Patient Registration Information **(Please use full legal name)**

Name:_____Date of Birth: _____

Address:_____City/State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone: _____

Email Address:_____Name of Employer: _____

Emergency Contact Name:_____Phone:_____Relationship:_____

Marital Status:____Single____Married____Divorced____Widowed____Other Primary Language: _____

PRIMARY INSURANCE INFORMATION (*important to get free insurance verification***)**

Insurance Name:_____Policy/ID #:_____

Group #_____

Insured Name:_____Insured's DOB:_____

Insured SSN#: _____

Claims Address & Phone #: _____

Guarantor Information (*if not patient***)**

Relationship of Guarantor to Patient: ____Spouse ____Parent ____Other _____

Name:_____Date of Birth: _____

Address:_____City/State:_____

Zip:_____ Home Phone:_____Social Security #:_____Sex:_M___F____

Name of Employer and Address:_____Work Phone: _____

SECONDARY INSURANCE INFORMATION (*if any***)**

Insurance Name:_____Policy/ID #:_____Group #_____

Insured Name:_____Insured's DOB:_____Insured SSN#: _____

Claims Address & Phone #: _____

By signing below, I am confirming that all information listed above is true to the best of my knowledge.

Signature:_____**Date:** _____

PERSONAL MEDICAL HISTORY

Anemia _____ Diabetes _____ High Blood Pressure _____ Obstructive Sleep Apnea _____

COPD/Asthma ____ Joint Problems/Arthritis _____ Back Pain _____ Kidney Disease _____

Liver disease _____ Bleeding Problems _____ Acid Reflux/Heartburn _____ Previous Blood Clots _____

Heart disease _____ Depression/Anxiety disorder _____ Headaches/Migraine_____ Gout _____

High Cholesterol _____ PCOS/Infertility _____ Hyperthyroidism _____ Hypothyroidism _____

Any other Medical conditions: _____

SURGICAL HISTORY

Procedure	Approximate date

Medications (pls list)

Allergies to Food/Medications? □No □Yes, If Yes, which? _____

Family History (pls list if any):

_____
_____
_____

Social History

Smoking: Current smoker _____, how many years? _____ Previous smoker _____ when stopped? _____

Alcohol: Y___ N ____ How much? _____

How did you hear about us? Doctor's referral _____ Friend/Family/Co-worker_____
Social Media (eg. Facebook, Twitter)_____ Adverts (magazine, TV etc) _____

HIPAA COMPLIANCE NOTIFICATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office.

If you wish to be contacted in the following manner {check all that apply)

____ Home Phone
____ OK to leave message
____ I.eave message with call back number
____ Written communication
____ OK to mail to home address.
____ OK to mail to work address.
____ OK to fax to his number_____

I acknowledge that I have read the HIPAA Notice of Privacy Practice available on the patient portal.

Patient Name: _____ Date of Birth: _____

Patient's signature: _____ Date: _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH LNFORMATION

I hereby grant permission to Dr. Chukwuma Apakama, staff of CGA Weight Loss and Surgical Specialists and contracted agencies to openly discuss my health information with the following persons. I understand that this authorization may only be revoked in writing.

(This section must be completed in order to discuss care with anyone other than yourself or another physician involved in your care, including your spouse, partner, children, parents etc.)

Name _____

Relationship_____

Phone Number_____

Name _____

Relationship_____

Phone Number_____

Name _____

Relationship_____

Phone Number_____

Patient Name _____

Patient Signature _____

Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

Patient Name:_____ **DOB:**_____

I request and authorize **Dr. Chukwuma Apakama of CGA Weight Loss and Surgical Specialists** to **OBTAIN** my medical records or otherwise obtain confidential information from other physicians/doctors' offices, hospitals or surgical centers that have or will be involved in my treatment. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. They include all doctor, or any other health care provider visits, laboratory and other diagnostic tests that would be needed in my treatment. These can be released to:

Chukwuma Apakama MD
CGA Weight Loss and Surgical Specialists
7711 San Jacinto Place Suite 200
Plano, TX 75024
Tel: (214) 440-1245
Fax: (214) 440-1246

I acknowledge that a copy of this would suffice in lieu of an original document.

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Representative's Relationship to Patient (if applicable) *Representative's Printed Name*

Unless otherwise revoke this authorization will never expire unless noted here, Expiration date……

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

DISCLOSURES AND CONSENTS

GENERAL CONSENT TO TREATMENT:

I hereby consent to evaluation (including interviews and examination), testing, and all treatment as directed by Dr. Apakama or any staff under his supervision.

I understand that if my procedure is a "self-pay" procedure (defined as a procedure including office visits, diagnostic and therapeutic procedures not covered or paid for by your insurance), all costs related to medical care before, including and after the surgery would be my responsibility or that of the person stated as guarantor.

ASSIGNMENT OF INSURANCE & BENEFITS:

In consideration of services rendered or to be rendered, hereby irrevocably assign, authorize and transfer to Dr. Apakama all rights, titles and interest in the benefits payable for services rendered to me or my dependents, provided in the policy(ies) of insurance. Said irrevocable assignment and transfer shall be the recovery on said policy(ies}of insurance but shall not be construed to be an obligation of Dr. Apakama to pursue any such rights of recovery provided. However, this assignment and transfer shall not take away my standing to make a claim or sue for benefits individually should any insurance carrier(s) deny the coverage.

