Baylor St. Luke's Medical Group

Brandon Fadner, MD
Minimally Invasive & Bariatric Surgery
1327 Lake Pointe Parkway, Suite 430 Sugar Land, Texas 77478

Registration Form

Date: _______________ PCP's Name: ___________________________________ PCP's Ph#: ____________________________

Patient Name: (Last)_____________________________(First)___________________________(Middle)____________________

DOB: _____________ Marital Status: ___Single ___Married ___Divorced ___Separated ___Widower Social Security: ______-______-_______

Race: ____________________ Ethnicity: ______________________ Religion Preferences: _______________________________

Email: ____ Language: ___________________ Interpreter Needed? __Y or __ N

Street Address: _____________________________________ Apt. #: ______ City: ____________ State: ______ Zip: ________

Cell Ph#: ________________________ Work Ph#: _______________________ Home Ph#: ______________________________

May we leave a detailed voice message? ___Y ___N Check all that apply: ___Cell ___Work ___Home

Employment Status: ___Full Time ___Part Time ___Unemployed ___Student ___Other

Employer Name: ____

Pharmacy Name: ____ Pharmacy Ph#: __________________________________

How did you hear about us? ____

Insurance Information (please give your insurance card and ID to the receptionist)

Primary Insurance		Secondary Insurance	
Name of Insurance:		Name of Insurance:	
Subscriber Name:		Subscriber Name:	
Relationship to subscriber:		Relationship to subscriber:	
Subscriber SS#:	DOB:	Subscriber SS#:	DOB:
Policy #:	Group #:	Policy #:	Group #:

In Case of Emergency

Name of local friend or relative (not living with you): __________________Rltp: ________________ Phone #: _______________

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance co to release and information required necessary to process my claim. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Signature ____

Authorizations and Assignments

Baylor St. Luke's Medical Group

Brandon Fadner, MD

Minimally Invasive & Bariatric Surgery **1327 Lake Pointe Parkway, Suite 430 Sugar Land, Texas 77478**

Thank you for choosing Baylor St. Luke's Medical Group Sugar Land. We realize you have a choice in selecting healthcare providers and we are honored you have chosen us. Our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact our office anytime Monday-Friday during our routine business hours if you have any questions, concerns or suggestions.

Office Policies

Dr. Brandon Fadner participates with many medical health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check-In

Please be prepared to submit the following documents when check in for each visit. These documents will be scanned and saved as part of your patient record.

- ☐ Current Insurance Card
- ☐ Current Photo Identification
- ☐ Update contact information, such as home address, phone numbers, contact information, email address, employer, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services rendered.

____________**Payment of Patient Responsibility**

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include know n deductibles, co pays, coinsurance and any past due amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For you convenience we accept: cash, checks, most major credit cards and debit cards.

Non-Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary," "experimental," "cosmetic," or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know your benefits and limitations or you current health care coverage. This clinic will provide medically necessary care based on patients' medical needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plans specific benefits and coverage limitations.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. The fee applies to payments made at our front desk, mailed in the Business office, electronically via the Internet, or payments made by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

Third Party Insurances

We do not file insurance claims to non-contracted Third Parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the time of service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

____________ **Appointment Scheduling**

Please be advised, as a courtesy, you will receive a call from our office to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office will result in a $25.00 fee assessed to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice, could result in your dismissal as a patient from the practice. As a courtesy to our scheduled appointments and doctor's schedule, if you are over 15 minutes late to your scheduled appointment we will need to reschedule and there will be a $25.00 fee assessed to your account.

____________ **Forms/Medical Records**

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We are happy to assist you by completing forms and generating medical letters for you upon your request. The fee for this is $25.00 and varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents or before they can be released.

____________ **Medical Records**

Requests for your medical records must be in writing via a medical records release form. Release of records is managed via on outside vendor. The cost is $25.00 for the 1st-20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is typically available by telephone Monday-Thursday 9:00 am-5:00pm and Friday 9:00am to 3:30pm. Because Dr. Fadner and clinical staff are most often tending to patients, it is typically necessary for you to leave a message so we may assist you in an adequate time and manner. Please leave pertinent information to include the reason for your call and the best number to contact you. We have an answering service to take you calls before and after our scheduled office hours.

- ☐ Emergency needs-always911
- ☐ Routine prescription refills-please contact your pharmacy first to initiate the refill request and the pharmacy will send authorization to the office for approval. Routine refills will be approved during regular office hours only. Requests for controlled substances or narcotics must be requested through the clinic clinical staff.

Authorization to Release Information

I hereby authorize Baylor St. Luke's Medical Group-Dr. Brandon Fadner to (1) Release any information necessary to insurance carriers regarding any illness and treatments; (2) Process insurance claims generated in the course of an examination or treatment: and (3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carriers including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Baylor St. Luke's Medical Group-Dr. Brandon Fadner for medical services rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I acknowledge I have requested medical services from Baylor St. Luke's Medical Group-Dr. Brandon Fadner, on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I agree to pay Baylor St. Luke's Medical Group-Dr. Brandon Fadner for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered, will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as a HMO or a PPO, I promise to pay for any services or products administered that are not covered under the plan, were not certified by the plan as medical necessary, or were denied by the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges. I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Authorization and Assignment Acknowledgement

My Signature certifies I have read and understand the above content of this document

____ _______________________

Print Patient Name **Patient Date of Birth**

____ _______________________

Signature **Date**

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

____ _____________________

Print Patient Name **Patient Date of Birth**

____ _____________________

Signature **Date**

Designation of Personal Representatives

Under the provisions of the Health Insurance Portability and Accountability Act (HIPPA) that became effective on April 14, 2003, health care providers and their staffs are limited in the information that they may share with individuals other than the patient or his/her parent or guardian. In many cases, patients would like to involve a member of their family or another person in the management of their health care. Such disclosures of information are permitted by HIPPA when the patient (or his/her parent or guardian) designates an individual(s) and his/her Personal Representative. Therefore, if you would like to designate one or more individuals to serve as your personal representative, please complete the information below.

Name of Patient: ____ Date: _____________________

I, the patient/parent/guardian hereby designate the individual(s) or the Personal Representative of the named above. By designating this individual(s) as my Personal Representative, I am pertaining to my health care (including appointments, diagnoses, treatment plans, insurance information and other related topics) This designation will remain in effect until such time as I revoke in writing.

Name of Personal Representative	Relationship	Phone #	Address

____ _____________________

Signature of Patient/Parent/Guardian Date

____

Relationship to Patient