DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

E-MAIL ADDRESS	**PCP**

PATIENT INFORMATION

Patient's last name	First:	Middle:	❑ Mr ❑ Miss ❑ Mrs ❑ Mrs	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? Sí ❑ No ❑	If not, what is your legal name	(Former Name):	Birth Date / /	Age:	Sex: M ❑ F ❑

Address	Social Security no.:	Home Phone no.: ( )

P.O. BOX	City	State:	Zip Code:

Occupation:	Employer:	**Cell pone no.:** ( )

Chose clinic because/referred to clinic by (please check one box) ❑ Dr. _____ ❑ Insurance plan ❑ Hospital
Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other Family memeber seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsable for Bill:	Birth Date / /	Address (if different):	Home phone no.: ( )

Is this person patient here: ❑ Sí ❑ No

Occupation:	Employer:	Employer Address:	Employer phone no.: ( )
Is this patient covered by insurance?	❑ Sí	❑ No	
Please indicate primary insurance	❑		

Subscriber's Name:	Subscriber's S.S. no.:	Birth Date / /	Group number	Policy no.:

Patient's relationship to subscriber: ❑ self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if aplicable):	Subscriber's name:	Group no:	Policy no.:

Patient's relationship to susbcriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone no.: ( )	Work Phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Houston Surgical Weight Loss, Irfan I. Wadiwala, D.O./ Alex Tse M.D www.houstonsurgicalweightloss.com or insurance company to release any information required to process my claims.

_____ _____

Patient/guardian signature *Date*

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Houston Surgical Weight Loss

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

Name (Last, First, M.I.): ❑ M ❑ F	**DOB**

Marital Status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed
Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	**YES**	**NO**

Other Problems

Check if you a ver, or have had, any symptoms in the following áreas to a significant degree and briefly explain.

❑ Skin	❑ Chest/Heart	❑ Recent Changes in:
❑ Head/Neck	❑ Back	❑ Weight
❑ Ears	❑ Intestinal	❑ Energy Level
❑ Nose	❑ Bladder	❑ Ability to Sleep

Houston Surgical Weight Loss

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

FAMILY HEALTH HISTORY

	AGE	SIGNIFICAL HEALTH PROBLEMS		AGE	SIGNIFICAL HEALTH PROBLEMS
FATHER			**CHILDRENS**	❑ M ❑ F	
MOTHER				❑ M ❑ F	
SIBLINGS	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F		**Grandmother** *Maternal*		
	❑ M ❑ F		**Grandfather** *Materna*		
	❑ M ❑ F		**Grandmother** *Paternal*		
	❑ M ❑ F		**Grandfather** *Paternal*		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhales.		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the drug	Reaction you had	

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Houston Surgical Weight Loss

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

AUTORIZATION TO RELEASE HEALTHCARE INFORMATION

Patien's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize DR. _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

To release healthcare information of the patient named above to**: DR. IRFAN I WADIWALA & DR. ALEX TSE**

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
  _____
- All healthcare information
- Other: _____

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma **venereum**, HIV 9Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

❑ YES ❑ NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ YES ❑ NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

Thank you for choosing Houston Surgical Weight Loss as your healthcare provider. We are committed to your experience with our office being a pleasant and positive one, and to your treatment being successful. The following is a statement of financial Policy, which we require you to sign and read prior to any visit and/or treatment. Please understand that payment of your bill is considered part of your treatment and we accept cash, debit and credit cards. All co-payments must be paid at the time of your visit.

Our dedicated staff will work diligently to ensure that your insurance claims are filed accurately and promptly. You will be required to show your insurance card at the time of service. If you cannot provide this information, you will be required to pay for the service rendered to you that day. **We require payment of co-pays at the time of your visit, as well as payment of deductible and coinsurance portions prior to scheduled surgeries. The amount required will be a result of verification of benefits provided by your insurance plan.** Uninsured patients should consult with our office Manager to discuss discounts and to make payment arrangements. It is patient's responsibility to forward any/all payments to the insurance provider in a timely matter to apply towards deductible/ Co-insurance. You can call your insurance provider to get information about where to submit your receipt. For any credit/debit card refund, a processing fee(s) will be added.

