CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

Dear _____,

The staff and surgeons at the CHRISTUS Southeast Texas Bariatric Center would like to extend a warm welcome to you and congratulate you on your decision to learn more about weight loss surgery. Thank you for giving us the opportunity to share with you our knowledge and expertise on this important topic.

Your consultation with Dr. Jerome Schrapps / Dr. Kevin Dean is scheduled for:

_____

We have enclosed the required registration forms for your appointment. Please complete these front and back prior to your appointment to help reduce any unnecessary wait time.

We look forward to meeting you and being part of your journey to better health! Please feel free to visit our website at www.setxweightloss.org to view video presentations of our procedures, read patient testimonials, and meet our staff.

3030 North Street Suite 340 Beaumont, TX 77702 409-839-5673

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*
3030 North Street | Suite 340 | Beaumont, Texas 77702 | 409.839.LOSE (5673)

PATIENT ENROLLMENT INFORMATION

PERSONAL INFORMATION:

DATE:

NAME: HEIGHT: WEIGHT:

DATE OF BIRTH: AGE: GENDER: ☐ MALE ☐ FEMALE SOCIAL SECURITY #:

DAY PHONE: EVENING PHONE: E-MAIL:

HOME ADDRESS: CITY/STATE/ZIP:

EMPLOYED BY: POSITION:

EMPLOYMENT ADDRESS:

CITY/STATE/ZIP: EMPLOYER PHONE:

EMERGENCY CONTACT: RELATIONSHIP TO PATIENT:

PHONE: ADDT'L PHONE PATIENT'S MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW/WIDOWER

INSURANCE INFORMATION:

INSURANCE CARRIER: POLICY #: GROUP #

SUBSCRIBER: SUBSCRIBER DATE OF BIRTH: AGE:

GENDER: ☐ MALE ☐ FEMALE SOCIAL SECURITY #: RELATIONSHIP TO PATIENT:

EMPLOYED BY: POSITION:

EMPLOYMENT ADDRESS:

CITY/STATE/ZIP: EMPLOYER PHONE:

PROTECTED HEALTH INFORMATION:

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information (PHI). I have had an opportunity to review this information before signing this form. I consent to CHRISTUS Southeast Texas Bariatric Center and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) to carry out treatment, payment, or health care operations. This includes any medical misinformation (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV-related information including HIV test result, if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to participation in this program (including pre-certification and verification, if necessary), or which may be needed to conduct continued care planning.

Patient Signature: _____ Date: _____

02-2008

How did you hear about us?

☐ **Newspaper** ☐ **Billboard** ☐ **Radio** ☐ **Television** ☐ **Mail**
☐ **Family/Friend** ☐ **Attended Seminar** ☐ **Referred by Physician**

Internet – *which search engine or Website led you to us?*

☐ Went directly to CHRISTUS Southeast Texas Bariatric Center's Website
☐ Google ☐ Yahoo! ☐ AOL ☐ MSN ☐ Ask.com
☐ Other _____

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*
3030 North Street | Suite 340 | Beaumont, TX 77702
409.839.LOSE (5673) | 409.839.5699 fax

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

CONFIDENTIAL PATIENT INFORMATION

NAME:			DATE:	BMI
DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:	

PAST MEDICAL / SURGICAL HISTORY

PREVIOUS SUGERIES / PROCEDURES

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

HOSPITALIZATIONS

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

ILLNESSES: Describe illnesses not requiring hospitalization, list any health conditions you are currently being treated for (ie. Diabetes, sleep apnea, high blood pressure, etc.)

