

ATLANTA BARIATRIC MEDICINE DIET & WELLNESS CENTERS®

Non-Surgical Obesity Management & Wellness Medicine

Lonny E. Horowitz, M.D. - Medical Director

ABBM- Board Certified



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11912 Jones Bridge Road Alpharetta, GA 30005

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6330 Primrose Hill Court Suite 202 Norcross, GA 30092

Tel. (770) 393-3438

(770) 393-DIET

mod 3/12 Pt. History Questionnaire

Patient History Form

We are committed to the total care of our patients. Nutritional disorders are serious medical problems deserving professional medical treatment. This is an integral part of our treatment philosophy. Our principle concern is for your good health and long term success. All of our patients care is tailored to their particular needs and is guided by our commitment to safe, effective, and ethical medical care. Your body is a complex machine with vital interactions between organ systems. For these reasons we use the most sophisticated methods of laboratory analysis and treatment modalities available.

We are honored to have you as our patient. Please help us begin your assessment and treatment by completing this history form. Please answer all questions and sign or initial all of the noted spaces. If you have difficulty with any part of this questionnaire do not hesitate to ask for assistance.

Please complete all questions to your best ability and sign the appropriate pages
Please Print

Date - / / **2012**

Name: First _____ MI _____ Last _____

Address: _____ Phone: H- _____

Street _____ W- _____

City, Town _____ State _____ Zip _____ Cell- _____

Sex: M F Date of Birth- ____/____/____ Age _____ SS# ____/____/____

Marital Status: M S D/S W Occupation: _____

Email- _____

Health Insurance Carrier 1. _____ 2. _____

Insurance Carriers Address: _____

Health Insurance Telephone Number (____) _____ Group/Policy Number _____

Health Insurance Policy Holder: _____ Holders SS# ____/____/____

Relationship to policy holder: _____ Holders Date of Birth ____/____/____

Were you referred to our program by a physician? Y N Doctor's Name_____

If you were not referred to our office by a physician, how did you hear about us?

If you were referred to our program by another patient, please tell us their name so that we may thank them for the referral.

Please list a personal physician whom we may contact for pertinent medical information:

Name-_____ Specialty-_____

Phone-_____ Date Last Seen By Doctor-_____

How long have you had a problem with your diet?_____Yrs.

How much weight do you feel that you need to gain or lose?_____Lbs.

How much do you weigh now _____Lbs? How much do you want to weigh?_____Lbs.

What is your Height?_____'_____" What do you consider to be your frame size? S M L

Have you been to any other "diet" control program? Y N

Name of program_____ Dates_____

Was a physician present at your previous program? Y N

Physicians Name-_____

Have you **EVER** taken **REDUX** or **Phen Fen**? Y N

If yes when_____ How long?_____ Have you been evaluated for valve disease with an Echo Cardiogram? Y N If yes what were the results?_____

Name of Doctor who Prescribed Redux or Phen Fen_____

Why did you stop attending your previous program?_____

Have you successfully controlled your eating and weight in the past? Y N

Have you had a significant weight loss in the past? Y N How much?_____Lbs.

Have you had a significant weight gain in the past? Y N How much?_____Lbs.

At what times are you most hungry?_____

Please list **all** of your **allergies to medications, foods, or any other substance:**

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Please list **all medications non-prescription or prescription** you have taken during the last 30 days:

1. _____ 4. _____ 7. _____ 10. _____

2. _____ 5. _____ 8. _____ 11. _____

3. _____ 6. _____ 9. _____ 12. _____

Are you currently or have you ever been treated with an MAO (mono amine oxidase) inhibitor? Y N
(antidepressant drugs such as: Parnate, Nardil, etc.)

If yes name of medication: _____ Date started _____

Date stopped _____

Past Hospitalizations (dates and reason for admission): _____

Major or severe illnesses (what and when): _____

Past Surgery (please list procedures and dates): _____

Please Mark Y = Yes answers

N = No answers

S = "Sometimes"

Do you have ?...

Bleeding Gums.. _____

Backaches..... _____

Coarse Hair _____

Palpitations..... _____

Dental Infections.. _____

Weakness..... _____

Sore Muscles..... _____

Chest Pain..... _____

Sore Mouth..... _____

Slow healing sores _____

Shortness of

Sinus Trouble..... _____

Stretch Marks.... _____

Breath..... Y

Lung Problems.. _____

Easy Bruisability _____

N

Have you ever had
an EKG?.....Y N

Chronic Cough... _____

Skin Rash..... _____

w/o exercise?..Y N

*Allergies..... _____

Leg Cramps..... _____

Headaches

When?..... _____

*from Medicine _____

Dizziness..... _____

(Migraine)..... _____

Results?... _____

*from Food..... _____

Fainting Spells... _____

Nosebleeds..... _____

*other..... _____

Tiredness..... _____

High Blood

Hay Fever..... _____

Dry Palms..... _____

Pressure..... _____

Asthma..... _____

Moist Palms..... _____

Low Blood Pressure...

