Heartland Surgical Care, LLC
Jesse J. Lopez, Jr., DO
7201 W 110th Street Suite 120, Overland Park KS 66210
P. 913-647-3999 F. 913-754-1046

Patient Information

File Charges to: ☐ Insurance ☐ Self-Pay ☐ Auto Accident

Referred by: ☐ Doctor ☐ Patient _____ ☐ Radio ☐ Other _____

Patient Full Legal Name: _____

Address: _____

_____
City *State* *Zip*

Date of Birth: _____ Age: _____ SS#: _____

Marital Status	Employment Status
☐Single	☐Full-Time
☐Married	☐Part-Time
☐Divorced	☐Retired
☐Separated	☐Unemployed
☐Widowed	

Medical Information

_____
Referring Physician Name

_____
Street Address

_____
City ***State*** ***Zip***

_____ _____
Telephone ***Fax***

_____
Primary Care Physician

_____
Street Address

_____
City ***State*** ***Zip***

_____ _____
Telephone ***Fax***

Insurance Information

_____
Primary Insurance

_____
Name of Insured

_____ _____
Policy Number ***Group Number***

_____ _____
Employer Name ***Relationship to Patient (Self, Spouse, Child, Other)***

_____ _____
Date of Birth (Policy Holder) ***SS # (Policy Holder)***

_____
Secondary Insurance

_____
Name of Insured

_____ _____
Policy Number ***Group Number***

_____ _____
Employer Name ***Relationship to Patient (Self, Spouse, Child, Other)***

_____ _____
Date of Birth (Policy Holder) ***SS # (Policy Holder)***

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Emergency Contact

_____ _____
Name *Relationship*

_____ _____ _____
Home Phone *Work Phone* *Cell Phone*

Do you have an Advanced Directive or Living Will ☐ Yes ☐ No

Employment Information

_____
Employer's Name

_____
Street Address

_____
City *State* *Zip*

_____
Telephone

Spouse Information

_____
Spouse's Name

_____ _____
Date of Birth *SS #*

_____ _____
Telephone *Cell*

Patient Confidentiality

I hereby authorize the release of medical Information to _____ _____
Name *Relationship*

I hereby authorize Jesse J. Lopez Jr., D.O. to leave information on my voicemail at ☐ Home ☐ Work ☐ Cell

Patient Signature _____ Date _____

Failure to notify Heartland Surgical Care LLC of Insurance Changes - Failure to inform us of insurance policy changes for primary and/or secondary insurance policies that you may have could result in you being responsible for unpaid balances. A 15% of allowable Service charge will be assessed upon any Days service where insurance changed occurred where you failed to notify us prior to billing the insurance company of record on your account. In instances where you fail to update us of those insurance changes within in the window for "Timely filling" with your insurance company will result in you being charged the cash pay price for that day's services on top of the 15% of allowable Service charge.

Patient Signature _____ Date _____

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Authorization Agreement

I authorize the release of Medical Records as needed to any physician, facility or other provider of services that Jesse J. Lopez Jr., D.O., asks to participate in my medical treatment.

Patient Signature _____ Date _____

Assignment of Benefits/Financial Agreement

I understand that I am primarily liable for payment of all medical services rendered and that Jesse J. Lopez. Jr., DO, is billing insurance as a courtesy. I agree to pay all sums not paid by insurance. If I fail to pay any balance due at the request of Jesse J. Lopez Jr., D.O., and my account is turned over to an attorney for collection, I agree to pay a reasonable attorney's fee of 15% of the balance due.