1	
2	
3	
4	
5	
6	
7	

ALLERGIES: List all

SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:

CURRENT MEDICATIONS: Include daily medications as well as those used as needed

MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:

PATIENT INFORMATION – 2

PHYSICIANS NAME:	PHONE	FAX
Primary Care:		
Pulmonologist:		
Gastroenterologist:		
Orthopedist:		
Neurologist:		
Cardiologist:		
Psychiatrist:		
Endocrinologist:		
Gynecologist:		
Other:		

SOCIAL HISTORY

Your occupation:	Spouse's occupation:
List any hobbies or volunteer work in which you participate:	
Number of children:	General health of children:

PERSONAL HABITS

Do you smoke? Y / N	How much?	How long have you smoked?	When did you quit smoking?
Do you drink alcohol? Y / N	How much?	How long have you drank?	When did you quit drinking?
Do you use illegal substances? Y / N	Ever used illegal substances? Y / N	What kind?	How often?
Do you exercise? Y / N	What kind of exercise?	How often do you exercise?	
Do you have any limitations to exercise?			

FAMILY HISTORY

RELATIONSHIP	AGE	HEALTH	IF DECEASED CAUSE	WEIGHT STATUS	RELATIONSHIP	AGE	HEALTH	IF DECEASED CAUSE	WEIGHT STATUS
Father		Good/Fair/Poor		Thin/Avg/Overweight	Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight
Mother		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight

Do you know of any blood relative who has had any of these conditions (If yes, give relationship of relative)

Stroke: Y / N ___________	Heart Disease: Y / N________________	Tuberculosis: Y / N_________	Problems with Anesthesia : Y / N ___________
High Blood Pressure: Y / N ___________	Cancer: Y / N _____________	Bleeding Tendencies: Y / N _________	Other:___________________________
Diabetes: Y / N ___________	Overweight (20-99 lbs.): Y / N _____________	Severely Obese (> 100 lbs.): Y / N ________	Other:___________________________

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

AUTHORIZATION FORM RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize my physician(s):

_____ at the following address(es):
(Patient Primary Care Physician(s) Name)

_____
(Patient Primary Care Physician(s) Address)

to use and disclose to the following party:

CHRISTUS Southeast Texas Bariatric Center,
3030 North St., Suite 340, Beaumont, Texas 77702
Fax (409) 839-5699 Phone (409) 839-5673

The use and disclosure will be made by the office staff of this facility. The health information to be used and/or disclosed is specifically described as follows (check all information to be released):

_____ Doctor's Office Notes and Reports
_____ Lab/X-Rays
_____ Communication Notes between Staff & Patient
_____Other Specific Testing:_____
_____

_____Hospital Records
_____PsychiatricNotes
_____HIV/Drug Screen

This authorization shall be in force and effective until the following event and/or date: _____, at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the aforementioned facility. I understand that a revocation is not retroactive to the extent that the facility has already used/disclosed information based on this current authorization. Also, a revocation is not effective if this authorization was a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure, I understand I have the right to: 1) Inspect or have a copy of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent state law provides greater access rights), 2) Refuse to sign this authorization; in which case we will be unable to process this request.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Date of Birth Social Security #

_____
Printed Name of Patient or Personal Representative

_____
Relationship of Personal Representative

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____ Date of Birth:_____

I hereby authorize medical providers and personnel of the CHRISTUS Southeast Texas Bariatric Center to discuss my protected health Information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ I **DO NOT** authorize the CHRISTUS Southeast Texas Bariatric Center to release **ANY** medical or appointment information to anyone.

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires.

- Unless specified above, this authorization will expire 365 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Center has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

_____	_____
Signature of Patient/Personal Representative	Printed Name of Patient/Personal Representative
_____	_____
Date	Description of Personal Representative's Authority

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

Patient Name: _____ Date of Birth _____
Please print

Guarantor if other than Patient _____ Relationship to patient _____
Please print

LETTER OF EXPLANATION – PROVIDER-BASED CLINICS

Thank you for choosing CHRISTUS Southeast Texas Health System as your health care facility to assist with your health care needs.

We share this notice to inform you of our billing policies for the **CHRISTUS Southeast Texas Bariatric Center.** Jerome Schrapps, MD and Kevin Dean, MD although independent of CHRISTUS, treat their clinic patients in the CHRISTUS facility.