Itchy Skin/Rash.. _____

Excessive

Swollen Hands... _____

Sweating.... _____

Heart Trouble.... _____

Arthritis..... _____

Brittle nails..... _____

Fast Pulse..... _____

Rheumatism..... _____

Hair Loss..... _____

Irregular Heart... _____

Please Mark Y = Yes answers

N = No answers

S = "Sometimes"

Do you have swollen legs or ankles?.... _____
 AM or PM?..... _____
 Painful or frequent urination?..... _____
 Kidney Trouble..... _____
 Tumor or Cancer?... _____
 Poor Digestion..... _____
 Bloating..... _____
 Gall Stone Trouble... _____
 Ulcers..... _____
 Heartburn..... _____
 Stomach pain:
 before meals..... _____
 after meals..... _____
 with solid food... _____
 with liquids..... _____
 from medications... _____
 Poor Bowel Action... _____
 Chronic loose stool... _____
 Chronic Constipation... _____
 Rectal pain..... _____
 Rectal Bleeding... _____
 Hemorrhoids..... _____
 Spells of exhaustion and fatigue?..... _____
 Tired and exhausted every AM?..... _____
 Are you often too tired to eat?..... _____
 Does working tire you out completely?.... _____
 Does nervous exhaustion run in your family?.. _____
 Have you ever had:
 A nervous Breakdown... _____
 Nervousness..... _____
 Shaking..... _____
 Trouble Sleeping... _____
 Have you been hospitalized for an emotional illness _____

 Women:
 Do you Menstruate... _____
 If not year stopped... _____
 Are you currently pregnant..... _____
 Days between periods... _____
 Flow is how long?... _____
 Scanty..... _____
 Heavy..... _____
 Cramping?..... _____
 (Women Continued...)

Do you take Birth Control Pills?... _____
 Do you have PMS?... _____
 Do you have headaches with your periods?... _____
 Before Period..... _____
 After Period..... _____
 Hot Flashes..... _____
 Miscarriages..... _____
 Children..... _____
 Ages..... _____

 Men:
 Do you have problems with impotence? _____
 Have you had prostate problems? _____
 Last prostate exam date _____

 (Males and Females)
 Are you now taking:
 Hormones..... _____
 Pain Medicine..... _____
 Cortisone/Steroids... _____
 Cold Medicines..... _____
 Heart Medicine..... _____
 Stomach Medicine... _____
 Water Pills..... _____
 Nerve Medicine..... _____
 Vitamins..... _____
 Laxatives..... _____
 Other Medication... _____
 Have you ever taken:
 Thyroid Medicine... _____
 Cortisone..... _____
 Barbiturates..... _____
 Tranquilizers..... _____
 Amphetamines..... _____
 Antidepressants... _____
 MAO Inhibitors.... _____

 Is or was your:
 Father Obese..... _____
 Mother Obese..... _____
 Your weight at:
 16 years old..... _____
 20 years old..... _____
 30 years old..... _____

Amount gained/lost during the last 3 mths.... _____
 the last 6 mths.... _____
 Diet problems started at age?..... _____

 Weight control in the past has been successful with:
 Diet control alone Y N
 Medication?... _____
 If yes what medication? _____

 What Year..... _____
 When did weight return or come back off?... _____
 Can you lose or gain without medication?... _____
 Do you eat?
 Breakfast... _____
 Lunch... _____
 Dinner... _____
 Between Meals..... _____
 After Bedtime..... _____
 In the Night..... _____
 Do you drink:
 Milk..... _____
 Tea..... _____
 Coffee..... _____
 Soft Drinks..... _____
 Alcoholic Beverages... _____
 Beer..... _____
 Wine..... _____
 Fruit Juice..... _____
 Water..... _____
 Number of glasses of fluid you drink daily.... _____
 What time do you:
 Awaken..... _____

 Eat Breakfast _____

 Start Work... _____

 Eat Lunch... _____

 Finish Work... _____

 Eat Supper... _____

 Go to sleep... _____

Breast Exam Questionnaire

(please ignore if you are male unless you have had a history of breast disease)

It is our policy to be as comprehensive as possible with the care of our patients. Obesity has been found to be a risk factor increasing a woman's likelihood of developing breast cancer and disease. For this reason we routinely perform a breast exam on our female patients as part of their initial physical examination regardless of when their last exam took place.

