LONG ISLAND BARIATRIC, PLLC

PATIENT INFORMATION

REFERRED BY:_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

SOCIAL SECURITY #_____-_____-_____DATE OF BIRTH _____/_____/_____ AGE_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated / SEX: ☐ MALE ☐ FEMALE

ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER NAME: _____ OCCUPATION _____

BUSINESS PHONE: ( ) _____

EMERGENCY CONTACT: _____ RELATIONSHIP_____

HOME PHONE: ( ) _____ WORK/CELL: ( ) _____

PREFERRED LANGUAGE: _____ ETHNICITY: ☐ HISPANIC OR LATINO NON HISPANIC OR LATINO

RACE: ☐ American Indian Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander ☐ Other Race White

PREFERRED COMMUNICATION: Phone Portal Letter None

EMAIL ADDRESS: _____

HEALTH INSURANCE INFORMATION

PLEASE SUBMIT ALL INSURANCE CARDS AND DRIVER'S LICENSE / PHOTO ID FOR SCANNING

PRIMARY INSURANCE COMPANY_____
MEMBER ID_____ GROUP NO._____
POLICY HOLDER INFORMATION: NAME_____
DATE OF BIRTH_____ SOC. SEC. #_____ SEX: ( ) M ( ) F
PATIENT'S RELATION TO INSURED_____

SECONDARY INSURANCE COMPANY_____
MEMBER ID_____ GROUP NO._____
POLICY HOLDER INFORMATION: NAME_____
DATE OF BIRTH_____ SOC. SEC. #_____ SEX: ( ) M ( ) F
PATIENT'S RELATION TO INSURED_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

IF YOU HAVE NO INSURANCE, YOU WILL BE REQUIRED TO PAY AT TIME OF SERVICE.
IF YOUR INSURANCE REQUIRES A REFERRAL AND YOU DO NOT HAVE ONE, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

I HEREBY AUTHORIZE PAAYAL P. MEHTA, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO DR. PAAYAL P. MEHTA, ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE_____ SIGNATURE_____

LONG ISLAND BARIATRIC, PLLC

715 Roanoke Ave, Suite 1, Riverhead, NY 11901
240 Sills Road, Suite 205, East Patchogue, NY 11772
Phone: (631) 963-4750 Fax: (631) 591-1842

Paayal P. Mehta, M.D., F.A.C.S

General Surgery Bariatric Surgery Laparoscopic Surgery Breast Surgery

GUARANTOR AGREEMENT

I. Individual's Responsibility for Non-Covered Services

In consideration of services rendered by Dr. Paayal Mehta to the undersigned patient, the undersigned promise(s) to pay Dr. Paayal Mehta any co-payment, coinsurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan, provided I am informed of same prior to the rendering of said services. If a surgical assist is required and the assistant does not participate with my insurance, I will be responsible for fees incurred for the services rendered.

II. Assignment of Benefit Proceeds

I hereby assign to Dr. Paayal Mehta all monies and or/benefits to which I am entitled from my insurer/HMO/third-party payor, government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records

I hereby authorize Dr. Paayal Mehta to release to my insurer/HMO/third-party payor, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services that are improperly billed.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF DR. PAAYAL MEHTA DATE

LONG ISLAND BARIATRIC, PLLC

715 ROANOKE AVENUE, SUITE 1, RIVERHEAD, NY 11901
240 SILLS ROAD, SUITE 205, EAST PATCHOGUE, NY 11772
Ph: 631-963-4750 Fax: 631-591-1842

Paayal P. Mehta, M.D., F.A.C.S.

We are required by law to maintain the privacy of our patients and provide individuals with our Notice of Privacy Practices with respect to your protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at (631) 963-4750.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Long Island Bariatric, PLLC** to use and/or disclose certain protected health information (PHI) about me to _____.

(name of friend, relative, spouse, etc.)

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____

Date: _____

LONG ISLAND BARIATRIC, PLLC

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240 SILLS ROAD, SUITE 205, EAST PATCHOGUE, NY 11772

Paayal P. Mehta, M.D., F.A.C.S.

Attention: Patients of Long Island Bariatric, PLLC

RE: Fee for missed appointments and appointments not cancelled 24 hours in advance

If you are a patient of Long Island Bariatric, PLLC and you ***cannot keep your appointment***, ***you must notify the office 24 hours prior to the day you are scheduled***.

Patients that fail to show up for their appointments that are scheduled with Deborah L. Sforza, R.D., CDN, Christina Harrington, R.D., or Iris Pappalardo, R.N., LCSW-R without notifying the office 24 hours in advance will be charged a fee of $50.00.

Patients that fail to show up for an appointment scheduled with Dr. Paayal Mehta without notifying the office 24 hours in advance will be charged a fee of $25.00.

Patients that cancel their appointment ***at least 24 hours before the day*** of their appointment will not be charged any fee.

Missed appointments without calling the office wastes time, is inefficient, and denies our other patients the ability to schedule their appointments on those days.

In order for our office to provide the best care and services possible, we need the help and cooperation of our patients. Let us all work together.

Thank you for you cooperation.

Signature: _____

Date:_____