Patient Signature _____ Date _____

Medigap/Medicare Supplement Plan Authorization

I hereby authorize payment of my Medigap/Medicare Supplement benefits to Jesse J. Lopez, Jr., DO, for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

_____ _____
Beneficiary Signature ***Date***

_____ _____
Medicare ID # ***Medigap Insurer***

_____ _____ _____
Telephone ***Street Address*** ***City*** ***State*** ***Zip***

Patient Signature _____ Date _____

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Patient Medical History Form

Patient Name _____ DOB_____ Date_____

Review of Symptoms (Please check symptoms that you have *had* or may be *experiencing*)

General/Constitution
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight Gain/Loss _____lbs.
- ☐ Decreased Appetite

Eyes
- ☐ Pain
- ☐ Loss of Vision
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Flashing Spots/Lights
- ☐ Glasses

Ears, Nose & Throat
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Bleeding Gums
- ☐ Mouth Sores
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Constant Throat Clearing
- ☐ Difficulty Swallowing

Musculoskeletal
- ☐ Swelling
- ☐ Deformities
- ☐ Fractures
- ☐ Decreased Motion

Cardiovascular
- ☐ Chest Pain with activity
- ☐ Shortness of breath at rest
- ☐ Shortness of breath w/activity
- ☐ Chest Pain at rest
- ☐ Leg Swelling
- ☐ Irregular Heartbeat
- ☐ Heart Palpitations

Respiratory
- ☐ Chronic Cough
- ☐ Coughing Up Blood
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Asthma
- ☐ Night Sweats

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Heartburn
- ☐ Regurgitation
- ☐ Difficulty Swallowing
- ☐ Pain with Swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Yellow Jaundice
- ☐ Stomach Pain
- ☐ Blood in Stools
- ☐ Black Tarry Stools
- ☐ Hemorrhoids
- ☐ Need for laxative/enema use

Prior Bariatric
- ☐ Gastric Bypass
- ☐ BPD
- ☐ VBG
- ☐ Lap-Band
- ☐ Other _____

Genitourinary
- ☐ Difficult Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urgency
- ☐ Kidney Stones
- ☐ Discharge from Penis/Vagina
- ☐ Erection Difficulties
- ☐ Prostate Problems

Skin & Breast
- ☐ Hives
- ☐ Rashes
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Arm/Leg Weakness
- ☐ Memory Loss
- ☐ Sensitivity of Hands/Feet

Psychiatric
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Psych Counseling
- ☐ Panic Attacks

Endocrine
- ☐ Heat/Cold Intolerance
- ☐ Flushing
- ☐ Increased Thirst
- ☐ Increased Salt Intake
- ☐ Fingernail Changes

Hematologic
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Clotting Tendency

Immunologic
- ☐ Rhinitis
- ☐ Skin Sensitivity
- ☐ Latex Allergy

Please List Allergies

_____
_____
_____
_____
_____
_____
_____

Surgical History (Please list all Surgical Procedures you have had in the past)

1 _____ Year _____ Surgeon _____
2 _____ Year _____ Surgeon _____
3 _____ Year _____ Surgeon _____
4 _____ Year _____ Surgeon _____
5 _____ Year _____ Surgeon _____
6 _____ Year _____ Surgeon _____

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Medical History (Please check all medical conditions you *have* or *have had* in the past)

☐ Aids	☐ Chemical Dependency	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Rheumatic Fever
☐ Anemia	☐ Deep Vein Thrombosis (DVT)	☐ HIV Positive	☐ Reaction to Anesthesia
☐ Asthma	☐ Emphysema	☐ Kidney Disease	☐ Suicide Attempt
☐ Arthritis	☐ Epilepsy	☐ Liver Disease/Jaundice	☐ Stroke
☐ Bleeding Disorder	☐ Goiter	☐ Migraines/Headaches	☐ Thyroid Problems
☐ Breast Mass	☐ Gonorrhea	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Gout	☐ Pacemaker	☐ Stomach Ulcers
☐ Bulimia	☐ Heart Disease	☐ Pneumonia	☐ Vaginal Infections
☐ Clotting Disorder	☐ Hepatitis	☐ Prostate Problems	☐ Venereal Disease
☐ Cancer	☐ Herpes	☐ Psychiatric Care	☐ Latex Allergy