1. Have you ever had a **Breast Operation** ? Y N If yes, please give us the date, place and diagnosis:

2. Has any close family member had Cancer of the Breast? Y N If yes, please give us the relationship:

3. Have you been told by a doctor that you have fibrocystic breast disease? Y N

4. Do you take Birth control or Hormone Replacement Medications? Y N

5. Do you smoke cigarettes Y N if so, how many? _____

6. Do you drink coffee or tea? Y N if so how much? _____

7. Were you at age 12 or under when your menstruation began? Y N Age _____

8. Have your menstrual periods persisted after age 54 ? Y N

9. Have you ever carried a pregnancy to term (9 months) ? Y N have you had more than 4 term pregnancies ? Y N

10. Were you over age 30 with your first pregnancy ? Y N

11. Have you ever taken hormone (Estrogen) replacement therapy ? Y N

12. Have you been instructed to perform breast self examination ? Y N

13. Do you examine your breasts monthly ? Y N

14. Have you ever had a breast mammogram ? Y N If so date of last mammogram _____

15. Do you understand that it is recommended that you have a yearly breast exam ? Y N

16. Do you understand that very tiny breast cancers may not be felt by your doctor and that is why repeat examinations are necessary ? Y N

17. Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on X-Ray? Y N

18. Do you have pain in your breasts ? Y N If so which breast, and does the pain come and go with monthly periods ? _____

19. Do you have a discharge from your nipple(s) ? Y N If so, which breast and is the fluid clear or bloody? _____

20. Have your breasts changed in size or shape recently ? Y N

21. Do you feel a definite "lump" in your breast ? Y N If so, where ? _____

23. Would you describe your breasts as generally "lumpy" ? Y N

Although I realize the inherent risks **I hereby refuse** to have a Breast Exam be performed:

Patient's Signature

Coronary and Diabetes Risk Data

A. Family history of heart disease (check correct answer)

- 1. 3 Relatives with heart disease before 60 years of age.
- 2. 2 Relatives with heart disease before 60 years of age.
- 3. 1 Relative with heart disease before 60 years of age.
- 4. 2 Relatives with heart disease after 60 years of age.
- 5. 1 Relative with heart disease after 60 years of age.
- 6. You have no family history of heart disease.
- 7. You do not know your family history of heart disease.

B. Personal History of Heart Disease

- 1. You have had or have been diagnosed to have heart disease.
- 2. You have never had heart disease.

C. Family History of Diabetes (answer only one)

- 1. You have diabetes that began before age 20.
- 2. You have diabetes that began between the ages of 20 and 60.
- 3. You have diabetes that began after the age of 60.
- 4. You have 2 relatives with diabetes.
- 5. You have one relative with diabetes.
- 6. You have no family history of diabetes.
- 7. You do not know your family history of diabetes.

D. Smoking Habits (answer only one)

- 1. You have never smoked cigarettes, cigars or a pipe.
- 2. You have quit smoking at least one year ago or now smoke a pipe or cigar without inhaling.
- 3. You have quit smoking cigarettes within one year or smoke less than 10 cigarettes per day.
- 4. You smoke one pack of cigarettes per day (20).
- 5. You smoke one and one half packs of cigarettes per day (30).
- 6. You smoke two packs of cigarettes per day (40).

E. Activity Level (answer only one)

- 1. Inactive- no regular physical activity with a sit down job.
- 2. Light Activity- no organized physical activity during leisure time with 3 to 4 hours of walking or standing per day.
- 3. Moderate Activity- occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- 4. Heavy Activity- consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling, or active sports at least three times per week.
- 5. Vigorous Activity- participation in extensive physical exercise for at least 60 minutes per session 4 or more times per week.

F. Behavior Style (answer only one)

- 1. You are always calm and easygoing.
- 2. You are usually calm and easygoing.
- 3. You are frequently calm with frequent impatience.
- 4. You are seldom calm and persistently driving for advancement.
- 5. You are never calm and have overwhelming ambition.
- 6. You are hard driving and never relax.

A number of risk factors are associated with an increased chance of developing coronary heart disease. Research has shown that the prediction of heart disease can be made well in advance of symptoms based on the answers to the personal risk profile you have just completed. This information with your physical examination and blood chemistry results will assist us in determining your general health profile and relative risk of cardiac disease.

Binge Eating Disorder Questionnaire

Due to recent research findings there are some interesting new approaches to the treatment of people who suffer from **BED** (Binge Eating Disorder). Please answer the following questions with the first answer that comes to mind. We are seeking your initial response, not a thought out answer.

1. Do you have an uncontrollable urge to eat more food in a short period of time (within any two hour period of time) excessive amounts of food more than most people would eat and feel satisfied? Y N
2. Do you feel a loss of control over how much food you consume during a particular eating period? Y N
3. Do you eat until you feel uncomfortably full? Y N
4. Do you find that you eat large amounts of food even when you are not particularly hungry? Y N
5. Do you sneak eat? (Eat alone because you feel embarrassed that you eat too much?) Y N
6. Do you purge after "overeating" by excessively exercising, vomiting or taking laxatives/enemas? Y N
7. Do you feel depressed or guilty after overeating? Y N
8. Do you overeat at least two days a week for the last six months? Y N

Depending on how you answered these questions you may have **BED** and be eligible for treatment specific for this disorder. Leading edge research is now under investigation with some very exciting and promising results.

