New Patient Intake Form

Patient's Full Name: _____ Age: _____ Sex: _____

Address: _____

Apt.#: _____ City _____ State: _____ Zip Code: _____

Best Phone #: _____ Email: _____

Social Security Number: _____ ____ _____

Date of Birth: _____ Marital Status: _____

Place of Employment: (N/A for not applicable) Phone: _____

Address: _____ Your Position: _____

Name of Spouse/Nearest Relative: _____ Relation: _____

Home Phone: _____ Other#: _____

Emergency Contact: _____ Phone: _____

Primary Doctor's Name: __ _____ Phone: _____

Onyeka Nwokocha, M.D., FACS, FASMBS
Certified by the American Board of Surgery
American Society for Metabolic and Bariatric Surgery
175 SW 7th St, STE 1511. Miami FL 33130
sosbariatrics@gmail.com
sosbariatrics.com
Phone 754.600.9504
Fax 760.267.9056

Referring Physician: _____ Phone: _____

What is the problem that you are coming to see the doctor for today? (*Please specify right or left side*):

_____
_

***If this visit is for weight loss, please answer the following below:

What is your current weight? _____ Height? _____
How much weight are you looking to lose? _____
List your medical problems, if any _____
List any surgeries you have had in the past _____
What diets or diet programs have your tried? _____
Reflux history, if any _____
Sleep history? How many hours? Do you have sleep apnea? Use CPAP? _____
What type of physical activities/exercise do you participate in? _____
List your medications, if any _____

I have reviewed the information on this form fully and completely. I certify that I am the patient or authorized guardian and that the facts above are true to the best of my knowledge. I understand that even though I may have insurance coverage, I am solely responsible for the payment of service.

Signature of Patient or responsible party: _____ Date: _____

Assignment and Release

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Sky on Sky Bariatrics & Surgery, PA Date: _____

Onyeka Nwokocha, MD, FACS, FASMBS

175 SW 7th st, STE 1511

Miami, FL 33130

Patient Name: _____

Employer: _____

Insurance provider(s) name: _____

Claim Group: _____

SS#/ID#: _____

I hereby instruct and direct _my insurance company_ to pay by check made out and mailed to:

Sky on Sky Bariatrics & Surgery, PA

Dr. Onyeka Nwokocha

175 SW 7th st, STE 1511

Miami, FL 33130

Or, if my current policy prohibits direct payment to a doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Sky on Sky Bariatrics & Surgery, PA

Dr. Onyeka Nwokocha

175 SW 7th st, STE 1511

Miami, FL 33130

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For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. THIS IS A

DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not

exceed my indebtedness to the abovementioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____
_____

- Policy Holder Signature Date

_____
_____

Claimant Signature, if other than Policy Holder Witness

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Out of Network Agreement (If applicable)

As discussed, your doctor is an out of network provider. A claim will be filed on your behalf by this office to your insurance company. Payment will be sent directly to you by the insurance company with an Explanation of Benefits (EOB). You agree to endorse the payment to us and supply us with a copy of the EOB. You may resolve a bill for any co-payment and deductible imposed by your insurance company.

_____

_____

Policy Holder Signature Date

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing service to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provide standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to ensure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment, or health care operations.

If you have any questions, comments, or objections to the privacy policies on this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our entire notice or privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____ Signature: _____

Date:_____

If minor, Signature of Parent of Guardian: _____

Date:_____

Thank you for allowing us to serve you.

****

For Office use only….

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