Under Provider Based billing, physician offices are considered to be departments of the hospital. Patients visiting a provider-based clinic may receive a bill from the hospital for facility-related fees, and a separate bill from either Jerome Schrapps, MD, LLC or Kevin Dean, MD for any professional services (physician services) they receive. The provider-based status essentially separates the fees out and they are billed separately.That is why patients will receive a separate bill from the hospital and another from the physician. There is no difference from the way CHRISTUS bills for other hospital based services like the emergency department, therapy services, lab services and surgical procedures.

In the provider based model in physician office locations, the total out-of-pocket expense for a visit could be more, could be the same, or could be less depending on the type of visit and individual's insurance coverage. Depending on one's insurance, this may mean that a patient will pay an additional co-pay and/or deductible (one for the hospital charges and one for the physician). The majority of our Medicare patients carries supplemental insurance and will not see a change in their total out of pocket.

As your health care provider, we are committed to offering you the best care possible. We are also committed to helping you understand our financial and billing policies; so if you have questions regarding these billing policy changes, please feel free to call our **CHRISTUS Health Customer Service Center at 1-800-756-7999 or locally 409-839-5673, if you have questions regarding Provider-Based Billing.**

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

Patient responsibility: You as the patient are ultimately responsible for all fees. All payments, co-payments, co-insurances, and deductibles are due at the time of service, including Physician charges. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary payments, co-payments, co-insurances, and deductibles at the time of service.

Patients with healthcare coverage: We do accept insurance assignment and will file your insurance claims for you, if you have provided a copy of your current insurance card at the time of service. You are responsible for all co-payments or balances as required by your specific insurance plan. You need to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If the initial given insurance coverage changes at any time during your care, immediately provide a copy of the new insurance card to a CHRISTUS Southeast Texas Bariatric Center patient representative or our insurance department. If your insurance plan requires a referral, this must be obtained from your primary care physician or specialist prior to coming in to the office. It is your responsibility to obtain this referral. If the referral is not received or obtained when you arrive for your visit your insurance company will not honor the visit so your appointment will be rescheduled.

If for any reason (i.e. policy exclusion) insurance does not pay even though prior-authorization has been obtained, then, I, the patient will be responsible for all charges incurred for office visits, surgical procedures, hospital, and anesthesia.

Patients without insurance coverage: If you do not have healthcare coverage, you are required to make a payment prior to seeing the physician and you are responsible for any additional charges.

CHRISTUS Southeast Texas Bariatric Centeraccepts the following methods of payment: Cash, check, money order, debit, MasterCard, Visa, Discover, American Express and Care Credit.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Patient Name_____

PatientSignature_____ **Date**_____

PERMANENT PART OF MEDICAL RECORD

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

What does "Provider Based" designation mean?

This is a Medicare status for hospitals and clinics that comply with specific Medicare regulations. Medicare has determined that CHRISTUS has met these regulations and has now been designated as such. This status requires that CHRISTUS bill Medicare in two parts.

How does "Provider Based" affect my billing?

When seeing a CHRISTUS healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under "Provider Based" status, Medicare requires Provider Based to bill all healthcare provider services in two parts. When your medical services are completed, CHRISTUS will submit one claim to Medicare, Facility Fee:

Facility Fee to Part A

When your medical services are completed, CHRISTUS Southeast Texas Bariatric Center will submit one claim to Medicare, Provider Fee:

Healthcare provider fee to Part B

You will receive two Medicare Summary Notices (MSNs) from Medicare. Once Medicare has processed their portion of the charges, the balance will be submitted to a secondary payer. If there is a balance after the secondary insurance processes the claim, or if you do not have secondary insurance, you will receive a bill for the remaining balance.

Medicare has designated CHRISTUS outpatient clinics as "Provider Based" facilities. As Medicare recipients, this designation affects the way your services are billed to Medicare. CHRISTUS is committed to providing you with the highest standard of medical care.

If you have any questions regarding **Provider Based Billing, please call us at 409-839-5673.**

If you have questions regarding your CHRISTUS bill, please feel free to call our **CHRISTUS Health Customer Service Center at 1-800-756-7999.**

Estimate of charges –
AFTER YOUR ANNUAL DEDUCTIBLE IS MET

Medicare requires that we provide you with an estimate of your Part A and Part B coinsurance amounts. These amounts will vary based on the type and number of services received.