Score -----/8

Patient Treatment Agreement & Consent

The programs on which you are placed are **NOT INTENDED OR SAFE FOR GENERAL USE**. They may be damaging and possibly fatal if given to unsupervised individuals. We assume **no responsibility** for the safety of persons who are **not under our current patients and under our direct supervision and care**. This **includes** spouses, children, family members, and all others not directly under the doctor's immediate and recent supervision. By signing this document you acknowledge and freely give your informed consent to be treated and examined by Dr. Horowitz and his staff. If you develop a **Medical Emergency** you can reach the doctor on call by calling **(404)609-1084**. This is a 24 hour emergency paging service. Dr. Horowitz or another qualified physician is always available to return emergency calls.

Please note that **all treatment plans given to you** by this office **remain the property of L. E. Horowitz, M.D.** These treatment plans must be **returned** to this office upon the completion of the specific phase of treatment for which it was provided. All printed information is **loaned** to our patients and is intended for the exclusive use of that particular patient. A charge of \$50.00 will be made for lost programs or failure to return same. **Use of any information given to our patients, by any individual other than the specific individual to whom it was issued, shall be viewed as theft of services and copyright infringement.** Violation of the aforementioned shall be prosecuted to the fullest extent of federal and state law. **This is for your protection. Don't share your treatment programs with anyone!**

The number of patients we see is limited each day and is by appointment only. If you are unable to keep your appointment you **must inform our office 24 hours** ahead of time to or be charged for the visit. Appointment time is reserved **for you**. Failure to inform us of your inability to keep your appointment incurs additional expense and inconvenience to our staff and to other patients. Please note that this policy is strictly enforced and that **your signature below serves as both acknowledgment and acceptance of this policy.**

Your signature below confirms your understanding of our office policies outlined above and serves as your authorization for our us to release your medical records to your health insurance company for reimbursement purposes. You and/or your insurance carrier will be billed for any additional expenses incurred in providing information for reimbursement of your medical claims. **You will be billed** for all additional medical records, summaries, correspondences or information that you request be forwarded to any other physician, insurance company, individuals or institutions. Payment for these copies must be received prior to these documents being sent.

This document serves as authorization for our office to submit charges directly to your insurance carrier for reimbursement of your laboratory and diagnostic studies. In the event that your health care insurance does not permit direct payment of benefits to the provider your signature will act as your authorization to mail these payments to our office in your name. **Please remember that you are ultimately responsible for all fees incurred in your treatment** including all co-payments, deductibles, as well as **any outstanding balances**. Outstanding balances carried for more than 90 days will incur additional finance charges as permitted by law and be directly billed to your credit card on file. Unless other specific written arrangements are made with our office **you will be responsible** to pay your balance and obtain any additional reimbursements due to you directly from your insurer.

Your signature **does not** serve as an authorization to release copies of your medical records to you or any party other than those listed above. Specific written authorization for release of medical records must be on file in our office before any of your medical record will be released to anyone other than your insurance carrier. Again, you are responsible for all charges incurred regarding **all copies** of records as well as any additional summaries, statements, letters of medical necessity, or any other administrative or medical information requested by you, your insurance company, or any other party. Any additional expenses incurred in the process of collecting payments for services rendered to you is yours/the patient's responsibility.

Thank you for your time and patience in filling out this questionnaire. We are happy to have you as our patient. Feel free to add additional comments to the back of this page.

If you are under 21 years of age the signature of a parent or legal guardian must accompany your signature for your treatment to be initiated.

Patient's Signature _____ Date _____/2012

Witnessed By _____ Date _____/2012

Office Policies and Guidelines

It is impossible for us to keep track of the individual requirements of all of the health insurance plans to which our patients belong. Each plan has different stipulations regarding it's policies. Some insurance companies have PPO, HMO, POS, or indemnity plans and it is possible that we may participate in one of these areas but not all.

It is your responsibility to furnish Lonny E. Horowitz, M.D. with correct insurance information and/or obtain a proper referral prior to your office visit. Regardless of your insurance carrier, you are ultimately responsible for payment of your balances. It is your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending upon your individual policy.

In the event that:

- 1) insurance coverage is not in effect because we are not a participating physician in your plan;
- 2) insurance coverage is not in effect on the date of your visit;
- 3) a non-covered lab test is ordered / performed;
- 4) a non-covered service is performed or denied by your plan as "not medically necessary" or "out of the usual and customary fee"

We will charge you directly for all fees related to your care.