I hereby authorize the insurance company(ies) herein listed above to pay directly to the office of Dr. Apakama all benefits due under said policy(ies) by reason of services rendered therein.

I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I will pay for all charges incurred or alternatively, for authorization shall be considered as effective and valid as the original.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have read a copy of the "HIPAA Notice of Privacy Practices" available on the patient portal. I hereby authorize, CGA Weight Loss and Surgical Specialists, or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, text, and email. I hereby authorize CGA Weight Loss and Surgical Specialists and representative to mail, call, text, or e-mail with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying the office to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SEVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

DISCLAIMER FOR OUT OF NETWORK FILING AND REFERRALS:

Our company and companies/facilities that we may refer you to may not be participating with your Insurance Carrier(s). Your claims may be filed with your out of network benefits and processed by your carrier as out of network. Your carrier will send an explanation of your claim and they will make you responsible for the amount that they do not pay on the claim. Please contact your insurance carrier to make sure that your visit will be in-network

I have read and fully understand the above Patient Registration Form Disclosures & Consents

Signature:_____ **Date:** _____

(Please sign here- Patient or Responsible Party if Patient is a Minor)

Name:_____ Date: _____

(Please print name of Patient or Responsible Party if different from Patient)

NO SHOW AND CANCELLATION POLICY

Patient Name:_____**DOB:**_____

At CGA Weight Loss and Surgical Specialists, we are happy to help you with your weight loss and general surgery needs. This includes being able to provide you an appointment when needed. We understand that circumstances change, and emergencies happen, and you must miss an appointment; however, when you do not call to cancel an appointment (otherwise known as a "NO SHOW"), you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. As a result of this, we have the following policy which we would like you to please read and acknowledge:

- If your Office Visit is missed without providing at least a 24-hour notice your account will be charged $50.00 (or the equivalent of your co-pay) as a "NO Show" fee. This is not covered by your insurance company.
- If your Upper endoscopy (EGD) appointment is missed or cancelled without providing a 48-hour notice, your account will be charged with a $100.00 "NO SHOW/Cancellation" fee (this will not be covered by your insurance company). This will not go towards the cost of your EGD.
- If you cancel your Surgery with less than 72 hours' notice, there will be a $750.00 Cancellation Fee charged to your account. (this is not covered by insurance)

I have read and understand the above policy on no-shows and cancellations.

Signature:_____**Date:** _____

(Patient or Responsible Party if a Patient is a Minor)

MEDICATION (INCLUDING CONTROLLED SUBSTANCES) POLICY

Patient Name:_____ **DOB:**_____

At CGA Weight Loss and Surgical Specialists, we are committed to assisting you with all your weight loss and surgery needs, which includes supplying necessary medications for you; however, we do have certain guidelines for all medications prescribed by our physician.

- Health maintenance medication refills must be refilled by your prescribing provider (i.e., PCP, Cardiologist, Pulmonologist). Please Discuss these medications with your prescribing provider prior to surgery and make appointments with same providers soon after your surgery as some of these medications may need to be altered.
- If you are on an anticoagulant or blood thinner (like Plavix, Warfarin (Coumadin), Heparin) it is important that you contact your prescribing provider (i.e., PCP, Cardiologist, Pulmonologist) and develop a plan for post-operative anticoagulants regimen.
- Controlled substances have the potential to be addictive and must be taken exactly as prescribed. You will only receive prescription narcotics from **one treating physician at a time**. If you are receiving narcotic medications from another physician, or if you are under contract with a pain management specialist, you should consult with your pain management physician to plan a post-operative pain control regimen.
- Do not use alcohol/illegal drugs while being prescribed narcotic pain medication(s). Pls notify us IMMEDIATELY if any other physician is currently prescribing you a controlled substance(s) or has prescribed one to you in the preceding thirty (30) days (including emergency rooms & urgent care centers). **Failure to do so is a *crime.* Obtaining or attempting to obtain drugs by fraud and or deceit and will be reported to the police.**
- I authorize Dr Apakama and his staff to communicate with all physicians that I have seen. I understand that it is illegal to share this medication and agree to keep my medication locked in order to prevent loss or theft. I understand that this medication may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment. As a result, I would refrain from driving, operating machinery and making important decisions when on these medications.

Signature:_____ **Date:** _____

(Patient or Responsible Party if a Patient is a Minor)

FAMILY MEDICAL LEAVE ACT (FMLA) / SHORT TERM DISABILITY (STD) / MEDICAL RECORDS POLICY

Patient Name:_____ **DOB:**_____

At CGA Weight Loss and Surgical Specialists, we are happy to assist you with the completion of any FMLA/STD forms required for leave of absence related to surgery and/or post-surgical complications, as well as the release of medical records to various other physicians involved in your care. we do have certain guidelines for completing the Forms for FMLA and/or STD and sending and releasing medical records.

