Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
4100 Lake Otis Parkway, #302
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

2021

PATIENT INFORMATION FORM

PATIENT INFORMATION

NAME – LAST: _____ FIRST: _____ M.I.: ____

DATE OF BIRTH: _____ GENDER: (M) / (F) NICKNAME: _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS:_____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

PARENT/GUARDIAN/SPOUSE

RELATIONSHIP TO PATIENT_____

NAME – LAST: _____ FIRST: _____ M.I.: ____

DATE OF BIRTH: _____ GENDER: (M) / (F)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

PRIMARY MEDICAL INSURANCE

Date of Accident/Injury:_____ CARDS SCANNED_____

_____
(Primary Insurance Company Name) (ID#) (Group#)

_____
(Policy Holder Name) (INSURED Date of Birth)

SECONDARY MEDICAL INSURANCE

CARDS SCANNED_____

_____
(Secondary Insurance Company Name) (ID#) (Group#)

_____
(Policy Holder Name) (INSURED Date of Birth)

EMERGENCY CONTACT INFORMATION

_____
(Name) (Phone)

_____
(Relationship)

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
4100 Lake Otis Parkway, #302
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

AGREEMENT FORMS (please initial or sign as indicated)

- May we leave you a detailed message: At home? YES NO Cell? YES NO

- May Dr. Todd and other staff members include your patient information in text messages regarding your care, understanding that typical text messages are not HIPAA secure, To You YES NO
  With our office staff YES NO or other providers? YES NO
- May Dr. Todd and other staff members include your patient information in email messages regarding your care, understanding that typical email communications are not HIPAA secure, To You YES NO
- May we send a detailed appointment reminder information to your, Cell (voice message) YES NO
  Cell (Text Message) YES NO Email YES NO

Date Signed: _____Patient Printed Name: _____Signature of Patient: _____

NOTICE OF SOCIAL MEDIA POLICY

I, the undersigned am aware that any contact with Alaska Bariatric Center and its staff may be documented and included in my medical records. This includes but is not limited to; emails, text messages, and all other forms of social media.

Signature of Responsible Party: _____Date:_____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible part also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer.

Signature of Responsible Party: _____Date:_____

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.
I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.
I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.
I, authorize this office, and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.
I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Signature of Responsible Party: _____Date:_____

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
4100 Lake Otis Parkway, #302
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

AKNOWLEDGEMENT OF EMERGENT CARE PRIORITY POLICY (DR. TODD PATIENTS)

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. We request that you please be patient and courteous to our staff should your appointment be delayed, or rescheduled. Please bear in mind that you shall receive the same priority in service should you ever require emergent medical attention while under Dr. Todd's care.

Signature of Responsible Party: _____Date:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1.) Alaska Bariatric may disclose my health information to: _____
Relationship: _____

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

2.) Alaska Bariatric may disclose my health information to: _____
Relationship: _____

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

HIPAA AGREEMENT FORM

The Alaska Bariatric Center's **Notice of Privacy Practices** is available for your review either via our website (www.alaskabariatric.com) or our Facebook page. The Notice of Privacy Practices provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure.

I understand that I have been offered a copy of the Alaska Bariatric Center's Notice of Privacy Practices.

Signature of Responsible Party: _____Date:_____

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
4100 Lake Otis Parkway, #302
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

BILLING FORMS

NOTIFICATION OF NON-COVERAGE OR POSSIBLE NON-COVERAGE

- Telephone Visit *(99441-99443)*
  - Due to the Pandemic, most insurance companies are covering these visits with applicable copay. This includes Medicare, Medicaid and Tricare. However, this may change at any time. We encourage patients to verify with their insurance company for coverage and restrictions.
- Insurance Lifetime Maximum
  - It is possible for a covered procedure to have a lifetime maximum payable amount. In these cases, the patient is responsible for the remaining balance. We encourage patients to verify with their insurance company for coverage and benefits to avoid unforeseen patient expenses.
- Usual and Customary
  - Insurance companies have set allowable amount. If a patient's insurance company is not contracted with our office, the patient is responsible for any difference between insurance allowable and charges accrued.

PLEASE SIGN BELOW AFTER READING THE ABOVE INFORMATION. YOUR SIGNATURE ACKNOWLEDGES THAT YOU ARE AWARE THAT THESE SERVICES MAY OR MAY NOT BE COVERED BY YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT.

Signature: _____ Date:_____

Printed Name: _____

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
4100 Lake Otis Parkway, #302
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

PATIENT NOTICE OF BILLING PRACTICES

PLEASE READ, INITIAL WHERE INDICATED, AND SIGN BELOW.

Payments for medical services provided by Alaska Bariatric Center is due at the time of service. We accept cash, most credit cards, personal checks, and money orders. Payment in full at time of service is required when:

- You do not have insurance coverage
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A referral or prior authorization was not obtained.
- Any procedures or treatments we believe are not covered by insurance.

Patient responsibility:

(Initial)

____ Insurance coverage is not a guarantee of payment.

____ We will bill your insurance company as a courtesy, if you present your insurance card(s) at the time of your appointment.

____ Any co-payments or "patient responsibility" must be paid at the time of service.

____ Any remaining balance, after all applicable insurance payments have been applied, is due upon receipt of billing statement.

____ Prior to receiving a surgery date, your account balance must be paid in full.

____ If payment in full is not received within 90 days from the date of the first statement, your account may be turned over to cornerstone credit services.

