Steven Batash MD PC

Weightloss Consultation

Patient Information

☐ Orbera Intragastric Balloon ☐ Endoscopic Sleeve Gastroplasty

Date (fecha**):** _______________

Language Preference (preferencia de idioma**):** ☐ English ☐ Spanish ☐ Russian ☐ Other

First Name (Primer nombre**):** __________________**Last Name (**apellido**):** ____________________

Date of Birth(Fecha de nacimiento)**:** _____/_____/_____ **Social security**(seguro social):___________________

Gender: ☐ F ☐ M **Marital Status** (Estado civil): ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address(dirección): ______________________________ **Apt#:** _Divo_

City(Ciudad)**:** _____________________**State (**Estatdo**):** _________ **Zip Code (**codigo postal**):** _____________

Phone (número de teléfono) **(Home):** _______________ **Cell:** _______________**Work:** __________________

Email (correo electrónico):______________________________**Occupation (**empleo**):** __________________

How did you hear about us? (¿Como supiste de nosotros?): _______________________

Emergency Contact (contacto de emergencia):

Name (nombre): _________________**Relation**(relación): ______________**Number**(Número):________________

Insurance Information

(Información del seguro)

☐ **Check box, if you do not have insurance. You can skip to the next page.**
(Marque la casilla si no tiene seguro. Puede pasar a la siguiente página.)

Primary Insurance (Seguro primario):______________________________**ID:** _______________________

Name of Subscriber (Nombre del Suscriptor) : _________________________ **SSN#:** _____-_____-_______

Subscribers Date of Birth (Fecha de nacimiento del suscriptor): ____/_____/______

Patients relationship to Subscriber (Relación con el suscriptor): _____________________________________

Steven Batash MD PC

Pharmacy Information

This information is needed for medications we may prescribe to you for this procedure
(Esta información es necesaria para los medicamentos que le prescribiremos para este procedimiento)
Pharmacy Name (Nombre de la farmacia)**:** ___________________________
Phone Number (número de teléfono)**:** _______________________

Primary Care Physician(Doctor Primario)**:**________________________________
Address(dirección): ____
City(Ciudad)**:** _________________ **State (**Estado)**:** _______**Zip Code (**codigo postal**):** ____________
Office Phone (número de oficina)**:** _______________________

Medical History: (List all current and past medical history)
Historial médico**:** (Anote todo el historial médico actual y pasado)

____
____
____

Current Medications:
Estas tomando alguna medicación: (Por favor, indique el nombre y la razón de su uso a continuación):

____
____
____

Are you allergic to any medications: ☐ **Yes** ☐ **No If yes, please list name below:**
¿Es alérgico a algún medicamento? (Si la respuesta es sí, por favor escriba el nombre abajo):

____
____
____

Written Financial Policy

Thank you for choosing Steven Batash MD. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Steven Batash MD requires payment prior to your procedure. If you choose to cancel your procedure we will issue a full refund. Steven Batash MD and the facility do not provide refunds once the procedure is done.

Steven Batash MD charges $30 for returned checks. If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

____

Patient Signature Date

____

Patient Name (Please Print) Date

[1]Subject to credit approval

Steven Batash MD PC

Name: ______________________________ **Date of Birth:**_____/_____/______

SS# / ID: ____________________________ **Phone #:** ______________________

AUTHORIZATION TO RELEASE AND OBTAIN

HEALTH INFORMATION PURSUANT TO HIPPA LAW 1996

I, or my authorized representative, authorize ____ to release my protected health information as set forth on this form and in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability act of 1996.

I have the right to limit which types of records can be obtained

- All medical records
- Parts of my medical records as described below: ____

____

I have the right to limit which types of records can be released as described below

- Authorization to release is limited to: _________________________

I have the right to request that part of my protected health information not be disclosed to family members or friends who may be involved in my medical care as described below

- I request my information not be disclosed to:___________________

I have the right to limit this authorization

- Specifically limit this authorization only to the person/provider Faculty or institution indicated: _________________________

I, or my authorized representative, authorize Dr. Steven Batash MD to obtain health information regarding my care and treatment from my primary care physician or any other healthcare provider or facility involved in my care for treatment, consultation or other purpose set forth on this form and in accordance with the Privacy Rule.

Purpose of authorization,

- Medical care/ treatment/consultation
- Other: ________________________

I have the right to limit this authorization to obtain protected health information to a certain provider/facility/ institution

- Authorization is limited to ______________________________ ______________________________
  Name of provider Telephone number

X____ Relation to patient: ____________________ Date____________
Signature of Patient (If minor, Parent/Guardian Signature)

HIPPA and PHI

I have received a copy of HIPPA Privacy Notice and policy, and understand that I can speak to HIPPA compliance officer if I have any further questions

X____ Relation to patient: ____________________ Date_____________
Signature of Patient (If minor, Parent/Guardian Signature)_

For Internal Use:

☐ Patient refused to sign ☐ Patient unable to sign for the following reason: ________________________________

Office Policies

1. **We provide services without regard to sex, race, religion, national origin or disability.** (Ofrecemos servicios sin consideración de sexo, raza, religión, origen nacional o discapacidad.)
2. **We don't honor DO NOT Resuscitate Directives and/or Living Wills (Resuscitation is a medical procedure which seeks to restore cardiac and/or respiratory function to individuals who have sustained a cardiac and/or respiratory arrest. "Do Not Resuscitate" ("DNR") is a medical order to provide no resuscitation to individuals for whom resuscitation is not warranted.)** En medicina, un "no resucitar" o "DNR", a veces llamado un "No Code", es una orden legal escrita, ya sea en el hospital o en una forma legal de respetar los deseos de un paciente a no tener CPR o cardíaca avanzada soporte de vida (ACLS) si su corazón se detuviera o si usted deja de respirar. (RESUCITAR es un procedimiento médico que busca restaurarla función cardiaca y/ o respiratoria a las personas que han sufrido una parada cardiaca y /o respiratoria y el DNR es para personas que no desean esos servicios. NOSOTROS NO HONRAMOS DNR (DO NOT RESUSCITATE POLICY)
3. **We provide you with a copy of the Patient Bill of Rights and responsibilities.** (Le proporcionamos una copia de la Carta de Derechos y Responsabilidades del Paciente)
4. **We encourage you to actively participate in your care.** (Le animamos a participar activamente en su cuidado).
5. **The following information is readily available to you: information regarding the ownership of the practice, the expertise of the associated physicians, the patient grievance process and safety inspection control practices.** (La siguiente información está disponible para usted: información sobre la propiedad de la práctica, la experiencia de los médicos asociados, el proceso de quejas del paciente y las prácticas de control de inspección de seguridad.)

I have reviewed and understand Office Policies: (He revisado y entiendo las Politicas de la officina):

Print Name X____ Date:_________
Signature(If minor, Parent/Guardian Signature) X_______________________________________ Date:_________
Relation to patient: ___________________________