



SOUTHERN CALIFORNIA ADVANCED LAPARO-ENDOSCOPIC SURGERY
S · C · A · L · E · S

Patient Registration Date ___/___/___

Last Name: _____ First: _____ MI: _____ Maiden: _____

Date of Birth: ___/___/___ Age: _____ Gender: Female Male

Social Security Number: _____ - _____ - _____ Drivers License No.: _____ State: _____

Marital Status: Single Married Divorced Widowed Partner Name of Spouse/Partner: _____

Home Address: _____	
City: _____	State: _____ Zip: _____ - _____
Billing Address: _____	
City: _____	State: _____ Zip: _____ - _____
Home Phone: () _____	Work Phone: () _____
Cell Phone: () _____	Pager: () _____
Fax: () _____	Email: _____@_____

Primary Care Physician: _____	Address: _____
Phone: () _____ - _____	Fax () _____ - _____
Referring Physician: _____	Address: _____
Phone: () _____ - _____	Fax () _____ - _____

Employer: _____	Job Title/Description: _____
Address: _____	Telephone: () _____ Ext: _____
Emergency Contact Person: _____	Relationship: _____ Phone: () _____
Address: _____	

Pharmacy of Choice: _____	Phone () _____
City & Cross Streets: _____	
I Am Allergic to the Following Medications: _____	

PRIMARY INSURANCE INFORMATION

Subscribers Name: _____	Relation to Patient: _____
Insurance Company Name: _____	
Group Number: _____	Deductible Amount: _____
ID#: _____	
Address to Send Claims: _____	
City: _____	State: _____ Zip: _____ - _____
Phone: () _____	Fax: () _____

SECONDARY INSURANCE INFORMATION

Subscribers Name: _____	Relation to Patient: _____
Insurance Company Name: _____	
Group Number: _____	Deductible Amount: _____
ID#: _____	
Address to Send Claims: _____	
City: _____	State: _____ Zip: _____ - _____
Phone: () _____	Fax: () _____

Patient Responsibilities

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes knowing which facilities can be used for radiology, laboratory, hospitalization or surgery.

The patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician **BEFORE** you schedule an appointment with our office. You will be held financially responsible if a referral/authorization is not obtained prior to your visit.

After your consultation appointment with SCALES, please contact our insurance/referral coordinator to determine if prior authorization is required for future visits, tests and the proposed surgical procedure. It can take weeks for your insurance company to process an authorization request. Please do not schedule any appointments prior to insurance approval. It is important that ample time be allowed for the authorization process. If the patient opts to begin care before this process has been completed, the patient will be held financially responsible for 100% of the charges at the beginning of your treatment.

After surgery, the authorization we obtain typically includes routine care within the "90-day global period". However, this should be confirmed by you. The insurance/referral coordinator can be reached at our phone (805) 230-0030, between the hours of 9:00 and 5:00.

All patients receiving bariatric treatment must meet with our financial consultant to review the cost of treatment and payment options. Please be advised that, due to the rising costs of business, our financial policies may change. Until you meet with the financial consultant, your individual surgical fee has not been established.

We will help you to the best of our ability, although ultimately, it is your responsibility to understand what provisions, restrictions and requirements are included and/or excluded in your specific insurance policy.

FINANCIAL RESPONSIBILITY

By signing and submitting this document, you are indicating that you agree to be financially responsible for any service rendered if payment is denied due to you direction to withhold this information from my insurance carrier.

You are also indicating that you understand that 1) SCALES is under no obligation to facilitate insurance payment, and that any insurance billing is done as a courtesy for you; 2) you understand SCALES makes no representation as to any insurance compensation you might receive; 3) it remains your sole responsibility to review your insurance policy and pursue any insurance monies you are entitled to; 4) you authorize your insurance carrier, or its intermediaries, to make payment directly to Southern California Advanced Laparo-Endoscopic Surgery any medical/surgical benefits otherwise payable to you for services rendered; 5) you accept responsibility for payment of all fees at published rates, unless you have other arrangements, which are enforceable only if they are in writing; 6) you understand that you are financially responsible for all charges whether or not paid by your insurance carrier.

AWARENESS OF CHARGES

There may be additional charges that you may not be aware of, or are not considering. These charges may be covered in all or part by your insurance company, or not covered at all. Charges for surgical care of obesity include, but are not limited to:

CLINIC FEES

- Surgeon's Consultation
- Surgeon's Preoperative Assessment(s)
- Bariatric Consultation
- Psychological Consultation
- Other Consults as needed

SURGEON FEE

- SURGICAL PROCEDURE
 - Weight Loss Surgery
 - Routine* Postoperative Care (typically for 90 days after surgery)

ASSISTANT SURGEON FEE

ANESTHESIOLOGIST FEE

HOSPITAL CHARGES

- Operating Room Charges
- Medicines and Anesthetics
- Supplies, Dressings, etc.
- Room Charges
- Procedure Charges

UNPLANNED CHARGES

- Additional Procedures if Indicated During or After Surgery
- Treatment of Complications
- Critical Care
- Extended Hospitalization
- Additional Consultations and Treatments
- Additional Medications

ADDITIONAL PROCEDURES

Additional surgical procedures may be indicated, suggested, or necessary during the course of your treatment, and may arise at any stage of your care:

- In the course of your preoperative evaluation
- During the surgical procedure
- Because of postoperative complications possibly due to complications and/or side-effects

These procedures may be electively performed, may need to be performed in order to complete the surgery, or may need to be performed emergently for your safety and well-being.

CO-PAYMENT REQUIRED AT TIME OF SERVICE

Your insurance company determines the amount of your co-payment and or deductible. This fee is required before service can be provided.

RETURNED CHECKS

A fee of \$25 will be charged for each check returned by your bank, payable by cashiers check, money order or cash.

PATIENT AGREEMENTS

CONSENT FOR TREATMENT

I authorize Southern California Advanced Laparo-Endoscopic Surgery to perform such procedures and/or treatment, as the physicians deem necessary.

RELEASE OF MEDICAL RECORDS

I authorize Southern California Advanced Laparo-Endoscopic Surgery to release the following medical information in order to process and secure payment of charges from my insurance company or its intermediaries:

- Medical Condition
- Psychiatric/Psychological/Mental Health

Assignment of Benefits

I, _____
(Print Name)

hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other plan to Southern California Advanced Laparo-Endoscopic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I hereby authorize the physicians and agents of Southern California Advanced Laparo-Endoscopic Surgery to perform any medical treatment as deemed necessary.

By your signature below, you are acknowledging that you have read and understand these issues described on these pages.

Signature of Patient

____ / ____ / ____
Date