understand that payment, proof of insurance, and/or copay is due at the time of service. I authorize Medicare or my insurance company to release

any information required to process my claims and to pay for the covered services rendered. I understand that I am financially responsible for any balance due.

Signature: ______________________________ Date: ______________________________

Authorization to Release Medical Information

Name of Patient: ______________________________ Date of Birth: ______________________________

Address: ______________________________

Phone Number: ______________________________ Last 4 Digits of SSN: XXX – XX – ______________________________

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information: ______________________________

Address: ______________________________

Phone Number: ______________________________ Fax Number: ______________________________

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Whole Health Weight Loss Institute · Phone: (707) 721-3500 · Fax: (707) 721-3499

The following health information that relates to service beginning from ________ to ________ may be released:

☐ Complete Records ☐ History & Physical ☐ Progress Notes ☐ Care Plan
☐ Pathology Reports ☐ Lab Reports ☐ Radiology Reports ☐ Hospital Reports
☐ Medication List ☐ Treatment Record ☐ Operation Reports ☐ Other: ______________

• The above person/organization receiving my medical information, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of providing care or receiving payment for said care.

• This authorization is valid for ONE YEAR following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

• By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

• I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature: ______________________________ Date: ______________________________

Patient's Name (printed): ______________________________

Practice Policies

We welcome you to our practice and thank you for the opportunity to care for you. To avoid any misunderstanding, please acknowledge your acceptance and understanding of our policies by initialing after each statement below.

Advanced Beneficiary Notice

I understand that my insurance carrier may decide to deny certain services as "not a covered benefit of my policy." Prior to these services being provided I will be given the cost of these items, and I will decide whether I wish to have them or not. In the event that I choose to have these services/items, I agree to be responsible for payment to this practice. I understand that I can appeal my insurance company's decision to deny payment.

__________ (initial)

Waiver of Benefits

I hereby authorize Whole Health Weight Loss Institute (Dr. Perryman) to release information acquired during the course of my examination and treatment to the Centers for Medicare and Medicaid Services (CMS) and its agents or any other third party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of benefits directly to Whole Health Weight Loss Institute.

__________ (initial)

Co-payment

Co-payment is due at the time of service. Due to increased administrative costs, I hereby agree to a charge of $25.00 for a processing fee if I do not pay my copayment at the time of service, or if I have not provided correct insurance information, or if my check does not clear the bank for any reason.

__________ (initial)

Whole Health Guide Replacement Policy

At your initial appointment you will be given our Whole Health Guide as a resource for your procedure. If lost, I agree to pay $25.00 for a replacement.

__________ (initial)

Missed Appointments

Time reserved for your doctor's appointment is important. We value you as a patient and reserve that time for your health needs and concerns. Not showing up for your appointment, or failing to notify the office at least 24 hours in advance if you need to cancel, means we are unable to use that time to see other patients. I understand and agree that I will be responsible for a missed appointment fee of $150 for an initial consultation, $75 for a follow-up, and $250 for a surgery/procedure, if I fail to show up or give cancellation notice of less than 24 hours prior to the scheduled time.

__________ (initial)

Name (printed): ______________________________ Date: ______________________________

Signature: ______________________________

Whole Health Weight Loss Institute

Scott Perryman, MD, FACS, FASMBS

Missed Appointments — Credit Card Authorization Form

This card-on-file authorization is used only in the event of a missed appointment or a cancellation made with less than 24 hours' notice.

Card Holder Name: ______________________________

Billing Address (where statement is mailed): ______________________________

____

Type of card: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number: ______________________________

Expiration Date: ______________________________ Security Code: ______________________________

(Security code is on the back of the card, except American Express, which is on the front.)

I hereby agree that the above credit card information will be utilized in the event that I fail to show for an appointment, or do not give the required 24-hour cancellation notice. The fee for a missed initial consultation is $150, the fee for a missed follow-up appointment is $75, and the fee for a missed surgery/procedure is $250.

Signed: ______________________________ Date: ______________________________

575 Lincoln Avenue, Suite 210 · Napa, CA 94558

Phone: (707) 721-3500 · Fax: (707) 721-3499 · whweightloss.com