☐ Other _____

Family Medical History (Please check all medical conditions that your blood relatives *have* and indicate the relationship)

☐ Asthma _____	☐ Heart Attack_____	☐ Breast Disease_____
☐ Bleeding Disorder _____	☐ Hepatitis_____	☐ Arthritis_____
☐ Heart Disease_____	☐ Crohn's_____	☐ Emphysema_____
☐ Liver Disease_____	☐ Alcoholism_____	☐ Kidney Disease_____
☐ Colitis_____	☐ Cancer_____	☐ Stroke_____
☐ Diabetes_____	☐ High Blood Pressure_____	☐ Depression_____
☐ Clotting Disorder_____	☐ AIDS_____	☐

☐ Other _____

Social History (Please check all that apply)

Do you smoke	☐ Yes	☐ No	Have you quit?	☐ Yes	☐ No
Do you or did you drink excessive Alcohol	☐ Yes	☐ No	Have you quit?	☐ Yes	☐ No
Do you use or have you used recreational Drugs	☐ Yes	☐ No	Have you quit?	☐ Yes	☐ No

Current Medications (Please list all current medications with dosages or provide a list)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Drug Allergies/Reactions _____

I have completed these forms to the best of my ability. I understand that I will be required to meet with the Surgeon prior to Surgery. This information will be used to assist in the pre-determination of my Surgery through my insurance company should I choose to pursue this avenue or to self-pay. **Patient Signature** _____ **Date** _____

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Patient Weight History Form 1

Patient Name _____ DOB_____ Date_____

□ Male □ Female □Adult □ Minor Child (less than 18 years of age)

Doctor List (Please list all Doctors who have assisted you with weight loss or are involved in your medical care)

Doctor Name	Type (reason seen)	Office Phone #	Office Address
1.			
2.			
3.			
4.			
5.			

Sleep Apnea Screen (Please Respond to the questions below)

□ Yes	□ No	Do you snore?
□ Yes	□ No	Do you make choking sounds while you sleep?
□ Yes	□ No	Do you stop breathing while asleep?
□ Yes	□ No	Do you fall asleep at inappropriate times such as while driving?
□ Yes	□ No	Do you sleep better in one position v. another? What position? _____
□ Yes	□ No	Do you get better sleep in a recliner chair or reclined position?

Procedure being Considered (Check Box)

All Procedures are performed laparoscopically.

□ Adjustable Gastric Band

□ Sleeve Gastrectomy

□ Intra-Gastric Balloon

□ Revision of: _____

□ Other: _____

Patient Signature _____ Date _____

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Patient Weight History Form 2

Patient Name _____ DOB_____ Date_____

Important Reminders

Did you check if your insurance company covers weight loss surgery? □ YES □ NO Result: _____

Does your insurance Company consider us an: □ In-Network Provider □ Out-of-Network Provider □ Non-Participating □ Preferred

Do you have a copy of your insurance pre-certification criteria for weight loss Surgery? □ YES □ NO (Please provide our office with a copy)

Can you demonstrate a documented 6 (six) months of a supervised Diet & Exercise Program? □ YES □ NO (Please provide our office with a copy)

Have you attended our Weight Loss Surgery Seminar □ YES □ NO (Please provide our office with a copy)

Have you read the educational information provided on our website? □ YES □ NO (www.akasacare.com)

Dieting History Last 5 (five) years only (Must be filled out – list all diet and exercise attempts. Use Extra sheet if necessary)

