Houston Weight Loss
IT'S TIME TO BE YOU

DR. IRFAN I. WADIWALA

Board Certified General Surgeon

& Weight loss Surgery

13323 Dotson Rd Suite 210
Houston, TX 77070
Ph. (281) 653-6544
FX (281) 807-9702

E-MAIL ADDRESS:	**PCP:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	**Cell phone no.:** ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 general, Laparoscopic & bariatric surgery Irfan I. Wadiwala, D.O. www.Houstonweightlossdr.com or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

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WEIGHTLOSS PATIENT INFORMANTION

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No

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MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize DR. _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

to release healthcare information of the patient named above to: **DR. IRFAN I WADIWALA**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Dr. Irfan Wadiwala

#drwadiwadiwalapatient

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Thank you for choosing General, Laparoscopic, & Bariatric Surgery as your healthcare provider. We are committed to your experience with our office being a pleasant and positive one, and to your treatment being successful. The following is a statement of Financial Policy, which we require you to sign and read prior to any visit and/ or treatment. Please understand that payment of your bill is considered part of your treatment and we accept cash, debit and credit cards. All co-payments must be paid at the time of your visit.

Our dedicated staff will work diligently to insure that your insurance claims are filed accurately and promptly. You will be required to show your insurance card at the time of service. If you cannot provide this information you will be required to pay for the service rendered to you that day. **We require payment of co-pays at the time of your visit, as well as payment of deductible and coinsurance portions prior to scheduled surgeries. The amount required will be a result of verification of benefits provided by your insurance plan.** Uninsured patients should consult with our Office Manager to discuss discounts and to make payment arrangements.
It is **patient's responsibility** to forward any/all payments to the insurance provider in a timely matter to apply towards deductible/co-insurance. You can call your insurance provider to get information where to summit your receipt. For any credit/debit card refund, a processing fee(s) will be deducted.

Insurance & Insurance Collection

Your insurance policy is contract between you and your insurance carrier, and we are not part of that contract. Though we are not contracted with your insurance, we will file your insurance as a courtesy and a service to you, and will absorb all costs incurred. Our staff will work diligently to insure that your insurance claims are filed accurately and promptly. However, should your insurance carrier not reimburse us within 60 days, the balance due then becomes your responsibility.
While we file all primary insurance claims, please understand that all insurance reimbursement can be a long difficult process, often resulting in prolonged delays and significantly reduced reimbursement. To assist us in expediting the claim payment process and reduce delays, please authorize and consent to the following:
Our practice is **NOT** responsible for any other charges such as: Hospital, anesthesia, labs, pathology, and radiology related to your surgical care.

Compliance & Disclosure under Texas Occupations Code - Section 102.006
In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility may or may not have affiliation and remuneration: Humble Surgical Hospital, The Woodlands Specialty Hospital, Houston Northwest Medical Center, Methodist Willowbrook Hospital, St. Lukes the Vintage Hospital, Cypress Fairbanks Medical Center, North Cypress Medical Center, Providence of North Houston and First Texas Hospital, Spring Excellence Surgical Hospital, Memorial Hermann Cypress Hospital.

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

I assign my insurance benefits and authorize payment to:
Irfan I. Wadiwala, DO/ General, Laparoscopic & Bariatric Surgery
I also authorize Dr. Wadiwala and or General, Laparoscopic & Bariatric Surgery to file appeals on my behalf and, if warranted, file complaint regarding my insurance carrier with the Texas Medical Association and the Texas Department of Insurance.

_____ _____

Signature Date

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Understanding My Insurance Coverage

Patient Name: _____

I, _____, have discussed my insurance coverage including any applicable *co-pays*, *co-insurances* and *deductibles* that may apply to my office visit and/or procedure performed by Irfan I. Wadiwala, D.O. with the office staff.

I understand that General, Laparoscopic & Bariatric Surgery office will collect from me today or set up payment plan arrangement with me for any applicable *co-pays*, *co-insurances* and *deductibles* that may apply to my office and/or procedures performed by Irfan I. Wadiwala, D.O.

It has been explained to me that insurance companies' process claims as they are received and any deductible amounts paid to General, Laparoscopic & Bariatric Surgery office may not in fact be applied to his claim(s) once my insurance process the claims(s). Further, it is my understanding that should this happen and an overpayment is applied to my account, that General, Laparoscopic & Bariatric Surgery office will refund me any overpayment that is due to me.

I understand that I am being charged based on my insurance benefits and verification.

_____	_____	_____
Patient Name/Guardian	**Patient Signature/Guardian**	**Date**

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Explanation and Assignment of Benefits

The following is a legal agreement between you and Hightech Surgical Associates, (the "Provider"), in which you will grant certain rights to the Provider to seek, receive, and/or compel payment from your health insurer. Health insurance is a contract between you and your insurer. In order for the Provider to collect money from your insurance company, you must assign that right to the Provider. By signing this document, you grant the Provider various rights to seek, receive, and/or compel payments on your behalf from your insurer (or other responsible party). The assigned rights include, among others, the right to collect payment, the right to process appeals for denied payments, and the rights to pursue legal action if your insurer (or other responsible party) fails to pay. Please carefully read the following and sign below to indicate your acceptance.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the Provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of its managed care network participation/status. I understand that I am financially responsible for all charges, regardless of any applicable insurance or benefit payments. I hereby authorize the Provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or settlement information upon written request from the Provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the Provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance, or Tort-feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medication I received from the Provider (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the Provider, including rights to any settlement, insurance, or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (the Provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statement about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefits plan, health care benefits plan, or plan administrator. The Provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care Reform legislation), ERISA, Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.
I have read and fully understand this agreement.

_____ _____

Patient Name Patient Signature