Initials	Item #	Policy
	1	Emergencies: Our office will make every effort to receive your calls and respond promptly in an emergency. If you do not receive and immediate response you will call 911, receive paramedic intervention and seek the nearest emergency room.
	2	Prescription Refills: It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications will be refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, after hours, or phone call prescription refill requests.
	3	Telephone encounters and sick patients: We do not treat new patients or new illnesses over the telephone. The doctor may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the phone. Such consultations are provided at a fee of \$35. Most insurance companies do not cover the costs for these encounters. Payment for these services is your responsibility.
	4	Information: You agree to provide and update as appropriate your correct name, current and correct address, cellular or other phone number, email address, insurance information, Social Security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.
	5	Financial responsibility: By these initials and your signature below, you accept financial responsibility for all charges rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.
	6	Payment methods: We accept cash, check and several major credit cards. Our staff may be contacted regarding credit cards accepted.
	7	Appointments: Our office will schedule appointments as a common courtesy and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of \$68 will be charged for non-cancelled and missed appointments. A pattern of missed appointments may result in discharge from our practice.
	8	Forms fees: Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: (a) duplicate prescriptions, orders or referrals - \$25; (b) single page forms- \$25; (c) multi-page forms \$50. Additional fees may apply at the discretion of the practice and upon notification to you.
	9	Medical records: The medical chart is the property of the practice. However copies of your pertinent medical information are available on request and are subject to a minimum fee of \$35. This fee is due prior to records being released and must be accompanied by a signed medical record release letter.
	10	Insurance copayments, deductibles and coinsurance: Insurance companies do not pay all fees and may exclude certain services and fees from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or noncovered services are to be paid in accordance with office policies. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.
	11	Usual and customary: Some insurance plans may indicate that our fees are above the "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, you accept full responsibility for and will be liable for our full fees.
	12	Slow insurance response: You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your unpaid services to be your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company. A late fee may be charged for patient balance due that are more than 30 days old.
	13	Collection and bank fees: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that are returned or cannot be cashed. You agree to be liable for all such fees with a minimum charge of \$35.
	14	Patient discharge: This practice reserves the right to discharge a patient for any reason. Please note that discharge may occur for failure to meet your obligations under this document. In addition, because of quality of care considerations, this practice may discharge you for failure to comply with treatment plan(s) as directed by the doctor.
	15	Insurance claims: If applicable, our office will submit insurance claims as a courtesy. You allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event that the payment for a claim for services unpaid by the patient is sent to you directly, you agree to endorse the payment over to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all of the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signed _____

Date _____/2012

*Atlanta Bariatric Medicine
Diet & Wellness Centers*

Lonny E. Horowitz, M.D. - Medical Director

7914 HWY 92 SUITE 110 WOODSTOCK, GA 30189

TEL. 770 393-3438

General Consent Form -

Patient Name: _____

A. Consent for medical treatment:

The undersigned hereby authorizes Dr. Horowitz and his staff to examine and furnish the patient named above with all treatments, obtain all laboratory tests, and provide drugs and supplies as Dr. Horowitz may deem necessary. This also acts as consent for the medical treatment of a minor when signed and witnessed below by a legal guardian and the minor child.

B. Authorization for release of medical information:

Authorization is hereby granted for Dr. Horowitz and/or his staff to release to the undersigned individual's insurance company or companies, their agents or other third party payers, all confidential information (including copies of confidential medical/mental health records) as may be requested or necessary for the completion of claim processing relative to my treatment.

C. Assignment of insurance benefits:

The undersigned authorizes the direct payment of fees due Dr. Horowitz for services rendered, by the undersigned and or my insurance carrier or carriers. I understand that I am financially responsible for charges not covered by this assignment of insurance benefits including all deductibles and co-payments.

Date

_____/_____
Patient
Legal Guardian

Time

Staff

Witnessing

**Atlanta Bariatric Medicine
Diet & Wellness Centers**
Lonny E. Horowitz, M.D. - Medical Director

7914 HWY 92 SUITE 110 WOODSTOCK, GA 30189

TEL. 770 393-3438

Diagnostic and Laboratory Testing Fees

June 6, 2007

To effectively and safely treat our patients we require that all of our patients undergo a number of diagnostic procedures and clinical laboratory tests. These examinations will be performed on you and the blood and urine specimens obtained from you during your initial visit to our office. If you have these tests performed off site or by another provider you will still be charged an interpretation fee as well as a consulting fee if additional tests need to be ordered or obtained from another provider.

Routine blood tests as well as urine screening are performed on all patients seen in our office. Some of these tests will be repeated every four months while under active treatment, others may only be performed once or may be repeated as you enter into the maintenance phase of treatment.

The following is a list of fee ranges for the various procedures and tests you will likely undergo. Please note that all of these fees are subject to change as a result of changes in our cost for each test.

<u>CPT Code</u>	<u>Description</u>	<u>Fee Range</u>
80019	Blood Chemistry Profile	\$50.00 - \$120.00
81000	Urinalysis	14.00 - 26.00
82977	Liver GGT Levels	20.00 - 40.00
84436	Thyroid T4 RIA	23.00 - 41.00
84443	Thyroid Stim. Hormone (TSH)	59.00 - 71.00
84479	Thyroid T3 Levels	23.00 - 41.00
83718	HDL Cholesterol Levels	23.00 - 35.00
83720	LDL Cholesterol Levels	35.00 - 42.00
84375	Serum Fructose Levels	15.00 - 18.00
84478	Triglycerides	23.00 - 35.00
82465	Cholesterol- Serum Total	23.00 - 32.00
80006	Serum Electrolyte Levels	26.00 - 32.00
95925	Somatosensory Testing (DM Screen)	271.00 - 540.00
94010	Spirometry	65.00 - 75.00
94010	Respiratory Flow Vol. Loop	40.00 - 50.00
80061	Cardiac Risk Profile/ Lip-Adi Rate	97.00 - 117.00
83036	Hemoglobin A _{1c}	40.00 - 50.00
85025	Complete Blood Count CBC w/Diff & Plts.	22.00 - 28.00

Note- All fees were determined to be within the usual and customary charges as determined by HIAA (Health Insurance Association of America.) Prevailing Medical Healthcare Charges approved by the Health Insurance Association of America for zip codes beginning with 300-303, 306, and 311 as of 05/30/89.