Diet Program (Drugs/Exercise/Diet Programs)	Is Documentation Available?	Year	Duration	Start/End Weight (lbs.)	Weight Loss (lbs.)	Weight Gain (lbs.)
□ Weight Watchers	□ YES □ NO		**yrs. mos.**	/		
□ Atkins	□ YES □ NO		**yrs. mos.**	/		
□ South Beach Diet	□ YES □ NO		**yrs. mos.**	/		
□ Nutri-System	□ YES □ NO		**yrs. mos.**	/		
□ Meridia	□ YES □ NO		**yrs. mos.**	/		
□ Fen-Phen	□ YES □ NO		**yrs. mos.**	/		
□ Xenical	□ YES □ NO		**yrs. mos.**	/		
□ P**hentermine**	□ YES □ NO		**yrs. mos.**	/		
□ Over-the-Counter	□ YES □ NO		**yrs. mos.**	/		
□ Exercise	□ YES □ NO		**yrs. mos.**	/		
□ Physician Supervised Plan	□ YES □ NO		**yrs. mos.**	/		
□ Other:						

Obesity Co-Morbidities (The medical Conditions listed below are associated with obesity. Please check all that apply to you)

□ **High Blood Pressure**	□ **Heartburn**	□ **Gall Bladder Disease**	□ **Heart Disease**
□ **Sleep Apnea**	□ **Hip/Knee/Ankle/Joint Problems**	□ **Vein Clots/Problems**	□ **Alcoholism**
□ **Back Pain**	□ **Psychiatric Problems**	□ **Liver Disease**	□ **Infertility**
□ **Asthma**	□ **Urinary Incontinence**	□ **Thyroid Disease**	□ **Lupus**
□ **Drug Dependency**	□ **Reflux**	□ **High Triglycerides**	□ **Immune System Disorder**
□ **Diabetes**	□ **High Cholesterol**	□ **Cancer**	□ **Other**

How many times have you been admitted to the hospital in the past 5 (five) years? _____

How many times have you been admitted to the Emergency Room in the past 5 (five) years? _____

Patient Signature _____ Date _____

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Patient Weight History Form 3

Patient Name _____ DOB_____ Date_____

In order to obtain pre-certification for your weight-loss Surgery the Surgeon has to submit a "**Letter of Medical Necessity**". This letter is written by a Doctor to your Medical Insurance Carrier to request permission for a weight-loss Surgery Operation. Your personal answers below will help the Doctor write a strong letter on your behalf. (PLEASE PRINT CLEARLY AND LEGIBLY)

What are your expectations from Weight-Loss Surgery?

Does your excess weight place limitations on your daily activities such as walking, tying your shoes or maintaining personal hygiene?

What is your understanding of lifestyle changes from weight-loss surgery?

Patient Signature _____ Date _____

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Patient Weight History Form 4

Patient Name _____ DOB_____ Date_____

I understand that as a Bariatric Surgery Candidate that there are certain tests and procedures that I will be required to complete prior to Surgery. I understand that these procedures are required and additional testing may be required as well.

Psychology consultation: All patients are required to undergo a psychology consultation. All insurance companies, heartland surgical care, and menorah Medical Center require this. This may or may not be covered by your insurance. This consultation is to ensure that the bariatric procedure is being done for the appropriate reasons, that the patient has the appropriate emotional and mental faculty to undergo bariatric surgery, as well as having a good support network in place. **Initial _____**

Nutrition consultation: All patients are required to undergo a nutrition consultation. All insurance companies, heartland surgical care and Menorah Medical Center require this. This may or may not the covered by your insurance. This consultation will teach the patient the proper types of dieting and eating that will be necessary before and after bariatric surgery. **Initial _____**

Physical therapy consultation: All patients are required to undergo a physical therapy evaluation. Some insurance companies and heartland surgical care require this. This may or may not be covered by your insurance. This evaluation is important as it teaches the patient safe movement and exercise techniques prior to and after surgery. In addition, it shows to the insurance company the patient's determination to remain active and exercise after their bariatric surgery. **Initial _____**

Sleep study: All patients are required to undergo a sleep study evaluation prior to bariatric surgery. This may or may not be a requirement by your insurance company, but is a requirement of Heartland Surgical Care. This may or may not be covered by your insurance. This test allows us to assess for the possibility of obstructive sleep apnea that can cause oxygen desaturation, which can lead to severe and significant complications after bariatric surgery. **Initial _____**