- If you require leave of absence documentation for your employer for upcoming surgery, it is your responsibility to provide our office with the necessary paperwork and contact information of whom to return it to prior to your scheduled surgery (preferably prior to your pre-op appointment).
- Pls allow 7 business days for completion of FMLA/STD forms and requests for medical records upon receipt of the required forms by our office. It is your responsibility to provide the necessary forms in advance.
- There will be a $30 fee due prior to your FMLA/STD being completed and processed. Also, an additional fee of $35 must be paid for any secondary request for completion.
- If you require a release to return to work, please contact our office via phone during normal business hours and provide the necessary contact information needed to forward your release to your employer.
- There will be a $50 fee due prior to releasing your medical records to yourself; however, there is no charge to release medical records to another physician for continuation of care. We must receive a signed request to release medical records. (A verbal request will not be honored.) You may contact our office to obtain this form.

I have read and fully understand the above
Policies regarding Medication Refills and FMLA/STD/Medical Records

Signature:_____ **Date:** _____

(Patient or Responsible Party if a Patient is a Minor)

FINANCIAL ARRANGEMENTS, MEDICAL INSURANCE AND OFFICE POLICY

Dr. Chukwuma Apakama and the staff of CGA Wight Loss are committed to always providing you our absolute best providing you exceptional and outstanding service in a comfortable and friendly environment. We understand that you had many options to choose from and we are privileged that you chose us as your practice to help you navigate and run this tough but extremely rewarding journey towards a healthier and better life.

If you have medical insurance, we are committed to helping you receive the maximum benefits available to you under the terms of your policy with the least amount of stress or worry on your part as possible. We would need your help and cooperation in order to achieve this and your overall health goals.

As a private practice, the same laws rule us as any business. We require that full payment be made at the time services are rendered. To make things easier for you, we will contact your insurance carrier to determine your benefit coverage, including your deductible before your initial office visit and your out-of-pocket costs when scheduling surge ry. It is our policy to collect your deductible prior to surgery if it has not been met in full.

Medicare Patients:

Chukwuma Apakama MD is a participating physician with Medicare. We will file all claims and accept assignments through Medicare. Unless secondary insurance information is provided, we request that your portion be paid at the time of service or within 30 days of notice by Me di care. Federal law requires that we bill 20% co-insurance and any unmet deductible after Medicare has paid their portion of the fees.

Regarding Medical insurance:

1. Your insurance is a contract between you, your insurance company and/or your employer. We are not a party to the contract except for any PPO or HMO in which we participate.
2. Our fees fall within the range of fees for the same services provided by other surgeons in the area and are considered customary by most standards.
3. Please be mindful that your insurance carrier may not cover all services. They may arbitrarily select certain services and exclude them from coverage. We would do our best prior to treatment to clarify your insurance coverage.

As healthcare providers we must reiterate that our relationship is with you and not your insurance company. Our focus is always on you and we will only recommend what is in your best interest and will not allow your insurance company to interfere with our recommendations and/or decisions. Should there for any reason be a conflict of interest with your insurance company, we will advise you honestly and frankly and seek your guidance. A complete recovery and successful treatment cannot be possible without your total cooperation and we anticipate that you would indeed always cooperate fully with us.
Pls inform us immediately should there be a change in your address, employer/employment situation, insurance etc to ensure that we continue to give you optimal care and service.
We realize that circumstances change and my hamper payment of your account. Please inform us should this happen and advise us so that payment arrangements can be made.

When you provide a check as payment, you authorize use either use the information on the check to make a one-time electronic payment or to process it as a check transaction. If your payment is returned due to insufficient funds, you authorize us to make a one-time electronic fund transfer from your account to collect a fee as allowed by state law.

We will file your insurance for services performed by Dr. Apakama providing that the deductible has been paid or that you pay the portion of your fee, which is under deductible or copay clause of your policy. This in no way relieves you of the responsibility for the bill. There is no charge for filing claims, however, if the insurance company does not process the payment within 60 days, we will look to you for the payment. We will send you a bill with the remaining balance after insurance pays. This payment will be due within 30 days of notification. Accounts that are 90 days old are automatically sent out of the office for collections by a third party.

Our Office hours are:
Monday-Friday from 8:30am to 5:30pm and Saturday 8.30am to 12.30am

Offices:
7711 San Jacinto Place Suite 200, Plano TX 75024 (Main office)

6121 N Highway 161, Suite 225, Irving TX 75038
Texas Health Hospital Mansfield, Professional Building 1,2302 Lone Star Road, Suite 160, Mansfield TX 76063.

Tel: (214) 440-1245 Fax: (214) 440-1246.

Dr. Apakama has the office covered during above mentioned office hours however, you can leave a message on voicemail or send a message through our patient portal and one of our staff members will return your call as soon as possible.

Medication refills will be handled during office hours. After hour refills will carry a fee for services unless in an emergency.

We hope that your visit to our office would be a pleasant one and we look forward in helping you win by losing!! Please do not hesitate to contact us should you have any further questions or concerns.

Best Regards Always,

Chukwuma Apakama MD

Pls sign to acknowledge that you have read the above policy

_____ _____

Patient Signature Date

_____

Patient Name