As a convenience to our patients we bill your health insurance carrier directly for the procedures/charges noted above. Some of these tests will be performed during your initial visit and again at four month intervals during your treatment. You will be responsible for all deductibles, co-payments or outstanding balances owed on your account. By initialing below you acknowledge this and consent to our performing these tests and processing your claim.

_____/_____
Patient Initials

Date

Staff Member (Witness)

Atlanta Bariatric Medicine Diet and Wellness Centers



Lonny E. Horowitz, M.D. -ABBM Board Certified

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6330 Primrose Hill Court Suite 202 Norcross, GA 30092

TEL. (770) 393-DIET - (770) 393-3438
FAX (770)-888-5437
dietmd@bariatrics.com
www.bariatrics.com

To all of our patients:

As we are sure you realize health insurance policies have dramatically changed over the past few years. Deductibles, reimbursement terms as well as provider status have all changed. As a result of these changes we are forced to make changes to several of our general office business policies.

We are no longer be able to provide general medical care without an additional charge. As an example, treatment for a cold or sinus infection will incur an additional charge which will be billed at the time of your office visit. We will make every effort to keep these charges in line with those of other general medical practices. Please note that these fees will be added to your routine visit.

All prescriptions and refills must be written for you during your office visit. We will no longer fill prescriptions by phone unless it is a medical emergency. There will be a telephone consultation fee of \$35.00 for all telephone prescription refills, pharmacy inquiries or calls requiring our being called by our answering service unless it is a medical emergency. Emergency medical care at night, on weekends or times other than normal office hours will not be subject to these charges.

Managed care has greatly affected your choices for laboratory testing. If you chose to use a laboratory other than ours to have lab work performed you will be charged an \$75.00 interpretation fee. This applies to all laboratory or diagnostic testing done in another doctors office or lab.

All correspondence and medical information we provide to insurance companies, doctors offices, and non-medical facilities will incur a minimum charge of \$35.00. This must be paid before any letters or information will be sent. Extra letters and provided to your insurance companies including explanations of medical necessity provided to your insurance carrier for reimbursement will all be subject to these charges.

Unfortunately, current medical insurance policies have required us to strictly limit the acceptance of co-payments for office visits and fees. As before, at your request we will provide you with a full statement of services. You will be able to file this with your particular insurers form for insurance reimbursement. We will expect that your fees will be paid in full at the time of your visit. We realize this will be a financial burden to some and in rare cases exceptions may be made however, delays in our collection of outstanding insurance balances has made this absolutely necessary. Balances outstanding for more than 90 days will be subject to additional finance charges as allowed by law and charged to your credit card on file.

Additionally, missed/late appointments without 24 hour notification are a major problem. We make every effort to accommodate appointment changes, however, you must call and confirm appointment changes or you will be charged for the visit. Every patient in our practice has signed an agreement with this policy when they first started their treatment and is a common practice to most medical offices. Though we recognize that emergencies occur the great majority of missed appointments are not due to emergent circumstances. It has never been our desire to enforce this policy but will if this becomes a frequent occurrence for you. We simply cannot tolerate this behavior.

We are sorry that these policies have become necessary. After 26+ years caring for our patients we continue to make your success and health our primary objective. We will continue to make every effort and provide you with the best care possible.

Sincerely,

Lonny E. Horowitz, M.D.

_____ Date ____/____/2012

Patient's Signature

Office Policies and Guidelines

It is impossible for us to keep track of the individual requirements of all of the health insurance plans to which our patients belong. Each plan has different stipulations regarding its policies. Some insurance companies have PPO, HMO, POS, or indemnity plans and it is possible that we may participate in one of these areas but not all.

It is your responsibility to furnish Lonny E. Horowitz, M.D. with correct insurance information and/or obtain a proper referral prior to your office visit. Regardless of your insurance carrier, you are ultimately responsible for payment of your balances. It is your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending upon your individual policy.

In the event that:

- 1) insurance coverage is not in effect because we are not a participating physician in your plan;
- 2) insurance coverage is not in effect on the date of your visit;
- 3) a non-covered lab test is ordered / performed;
- 4) a non-covered service is performed or denied by your plan as "not medically necessary" or "out of the usual and customary fee"

We will charge you directly for all fees related to your care.