Esophagogastroduodenoscopy (EGD): All patients are required to undergo an EGD. This test allows us to evaluate the stomach prior to surgical intervention to evaluate for the possibility of polyps, tumors, hiatal hernias, or ulcers prior to your bariatric surgery. This procedure is typically covered by your insurance company, but may require a preauthorization. We will do our best to assist in this matter, but regardless of whether or not prior authorization is obtained, the ultimate financial responsibility of this procedure still is upon the patient. **Initial _____**

Other consultations: Based on your medical history or present medical condition you may be required to undergo a cardiology and/or pulmonary consultation to ensure the safest surgery possible. These typically are covered by your insurance, but make sure you use an in network provider. **Initial _____**

In instances where I may owe a Deductible, Co-Pay or Co-insurance for an EGD, Sleep Study, the Surgery itself or any other procedure that may be required prior to surgery, that I will pay the amount due at or prior to the time of service.

Sincerely,

Dr. Jesse J. Lopez, Jr., D.O.
and HSC Staff

PRINTED NAME: _____ Initial _____

SIGNATURE: _____ DATE: _____
(By signing and dating above, I acknowledge that I have read and understand the policies outlined).

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Printable Information Release

I hereby grant permission to Heartland Surgical Care LLC to collect and store UNIDENTIFIABLE information about myself in their database for the purpose of research and/or publication, without further consideration. I acknowledge that the UNIDENTIFIABLE information will be the property of Heartland Surgical Care LLC, and they maintain the right to use this information at their discretion. I also acknowledge that Heartland Surgical Care may choose not to use my UNIDENTIFIABLE information at this time, but may do so at its own discretion at a later date.

Patient Printed Name _____

Patient Signature _____ Date _____

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Medical Records Release Authorization

I _____, (Please Print Your Name) Patient's Date of Birth _____

Patient's Social Security # _____, Authorize and request, _____

(Please print the name of the facility releasing the records) To release, for the purpose of continued care, THE FOLLOWING RECORDS REQUESTED:

- ☐ **All Records, notes and films, etc.**
- ☐ **Specific Records:_____**
  (Please specify records to be released)

To Dr. Jesse Lopez at: **Heartland Surgical Care, LLC**
14205 Metcalf Ave
Overland Park KS 66223
Phone 913-647-3999

OR FAX TO: **913-667-2762**

I understand that my medical records (including psychiatric, alcohol and drug abuse information) may be protected by Federal Regulations. I also understand that I may revoke this consent at any time in writing. Otherwise, the consent will expire automatically as stated below. I understand that my records may contain information regarding the diagnosis or treatment of HIV, AIDS, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

NOTE: This information is strictly confidential. The record has been released by the patient and/or guardian and is strictly for the person to whom it is addressed. Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. This authorization will expire 90 days from date of signature. It is expressly agreed that a photocopy of this authorization shall be as valid as the original.

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Dear Valued Heartland Surgical Care LLC Patient,

In our continuing efforts to communicate effectively with our patients and to continue the exceptional care that our office provides, we will periodically confirm policy practices in writing to ensure patient awareness. Most of the policies you are already aware of; however a new policy regarding Balances Due on Account will become effective January 01, 2012 ***(Revised January 01, 2017)***

Please note the following policies that are in place at our office:

1. LAP BAND CONSULTATIONS: Benefits will be verified prior to your appointment and you will be required to pay your deductible, coinsurance and/or co-pays at the time of Service. **Insurance will be billed.** If there is any additional balance, you will be notified with a statement. Balances are due upon receipt. If there is an overpayment, the credit will be left on the account for future visits. If we cannot verify your benefits or find that you do not have Bariatric coverage for weight- loss surgery, a consultation charge of $275.00 will apply. If Dr. Lopez is out of network with your insurance company, you will be required to pay an initial deposit of $275.00. **Initial _____**

