

Date: _____

PATIENT INFORMATION

Legal Name: _____
 Home Address: _____

 City, State, Zip: _____
 Employer: _____
 Occupation: _____
 Employer Tel #: (_____) _____
 City, State, Zip: _____

Social Security #: _____
 Age: _____ Date of Birth: _____
 Marital Status: _____ Sex: M F
 Home Phone: (_____) _____
 Work Phone: (_____) _____
 Cell Phone: (_____) _____
 Email Address: _____
 Emergency Contact Name: _____
 Emergency Phone: (_____) _____

INSURANCE INFORMATION

(Subscriber is the individual under whose name the family or individual is insured)

Primary Insurance: _____
 Subscriber Name: _____
 Subscriber Address: _____
 City, State, Zip: _____
 Subscriber Date of Birth: _____
 Subscriber Social Security #: _____
 ID #: _____
 Group #: _____

Secondary Insurance: _____
 Subscriber Name: _____
 Subscriber Address: _____
 City, State, Zip: _____
 Subscriber Date of Birth: _____
 Subscriber Social Security #: _____
 ID #: _____
 Group #: _____

PRIMARY CARE DOCTOR

Name: _____
 Address: _____
 City, State, Zip: _____

Tel: (_____) _____
 Fax: (_____) _____
 (For Office Use Only): _____

CONSENT TO RELEASE INFORMATION

By signing below, I as above, authorize _____ (relationship to patient _____) to communicate with the staff at The Institute for Advanced Bariatric Surgery (IABS) for routine maintenance of continuity of care. I understand IABS will continue to comply with HIPAA privacy practices.

PLEASE READ THE STATEMENT BELOW CAREFULLY

Dr. Paramjeet Sabharwal and Dr. Wanda Kaniewski will be referring me to Minimally Invasive Surgery Hospital (MISH) for surgery /procedures /admissions; I have been informed that Dr. Sabharwal and Dr. Kaniewski own and operate MISH, and that I am free to obtain weight loss surgery services and any other services at a hospital other than MISH. Understanding these things, I choose to have Dr. Sabharwal and Dr. Kaniewski perform these services at MISH. This information is important for me to understand so that I know I have a choice of doctors and hospitals. To learn how to obtain information about other options I can speak with the doctor or staff.

I hereby authorize release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier as per HIPAA privacy practices. Furthermore, I authorize payment directly to Dr. Kaniewski, Dr. Sabharwal or any Licensed Health Care Practitioner providing care or treatment to me at this office, the benefits otherwise payable to me for services as described. I am responsible for any amount not covered by insurance except that which is limited by contract between Dr. Kaniewski, Dr. Sabharwal or Licensed Health Care Practitioner and the insurer. I understand that Dr. Kaniewski, Dr. Sabharwal or any Licensed Health Care Practitioner reserves the right to bill finance charges at 1½% per month on patient balances unpaid after 60 days. In the event that my account is pleaded in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. I further agree that should any dispute arise out of any health care treatment provided by Dr. Kaniewski, Dr. Sabharwal or Licensed Health Care Practitioner, all disputes or lawsuits shall be exclusively pursued in the District Court of Johnson County, Kansas. A copy of this signature is valid as the original.

_____ Date

_____ Patient Signature

_____ Insured's Signature