Initials	Item #	Policy
	1	Emergencies: Our office will make every effort to receive your calls and respond promptly in an emergency. If you do not receive and immediate response you will call 911, receive paramedic intervention and seek the nearest emergency room.
	2	Prescription Refills: It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications will be refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, after hours, or phone call prescription refill requests.
	3	Telephone encounters and sick patients: We do not treat new patients or new illnesses over the telephone. The doctor may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the phone. Such consultations are provided at a fee of \$35. Most insurance companies do not cover the costs for these encounters. Payment for these services is your responsibility.
	4	Information: You agree to provide and update as appropriate your correct name, current and correct address, cellular or other phone number, email address, insurance information, Social Security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.
	5	Financial responsibility: By these initials and your signature below, you accept financial responsibility for all charges rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.
	6	Payment methods: We accept cash, check and several major credit cards. Our staff may be contacted regarding credit cards accepted.
	7	Appointments: Our office will schedule appointments as a common courtesy and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of \$68 will be charged for non-cancelled and missed appointments. A pattern of missed appointments may result in discharge from our practice.
	8	Forms fees: Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: (a) duplicate prescriptions, orders or referrals - \$25; (b) single page forms- \$25; (c) multi-page forms \$50. Additional fees may apply at the discretion of the practice and upon notification to you.
	9	Medical records: The medical chart is the property of the practice. However copies of your pertinent medical information are available on request and are subject to a minimum fee of \$35. This fee is due prior to records being released and must be accompanied by a signed medical record release letter.
	10	Insurance copayments, deductibles and coinsurance: Insurance companies do not pay all fees and may exclude certain services and fees from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or noncovered services are to be paid in accordance with office policies. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.
	11	Usual and customary: Some insurance plans may indicate that our fees are above the "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, you accept full responsibility for and will be liable for our full fees.
	12	Slow insurance response: You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your unpaid services to be your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company. A late fee may be charged for patient balance due that are more than 30 days old.
	13	Collection and bank fees: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that are returned or cannot be cashed. You agree to be liable for all such fees with a minimum charge of \$35.
	14	Patient discharge: This practice reserves the right to discharge a patient for any reason. Please note that discharge may occur for failure to meet your obligations under this document. In addition, because of quality of care considerations, this practice may discharge you for failure to comply with treatment plan(s) as directed by the doctor.
	15	Insurance claims: If applicable, our office will submit insurance claims as a courtesy. You allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event that the payment for a claim for services unpaid by the patient is sent to you directly, you agree to endorse the payment over to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all of the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signed _____

Date _____/2012

Patient's Copy

Diagnostic and Laboratory Testing Fees

June 6, 2007

To effectively and safely treat our patients we require that all of our patients undergo a number of diagnostic procedures and clinical laboratory tests. These examinations will be performed on you and the blood and urine specimens obtained from you during your initial visit to our office. If you have these tests performed off site or by another provider you will still be charged an interpretation fee as well as a consulting fee if additional tests need to be ordered or obtained from another provider.

Routine blood tests as well as urine screening are performed on all patients seen in our office. Some of these tests will be repeated every four months while under active treatment, others may only be performed once or may be repeated as you enter into the maintenance phase of treatment.

The following is a list of fee ranges for the various procedures and tests you will likely undergo. Please note that all of these fees are subject to change as a result of changes in our cost for each test.

CPT Code	Description	Fee Range
80019	Blood Chemistry Profile	\$50.00 - \$120.00
81000	Urinalysis	14.00 - 26.00
82977	Liver GGT Levels	20.00 - 40.00
84436	Thyroid T4 RIA	23.00 - 41.00
84443	Thyroid Stim. Hormone (TSH)	59.00 - 71.00
84479	Thyroid T3 Levels	23.00 - 41.00
83718	HDL Cholesterol Levels	23.00 - 35.00
83720	LDL Cholesterol Levels	35.00 - 42.00
84375	Serum Fructose Levels	15.00 - 18.00
84478	Triglycerides	23.00 - 35.00
82465	Cholesterol- Serum Total	23.00 - 32.00
80006	Serum Electrolyte Levels	26.00 - 32.00
95925	Somatosensory Testing (DM Screen)	271.00 - 540.00
94010	Spirometry	65.00 - 75.00
94010	Respiratory Flow Vol. Loop	40.00 - 50.00
80061	Cardiac Risk Profile/ Lip-Adi Rate	97.00 - 117.00
83036	Hemoglobin A1C	40.00 - 50.00
85025	Complete Blood Count CBC w/Diff & Plts.	22.00 - 28.00

Note- All fees were determined to be within the usual and customary charges as determined by HIAA (Health Insurance Association of America.) Prevailing Medical Healthcare Charges approved by the Health Insurance Association of America for zip codes beginning with 300-303, 306, and 311 as of 05/30/89.