2. GENERAL SURGERY CONSULTATIONS: Benefits will be verified prior to your appointment and you will be required to pay your deductible, coinsurance and/or co-pays at the time of service. **Insurance will be billed**. If there is an additional balance, you will be notified with a statement. Balances are due upon receipt. If there is an overpayment, the credit will be left on the account for future Visits. If we cannot verify your benefits or find that you do not have coverage, a consultation charge of S275.00 will apply. **Initial _____**

3. CANCELLATIONS AND NO-SHOWS APPOINTMENTS: As a busy Specialist Practice, we are generally booked out 30 days or more. In an effort to take care of as many patients as possible, we require three business days' notice in advance of your scheduled appointment to make changes to or cancel you appointment with us. **Please note:** You are responsible for your appointments in our office. We make courtesy calls as time allows as a courtesy to you. We are not required to make such calls. You are ultimately responsible for keeping your appointment date and time with us. If for any reason you are unable to keep your appointment with our office you are required to provide our office with (3) business days advance notice (business days are defined as Monday through Friday and DO NOT INCLUDE Weekend days). Failure to provide such notice will result in a **$55.00 fee** for each occurrence, ***regardless of the reason for such cancellation***. This fee, if assessed on your account will need to be paid at/or before your next appointment **without exception**. This proper notice helps us to provide the best possible care for our patients and allows us the time to provide additional time for patients who have been unable to schedule appointments with us. If you are late for your appointment, you may be required to reschedule your appointment. **Initial _____**

4. RETURN CHECKS: All checks retuned for insufficient funds will be charged a $35.00 return check fee in addition to any bank fees or charges that are assessed. These charges plus the amount due must be paid in full within 14 business days. Payments acceptable for these charges are cash or cashier's check. Failure to reimburse these charges within 14 (fourteen) business days will result in the charges being turned over to the collection agency. Any additional payments to Heartland Surgical Care LLC must be paid by cash or cashier's check. The charges must be paid in full prior to scheduling another appointment with Dr. Lopez. **Initial _____**

5. BALANCES DUE ON ACCOUNT: Statements are due in full upon receipt. Interest will be charged on unpaid balances more than 30 days past due at a rate of 18%, with interest accruing from the date of the first billing statement. After 90 days, the balance will be closed with Heartland Surgical Care LLC and forwarded out of this office for collections. Balances will need to be paid in full prior to scheduling another appointment with Dr. Lopez. We collaborate with Med Loan financing should you qualify. You can apply with them here. https://www.medloanfinance.com/. (*Please note that our office does not have any influence on approval of credit for Medical Loans. We can only assist you with an estimate of the amount of funds you may need to apply for. Any amount communicated for that purpose is simply an estimate. The final amount may be more or less depending on coverage and other variables etc.)* **Initial _____**

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6. DISABILITY/INSURANCE FORMS/PRE-AUTHORIZATIONS FOR MEDICATIONS ETC: There is a $30.00 fee for the office to fill out any Disability/Insurance Forms or to obtain a Pre-Authorization for medication for you. These forms are filled out in the order they are received and will be sent to the patient or employer when completed. These forms will not be able to be picked up at that day's appointment; they will be mailed or faxed to an employer, Insurance Company/Pharmacy or available for pick-up within 7 days. **Initial _____**

7. CASH PAY POLICY FOR UNCOVERED SERVICES: **Lap-Band Fills/Unfills**- In certain instances where approved by Dr. Lopez you may be eligible for our Cash Pay Policy. Some examples may be but are not limited to a lack bariatric coverage or a non-insured person. These instances are reviewed and approved by Dr. Lopez singularly. **Saliva Hormone Testing – Saliva** testing is considered experimental by Insurance Companies and therefore is a non-covered service and we will not bill your insurance for this testing. Your HSA/FSA ***may*** cover this expense and or Insurance ***may*** reimburse you directly. The ash Pay Policy for each of those services is attached separately. **Initial _____**