____ Cancelled appointments require 24 hours' notice; otherwise they will be subject to a $25 charge.

____ If we do not receive response from your insurance company within 45 days from the date we bill them, then the balance will become patient responsibility.

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons may include, but are not limited to:

- Your deductible has not been met.
- You have not received the proper referral or preauthorization for the visit or procedure.
- The services or procedures are not covered by your insurance company. *We will inform you when we know a treatment/procedure will not be covered. Some insurance policies have exclusions for bariatric surgery. If there is any uncertainty about coverage, we would be happy to provide you with an estimate of your fees prior to treatment. You are responsible for all non-covered services at the time of your visit.*

We may choose to use an independent laboratory. If so, this lab will bill separately for these services. We will provide your insurance information to the lab so that they may file a claim with your carrier. The lab will then bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill. This also applies to any other testing we may order for you that is performed by another provider.

By signing my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them

Signature: _____ Date: _____

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
2841 Debarr Rd. Suite 22
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

MEDICAL HISTORY QUESTIONAIRE

Patient Name: _____ DOB: _____

Medications: _____
_____
_____
_____
_____
Herbs/Supplements: _____
_____
_____
Medication Allergies (specify reaction):
_____
_____
_____

Surgeries (Please include Date)

Tonsils _____ Thyroid _____
Appendix _____ Hernia _____
Gallbladder_____ Breast _____
Stomach _____ Uterus _ _____
Kidney _____ Ovaries_____
Colon _____ Prostate_____
Other:_____
_____
_____

Immunization (Indicate what year)

Tetanus _____
Measles/Mumps/Rubella _____
Influenza _____
Pneumonia (Prevnar) _____
Pneumonia (Pneumovax) _____
Hepatitis A _____
Hepatitis B _____
Shingles _____
Other: _____

Habits

Current smoker (packs/day) _____
Former smoker (date quit) _____
Chew (Times per week) _____
Alcohol (Drinks per week)_____
Other substance use _____
Caffeinated beverages (per day)_____
Exercise: Type _____
How many minutes per:
Day _____ Week: _____

Preventative Care

Colonoscopy: Year _____
Normal? Yes No
Pap: Year: _____
Normal? Yes No
Mammogram: Year _____
Normal? Yes No
DEXA scan: Year _____
Normal? Yes No

Family Health History (Which family member [sibling, parent, or child] AND age at diagnosis)

Diabetes _____
Heart Disease _____
High blood pressure _____
Obesity_____
Gout _____
Osteoporosis _____
Colon Cancer_____
Breast Cancer_____
Prostate Cancer_____
Other Cancer _____

Updated on:

Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____

Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____
Date: _____ Initials: _____

Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
2841 Debarr Rd. Suite 22
Anchorage, AK 99508
Phone (907)929-4263 Fax (907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

PERSONAL HEALTH HISTORY

General
- ☐ Tire easily/weakness
- ☐ Marked weight changes
- ☐ Night sweats
- ☐ Persistent fever
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Lumps/Masses felt

Neurological
- ☐ Alzheimer's Dementia
- ☐ Seizures or Epilepsy
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis

Skin
- ☐ Acne
- ☐ Cold sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Skin cancer or pre-caner

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Addiction to drugs
- ☐ Alcoholism
- ☐ Insomnia

Eye, Ear, Nose, & Throat
- ☐ Visual impairment
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Sinusitis, frequent
- ☐ Ear infections, frequent

Kidney
- ☐ Kidney failure
- ☐ Kidney stones

Lung and Respiratory
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Emphysema (COPD)
- ☐ Tuberculosis or positive PPD
- ☐ Chronic cough

Allergy, Immune
- ☐ Seasonal or environmental allergies
- ☐ Other non-medication allergies
  Specify: _____
- ☐ Anaphylaxis
- ☐ Urticaria (hives), frequent

Heart and Vascular
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Angina (cardiac chest pain)
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Atrial fibrillation
- ☐ Congestive heart failure

Endocrine
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Thyroid disorder
- ☐ Vitamin D deficiency
- ☐ Long term steroid treatment

Gastrointestinal
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Colon polyps
- ☐ Hemorrhoids
- ☐ Hepatitis (type) ___
- ☐ Irritable bowel syndrome
- ☐ Reflux disease (GERD)
- ☐ Ulcers (Stomach or Duodenal)

Genitourinary, STD, Reproductive
- ☐ Genital herpes
- ☐ Genital warts
- ☐ HIV/AIDS
- ☐ Prior Chlamydia or Gonorrhea
- ☐ Syphilis
- ☐ Infertility
- ☐ Erectile dysfunction
- ☐ Prostate enlargement (BPH)
- ☐ Endometriosis
- ☐ Menopause (age) ____
- ☐ Urinary tract infections, frequent
- ☐ Urinary incontinence
- ☐ Vaginal yeast or infections, frequent

Number of pregnancies _____
Number of live births _____
Miscarriages/abortions _____
Current method of birth control
_____

Musculoskeletal
- ☐ Back pain
- ☐ Gout
- ☐ Neck Pain
- ☐ Osteoarthritis (specify locations)

_____
- ☐ Rheumatoid arthritis

Cancers and Blood
- ☐ Anemia (low blood count)
- ☐ Blood clots (specify location)

_____
- ☐ Cancer (specify type)

_____
- ☐ Blood transfusion

Other Illness or Significant Injuries

_____
_____
_____