As a convenience to our patients we bill your health insurance carrier directly for the procedures/charges noted above. Some of these tests will be performed during your initial visit and again at four month intervals during your treatment. You will be responsible for all deductibles, co-payments or outstanding balances owed on your account. By initialing below you acknowledge this and consent to our performing these tests and processing your claim.

_____/_____
Patient Initials Date

Staff Member (Witness)

Patient's Copy

Patient Treatment Agreement & Consent

The programs on which you are placed are **NOT INTENDED OR SAFE FOR GENERAL USE**. They may be damaging and possibly fatal if given to unsupervised individuals. We assume **no responsibility** for the safety of persons who are **not current patients or under our direct supervision and care**. This includes spouses, children, family members, and all others not directly under the doctor's immediate and recent supervision. By signing this document you acknowledge and freely give your informed consent to be treated and examined by Dr. Horowitz and his staff. If you develop a **Medical Emergency** you can reach the doctor on call by calling **(404)609-0884**. This is a 24 hour emergency paging service. Dr. Horowitz or another qualified physician is always available to return emergency calls. In the event that you cannot contact Dr. Horowitz immediately please dial 911 and/or go to the nearest emergency room for care.

Please note that **all treatment plans given to you** by this office **remain the exclusive property of Lonny E. Horowitz, M.D.** These treatment plans must be **returned** to this office upon the completion of the specific phase of treatment for which it was provided. All printed information is **loaned** to our patients and is intended for the exclusive use of that particular patient. A charge of \$50.00 will be made for lost programs or failure to return same. **Use of any information given to our patients, by an individual or group other than the specific individual to whom it was issued, shall be viewed as theft of services and copyright infringement. Violation of the aforementioned shall be prosecuted to the fullest extent of federal and state law. This is for your protection. **Don't share your programs with anyone!****

The number of patients we see is limited each day and is by appointment only. If you are unable to keep your appointment you **must inform our office 24 hours** ahead of time to or be charged for the visit. Appointment time is reserved for you. Failure to inform us of your inability to keep your appointment incurs additional expense and inconvenience to our staff and to other patients. Please note that this policy is strictly enforced and that **your signature below serves as both acknowledgment and acceptance of this policy.**

Your signature below confirms your understanding of our office policies outlined above and serves as your authorization for our us to release your medical records to your health insurance company for reimbursement purposes. You and/or your insurance carrier will be billed for any additional expenses incurred in providing information for reimbursement of your medical claims. **You will be billed** for all additional medical records, summaries, correspondences or information that you request be forwarded to any other physician, insurance company, individuals or institutions regardless of intended purpose for their use. Payment for these copies must be received prior to these documents being sent.

This document serves as authorization for our office to submit charges directly to your insurance carrier for reimbursement of your laboratory and diagnostic studies. In the event that your health care insurance does not permit direct payment of benefits to the provider your signature will act as your authorization to mail these payments to our office in your name. **Please remember that you are ultimately responsible for all fees incurred in your treatment** including all co-payments, deductibles, as well as any outstanding balances. Outstanding balances carried for more than 90 days will incur additional finance charges as permitted by law and be directly billed to your credit card on file. Unless other specific written arrangements are made with our office you will be responsible to pay your balance and obtain any additional reimbursements due to you directly from your insurer.

Your signature does not serve as an authorization to release copies of your medical records to you or any party other than those listed above. Specific written authorization for release of medical records must be on file in our office before any of your medical record will be released to anyone other than your insurance carrier. Again, you are responsible for all charges incurred regarding all copies of records as well as any additional summaries, statements, letters of medical necessity, or any other administrative or medical information requested by you, your insurance company, or any other party. Any additional expenses incurred in the process of collecting payments for services rendered to you is your/the patient's responsibility.

Thank you for your time and patience in filling out this questionnaire. We are happy to have you as our patient. Feel free to add additional comments to the back of this page.

If you are under 21 years of age the signature of a parent or legal guardian must accompany your signature for your treatment to be initiated.

Patient's Signature _____ Date _____/2012

Patient's Copy

Witnessed By _____ Date _____/2012

*Atlanta Bariatric Medicine
Diet and Wellness Centers*



Lonny E. Horowitz, M.D. -ABBM Board Certified

**7914 Hwy 92 Suite 110 Woodstock, GA 30189
11912 Jones Bridge Road Alpharetta, GA 30005
1861 Peeler Road Suite #100 Atlanta / Dunwoody, GA 30338
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FAX (770)-888-5437
dietmd@bariatrics.com
www.bariatrics.com

To all of our patients:

As we are sure you realize health insurance policies have dramatically changed over the past few years. Deductibles, reimbursement terms as well as provider status have all changed. As a result of these changes we are forced to make changes to several of our general office business policies.

We are no longer be able to provide general medical care without an additional charge. As an example, treatment for a cold or sinus infection will incur an additional charge which will be billed at the time of your office visit. We will make every effort to keep these charges in line with those of other general medical practices. Please note that these fees will be added to your routine visit.

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Sincerely,

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_____ Date ____/____/2012

Patient's Signature

Patient's Copy