8. INSURANCE - **Failure to notify Heartland Surgical Care LLC of Insurance Changes -** Failure to inform us of insurance policy changes for primary and/or secondary insurance policies that you may have could result in you being responsible for unpaid balances. A 15% of allowable Service charge will be assessed upon any Days service where insurance changed occurred where you failed to notify us prior to billing the insurance company of record on your account. In instances where you fail to update us of those insurance changes within in the window for "Timely filling" with your insurance company will result in you being charged the cash pay price for that day's services on top of the 15% of allowable Service charge. **Initial _____**

We pride ourselves in providing our patients with the finest care available. In order to ensure our ability to provide these services, we appreciate you taking the time to read this statement regarding our financial policies. Thank you for your understanding and compliance in the policies of Heartland Surgical Care LLC.

Sincerely,

Dr. Jesse J. Lopez, Jr., D.O.
and HSC Staff

PRINTED NAME: _____ Initial _____

SIGNATURE: _____ DATE: _____
(By signing and dating above, I acknowledge that I have read and understand the office policies outlined).
(Office policies updated 01/01/17)

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LAP BAND FILL/ UNFILL CASH PAY PRICE EFFECTIVE AUGUST 1st, 2017

- The cash pay price for a fill/unfill of your LapBand is $222- **This covers the fills/unfills ONLY! This does not include the office visit, fluoroscopy, or upper GI.**
- Heartland Surgical Care will bill your insurance for an office visit, fluoroscopy, and an upper GI. Once we receive an explanation of benefits from your insurance company, if you owe any deductible or co-insurance towards the office visit or the fluoroscopy, we will write that amount off as a courtesy.
- We will only collect any portion the insurance company says you owe towards the **upper GI.** The upper GI procedure is not included in the cash pay price.

Thank you,

Dr. Jesse Lopez, D.O. and Staff

PRINTED NAME: _____ Initial _____

SIGNATURE: _____ DATE: _____
(By signing and dating above, I acknowledge that I have read and understand the office policies outlined).

Approved: _____ Date: _____

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P. 913-647-3999 F. 913-754-1046

Hormone Saliva Testing Policy
Effective August 1, 2017

Saliva Testing is essential in managing Menopause, Manopause, PMS and various other Hormonal Imbalances. Understanding the Saliva Levels of Hormones help to guide the management of symptoms and are more reflective of actual tissue levels than blood testing alone which may come back normal despite tissue levels being low etc. Due to the increased cost of testing to our facility, effective August 1, 2017 the cost for the Saliva Kit and testing will increase to **$260.00**. Most insurance companies do not cover the test or cost incurred by our facility so we will not submit the testing to your insurance carrior; rather **you must pay for the testing** at the time you are provided with the test kit and it is then ***UP TO YOU TO SEND IN THE RECEIPTS for reimbursement from any Health Savings Plan, Health Reimbursement Account or Flexible Spending account. You may use any of these accounts to pay for the cost of the kit in office if you have a spending card in hand for such***. Saliva testing will be needed approximately one to two times per year after the initial comprehensive assessment. We will provide you with the codes necessary to file directly to your carrier for each panel type.

CPT CODE(S):	**DIAGNOSIS CODE:**
S3650 Estradiol –**AT HOME SALIVA TEST**	E34.9
S3650 E3- Estriol –**AT HOME SALIVA TEST**	E34.9
S3650 Estrone –**AT HOME SALIVA TEST**	E34.9
S3650 Progesterone –**AT HOME SALIVA TEST**	E34.9
S3650 Testosterone –**AT HOME SALIVA TEST**	**E28.1** (*for women*) **E29.1** (*for men*)
S3650 DHEA–**AT HOME SALIVA TEST**	E34.9
S3650 Cortisol (Qty 4) –**AT HOME SALIVA TEST**	E27.1

Please note: These tests are NOT performed at/by our facility/office. Patients perform the saliva test at home by themselves and send them to a 3rd party lab after completeing the test for analysis. You will be provided with the kit and instructions during your visit with us. Thank you.