Estimate of coinsurance amounts:

	Part A	Part B
Office Visit	$14-$15	$2-$40

Why does the Medicare Secondary Payor (MSP) Questionnaire need to be completed?

As a participating Medicare provider, CHRISTUS is required to screen Medicare patients according to the Medicare Secondary Payor (MSP) rules. At each visit, business services representatives will ask you the MSP questions. These questions will help to confirm if Medicare or another payer should process the claim as primary.

Commercial Insurance

All pricing is an estimate **AFTER YOUR ANNUAL DEDUCTIBLE IS MET.** Your claim will be processed under the guidelines of your Insurance Company; for covered services and assignment of your out-of-pocket. Our price estimator tool will evaluate your insurance coverage based on the last time the insurance company updated their records with your current or previous claims.

Thank you for choosing CHRISTUS Southeast Texas Bariatric Center as your healthcare provider.

Please note: The total cost of charges for Medicare patients will not exceed charges incurred by non-Medicare patients receiving the same services.

CHRISTUS SOUTHEAST TEXAS
Health System

NOTICE OF MEDICARE NON COVERED OUTPATIENT DRUGS

Medicare does not pay for self administered drugs. These

include: 1) all medications given by mouth
2) eye drops
3) insulin by injection in some cases

The above drugs are the payment responsibility of the patient. These may not be paid by your second insurance carrier because they are considered non covered by Medicare. (Examples: AARP, Medicaid)

I understand I am totally responsible for outpatient drugs not covered by Medicare.

_____	_____	_____
Patient Signature	Date	Witness

PERMANENT PART OF MEDICAL RECORD

CHRISTUS SOUTHEAST TEXAS Health System

FACILITY CARE CONSENT

1. **General Consent:** I consent to the rendering of medical care which may include diagnostic testing (such as labs and x-rays), injections, immunizations, medications, and such other medical treatment as my attending or other physician(s) consider to be necessary at **CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM** ("Facility"). I have the right to discuss treatment and procedures with the physician beforehand. I have the right to consent or refuse any treatment. Some medical services may be offered via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different location, and I consent to such services. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Facility may be under the direction of an independent provider, who is not an employee of the Facility. The Facility is not responsible for the medical care, medical judgment, and plan of care provided by non-employees.

2. **COVID-19:** I acknowledge that Coronavirus 2019 (COVID-19) is a novel virus that spreads easily among people, and has spread within this area and throughout the state, and nearby states. Much is still being discovered about this virus, but data has shown it spreads when someone with the virus talks, coughs, or sneezes and the respiratory droplets released into the air are inhaled or on a surface touched by another person. As such, I understand that I may be exposed to and acquire this disease anywhere, and that avoidance of transmission is extremely difficult to control perfectly in any environment. However, I understand that the Facility has implemented numerous safety measures designed to protect me and others from exposure to the virus, and I agree to comply with all such Facility requirements. I agree that I have advised the Facility personnel of any potential symptoms of COVID-19 I or anyone I live with is currently experiencing, as well as any known exposure to other persons who are believed to have the virus.

3. **Personal Property:** I understand that I am responsible for my personal property while at the Facility. The Facility is not responsible for keeping my property safe.

4. **Financial Assistance:** If I cannot afford my Facility medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Facility's plain language summary of its Financial Assistance Policy. The full policy and more information are available at www.christushealth.org/charitycare.

5. **Release of Information:** I allow the Facility to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Facility's Notice of Privacy Practices. I agree that all records about my treatment are the Facility's property. I understand that medical records and billing information created or maintained by the Facility are available to Facility workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.

6. **Medicare/Medicaid Benefits:** If applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.

7. **Communication:** I authorize the Facility (including any billing service, collection agency, agent, or contractor on the Facility's or contractor's behalf) to contact me by phone at any number that I have provided to the Facility at any time. The Facility may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Facility may use pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Facility may send me voicemail messages, text messages, or e-mails. I allow the Facility to contact me using any e-mail address that I have given it or any e-mail addresses that the Facility may obtain for me in the future.

