

WHOLE HEALTH WEIGHT LOSS INSTITUTE

Crystine Lee, M.D. and Scott Perryman, M.D.

Patient Information	
Patient FIRST Name:	Middle Initial:
Patient LAST Name:	Date of Birth:
Address (Street, Zip):	Sex:
Phone Number(s): Cell: Home:	Ethnicity: Race:
Email Address:	SSN:
Pharmacy Name:	Phone Number:
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 bill is NOT the same as the person listed above, please fill out 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:

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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 to the following persons or organizations:

**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 (please specify):

- 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

Patient's Name

Date

Novato Clinic
165 Rowland Way Suite #200
Novato, CA 94945

Napa Clinic
1300 Main St. Suite #200
Napa, CA 94559

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Advanced Beneficiary Notice

We expect that there may be times when your insurance company will deem certain services to not be a covered benefit of your policy. If your insurance company denies these items, we ask that you acknowledge this and agree to be financially responsible:

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 WHWL (Drs. Lee and 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 the medical practice of Drs. Lee and Perryman.

_____ (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 make that time for your health needs and concerns. Not showing up for your appointment or failing

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to notify the office at least 24 hours in advance if you need to cancel, means that we are unable to utilize 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 for my appointment or give cancellation notice of less than 24 hours prior to the scheduled time.

_____ (initial)

(Printed)Name: _____ Date: _____

Signature: _____

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Missed Appointments

Credit Card Authorization Form

Card Holder Name _____

Address (where statement is mailed) _____

Type of card:

Visa () Mastercard () Discover () American Express ()

Credit Card Number: _____

Expiration Date: _____

Security Code: _____ (on the back, except Amex 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 policy. 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/or procedure is \$250.

Signed

Date