PRINTED NAME: _____ Initial _____

Heartland Surgical Care, LLC
Jesse J. Lopez, Jr., DO
7201 W 110th Street Suite 120, Overland Park KS 66210
P. 913-647-3999 F. 913-754-1046

SIGNATURE: _____ DATE: _____
(By signing and dating above, I acknowledge that I have read and understand the office policies outlined).

Attention all Patients:

- All Co-Payments, Co-insurance Payments and Deductible Amounts are due at the time of service.

- All no-call/no-show missed appointments will be charged a $50.00 cancellation fee applied to their patient account.

- Also effective immediately, we will now be fully enforcing our previous finance charge policy on all unpaid balances. If there are any questions, please inquire with our staff.

- Please present your insurance card at the time of each visit to insure any changes to your insurance plan are on file at the time of service. Failure to inform us of insurance policy changes for primary and/or secondary insurance policies that you may have could result in you being responsible for unpaid balances. **Failure to notify Heartland Surgical Care LLC of Insurance Changes** - Failure to inform us of insurance policy changes for primary and/or secondary insurance policies that you may have could result in you being responsible for unpaid balances. A 15% of allowable Service charge will be assessed upon any Days service where insurance changed occurred where you failed to notify us prior to billing the insurance company of record on your account. In instances where you fail to update us of those insurance changes within in the window for "Timely filling" with your insurance company will result in you being charged the cash pay price for that day's services on top of the 15% of allowable Service charge.

Thank you for your cooperation,

HSC STAFF
DR. JESSE J. LOPEZ, JR., D.O.

PRINTED NAME: _____ Initial _____

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MEDICATION REFILL POLICY

We make every attempt to process a request for a routine prescription refill within 3-5 regular office days. Prescription requests received on Friday ***may not*** be processed until Wednesday. Do not wait until you are completely out of medication before calling to request a refill. A prescription request may be delayed if it requires your physician's approval. Approval may take 3-5 days, depending on the doctor's office schedule. If you have not had a routine appointment for a long time, you may be asked to schedule an appointment before any refills will be given. Absolutely no refills will be authorized if it has been more than one year since your last office appointment.

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three to five business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

- Medication refills will only be addressed during regular office hours (Monday-Friday 9am-5pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

- Some medications require prior-authorization. There is a fee for obtaining a prior-authorization for this purpose of 25.00, which is non-refundable; we will collect this amount before submitting for a prior-authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations ***can*** result in a denial of refills. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary depending on the type of medication prescribed. Please be sure you have enough medication to last until your next scheduled visit. If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider ***may*** agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is **your responsibility** to schedule an appointment before you run out of medication. **You should schedule your next visit before you leave our office.**

- If you have any questions, regarding medications please discuss these during your appointment. If for any reason, you feel your medication needs to be adjusted or changed please contact us immediately. You may be required to be seen for an evaluation in order to make these adjustments in medication.

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- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

PRINTED NAME: _____ Initial _____
SIGNATURE: _____ DATE: _____
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HEARTLAND SURGICAL CARE
NON-COVERED SERVICE WAIVER

(1) The procedure you are requesting is not a covered benefit by your insurance company.

(2) The patient and physician acknowledge that neither will submit a claim to the insurance company.

(3) Please sign the acknowledgement below that you understand this procedure is patient responsibility.

(4) The procedure: _S3650 AT HOME SALIVA TEST_____

Diagnosis:

(5) _____

(6) Charges:_$260.00_____

(7) Date of Procedure:_____

(8) Physician Signature:_____
Date

(9) Patient Signature:_____

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Date

(10) Witness Signature:_____

Date

Signature Certification page

Patient Name _____ DOB_____ Date_____

By signing and dating below, I certify that this is my signature and my initials, and that no one has signed my patient forms, policies and procedures other than me the above named.

PRINTED NAME: _____ Initial _____

SIGNATURE: _____ DATE: _____