_____Patient Initials

8. **Testing After Accidental Exposure and State Reporting:** If a healthcare worker accidentally touches my blood or other body fluids, state law allows the Facility to test me for certain diseases. These diseases include human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Facility is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or Centers for Disease Control.

9. **Photography:** I consent to the Facility videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for quality improvement, treatment or operations, or deidentified for medical education or research. I will talk with my doctor if I do not want my recordings used for these purposes.

10. **Ethics:** The Facility is a Catholic health ministry dedicated to helping the sick and injured in compliance with the *Ethical and Religious Directives for Catholic Health Facilities*. The Facility may not be used for procedures that violate the directives.

11. **Teaching and Observation:** I understand that the Facility may be a teaching facility. I consent to medical residents and fellows who have a formal affiliation with the Facility to participate in my care as supervised by the treating providers and permitted by Facility policy. Students, residents, and fellows and those from other non-affiliated programs, as well as vendors may observe my care consistent with Facility policy and as approved by my treating physician.

12. **Assignment of Benefits:** I hereby assign payment otherwise payable to me from governmental payers (such as Medicare), insurance carriers, employee health benefit plans and other third-party payers (collectively referred to as "Plans") to Facility and other health care providers who provide services, care or treatment to me at the Facility.

    I acknowledge that I am responsible for knowing the limitations of my Plan benefits and understand that I may be personally responsible for paying the charges billed for services, care or treatment that my Plan deems to be: (i) not a covered benefit; (ii) in excess of the Plan's benefit limitation; or (iii) not medically necessary, investigational or experimental.

The Facility will make a reasonable effort to verify my Plan's coverage for the services, care and treatment I expect to receive at the Facility and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and treatment provided to me by the Facility and its health care providers, I am responsible for paying the billed charges for such items, consistent with applicable law, applicable contractual discounts and the Facility's patient financial assistance policies. Upon request, an authorized Facility representative will be made available to explain eligibility for financial assistance under such policies.

If the Facility refers my account for collection, I will be responsible for paying the cost of collection, including reasonable attorneys' fees, expenses and interest as allowed by law.

Professional services rendered by independent physicians or healthcare professionals may not be part of the Facility bill. In many instances, there will be a separate charge for professional services you receive at the Facility, and you will receive a separate bill for these professional services in addition to the bill for Facility services. Please understand that you may not actually see or be examined by all physicians or healthcare professionals who participate in your care or provide services to you or on your behalf. For example, you may not see physicians providing radiology, pathology, and EKG interpretation.

_____Patient Initials

FACILITY CARE CONSENT

13. **Patient Rights and Advance Directives:** The Facility provided me a copy of the Patient Rights and Responsibilities when I arrived to the Facility. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Facility an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order, I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.

14. **Notice of Privacy Practices:** I have been offered a copy of the Facility's Notice of Privacy Practices at this or an earlier visit. The Facility will give me a copy of the Notice of Privacy Practices any time I ask for one.

15. **Insurance Information:** I have provided the Facility with complete and correct insurance information, which includes any primary, secondary, and tertiary insurance plan and any responsible party that could be responsible for payment of services provided by the facility. I have, to the best of my knowledge, communicated the appropriate filing order for all insurance plans and responsible parties provided.

16. **Health Information Exchange and Physician Messaging**: This provider participates in Health Information Exchanges (HIEs) and physician messaging. HIEs are electronic systems that allow health care providers to share information about patients. HIEs give information (like your allergies, medicines, and test results) from other doctors or Facilities to your current provider. The information may help your provider make more informed treatment decisions. The HIE also helps you receive efficient care because your health information is more easily available to providers when they need it. You have the right to choose if you want to participate in the HIE. Your information will be stored within the CHRISTUS HIE system, but it will not be visible to non-CHRISTUS providers unless you choose to participate. Your treatment is not conditioned on your decision. You can access medical care at CHRISTUS whether or not you participate in the HIE. You may change your decision at any time by notifying the Facility admitting staff and completing a new authorization form. Physician messaging is a CMS requirement that requires a Facility, if no objection is communicated by the patient, to advise a patient's primary care provider of any admission, transfer, or discharge into the facility via a direct messaging address that is established by the provider and provided to the facility for this purpose.

_____ **Yes, I authorize the release of my medical information through the Health Information Exchange and Physician Messaging.** I allow the HIE to share my health information. I understand this may include information created both before and after the date I sign this form. I understand that my medical records are confidential. They cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed by this authorization may be subject to re-disclosure to the extent permitted by applicable laws. I understand that my health information in the HIE may include: genetic information (including genetic test results), substance abuse records, mental illness records, or communicable disease status, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). OBSTETRIC PATIENTS ONLY: I authorize the HIE to include information about any child/children born to me during this hospitalization.

_____ **No, I do NOT authorize the release of my medical information through the Health Information Exchange or Physician Messaging.** I do not want my information to be shared through the HIE. I understand that my providers may have less information about me when making decisions about my care. If I decide to participate in the HIE at other participating providers, they will not receive information from CHRISTUS unless I submit a new copy of this form and authorize the release of my CHRISTUS medical information

TEXAS ONLY: Texas law requires all health care providers to notify patients that we must collect statistics on services performed by CHRISTUS. We submit that information to the Texas Healthcare Information Collection program. You cannot opt out of this data collection, but the data will not personally identify you. Additional information is provided to you on the *Texas Department of State Health Services Patient Notification of Data Collection* form or you may contact the State Department at 512-776-7261 or www.dshs.state.tx.us/thcic.

_____Patient Initials

CHRISTUS
SOUTHEAST TEXAS
Health System

Facility Care Consent

17. **Facility Directory:** Unless I object, the Facility will include my name, location in the facility (room number), and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to Facility) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Facility Directory.

(If you object, initial below.)

_____ I ***DO NOT*** want any information about me to be included in the Facility Directory. I understand that mail, flowers, telephone calls, and visitors will be refused on my behalf because Facility staff cannot acknowledge my presence in the Facility. If I make phone calls from the Facility, caller ID may show call recipients that I am calling from the Facility.

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient or I am the patient's legally authorized representative and/or guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

X_____ **X**_____

Signature of Patient/Legally Authorized Representative **Date**

X _____

Patient's Name Printed

_____

Name of Legally Authorized Representative (if not Patient) _____

Relationship to Patient

_____ _____

Facility Representative **Date**

_____ _____

Facility Representative (Secondary Witness if Needed) **Date**

CHRISTUS® SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*

MEDICAL & DIETITIAN APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for choosing The CHRISTUS Southeast Texas Bariatric Center. When you schedule an appointment with our office we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please See our Appointment Cancellation/No Show Policy Below:

Effective January 1, 2018 we will not be charging for the first time that you do not show up for an appointment or reschedule within 24 hours of the visit. **We understand that unforeseen events can make this necessary.**
Any patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $40.00 fee for physician visit or $20.00 for dietitian visit. **The fee is the patient's responsibility and can't be billed to your insurance company. It is due at the time of your next office visit.**

As a courtesy, our office uses an automated system for appointment reminders. If you don't confirm your appointment via the automated system we make reminder calls. We want to do everything possible to help you make it to your scheduled visit. It will help us tremendously if you can make sure that we are updated regarding any changes to your phone numbers or email.
If you reach a point during the process of working towards surgery that you are no longer able to continue, or simply do not wish to continue, please contact our program coordinator and she will make sure that you do not receive unwanted correspondence.

You may contact our office 24 hours a day, 7 days a week at the Number below. Should it be after regular business hours Monday through Thursday 8am-4pm, Friday 8am-12 noon, or a weekend, you may leave a message on the office voicemail system. Messages are checked daily, except on weekends.

Thank you,

CHRISTUS Southeast Texas Bariatric Center

I have read and understand the above policy _____ Date _____

3030 North Street, Suite 340 / Beaumont, TX 77702 / Tel 409-839-5673 / Fax 409-839-5699