Insurance & Insurance Collection

Your insurance policy is contract between you and your insurance carrier, and may or may not be part of that contract. Though we are not contracted with your insurance, we will file your insurance as a courtesy and a service to you and will absorb all costs incurred. Our staff will work diligently to ensure that your insurance claims are filed accurately and promptly. However, should your insurance carrier not reimburse us within allowed time frame, the balance due then becomes your responsibility. While we file all primary insurance claims, please understand that all insurance reimbursement can be a long difficult process, often resulting in prolonged delays and significantly reduced reimbursement. To assist us in expediting the payment claim process and reducing delays, please authorize and consent to the following: Our practice is **NOT** responsible for any other charge such as: Hospital, anesthesia, labs, pathology, and radiology related to your surgical care.

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising mt rights with respect to the in-network or out of network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (b) that he/ she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility may or may not have affiliation and remuneration: Humble Surgical Hospital, Methodist Willowbrook Hospital, St. Lukes the Vintage Hospital, Memorial Hermann Cypress Hospital, HCA tomball,Townsen Hospital System.

I certify that I was informed of the effective alternative resources reasonable available at the time of the decision-making, and my decision to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this disclosure and authorization form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

I assign my insurance benefits and authorize payment to:
Irfan I. Wadiwala, DO & Alex Tse M.D/ Houston Surgical Weight Loss
I also authorize Dr. Wadiwala & Dr Tse and/or Houston Surgical Weight Loss to file appeals on my behalf and, if warranted, file complaint regarding my insurance carrier with the Texas Medical Association and the Texas Department of Insurance
Signature: _____ *Date:* _____

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Houston Surgical Weight Loss

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA OR OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HELATH BENEFITS PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

Patient Name: _____
DOS: _____
ID#: _____
Provider: Dr. Wadiwala DO/ Dr Tse M.D: and any other services performed by Dr. Wadiwala DO/ Dr. Tse M.D or Houston Surgical Weight Loss Surgeons.

Employee Information who holds insurance policy
Employee Name and DOB: _____
Employer Name: _____
Employer Address: _____

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I Hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the provider, and **Houston Surgical Weight Loss Surgeons** ("My Authorized Representatives") I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan.
- ✓ Discuss or divulge any of my personal health information (PHI) or that of my dependents with any third party including the health plan.
- ✓ Obtain copies of Plan documents, Policy documents and Summary Plan Description.
- ✓ File appeals with employers who sponsor patient's health plan and provide any necessary personal health information (PHI) employer as required to perfect appeals. I specifically authorize release of my PHI to my employer for the purpose of appeal.

I certify that the health insurance information that I provided to the provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from providers are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductible.

Authorization to Release Information I hereby authorize my authorized representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization I Hereby designate, authorize, and covey to My Authorized representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my authorized representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan: and (20 the right and ability to act as my authorized representative to purse such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and to act as my authorized representative with respect to a benefit plan governed by the provisions of ERASA as provided in 29 C.F.R. 2560.5031 (b)(4) with respect to any healthcare expense incurred as a result of the services I received from provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims. A photocopy of this assignment/Authorization shall be as effective and valid as the original.

Patient: _____ Date: _____

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

Understanding My Insurance Coverage

Patient Name: _____

I, _____, have discussed my insurance coverage including any applicable *co-pays*, *co-insurances* and *deductibles* that may apply to my office visit and/or procedure performed by Irfan I. Wadiwala, D.O. / Alez Tse M.D. with the office staff.

I understand Houston Surgical Weight Loss office will collect from me today or set up payment plan arrangement with me for any applicable co-pays, co-insurances and deductibles that may apply to my office and/or procedures performed by Irfan I. Wadiwala, D.O / Alez Tse M.D.

It has been explained to me that insurance companies' process claims as they are received and any deductible amounts paid to Houston Surgical Weight Loss office may not in fact be applied to his claim(s) once my insurance processes the claims(s). Further, it is my understanding that this should happen, and an overpayment is applied to my account, that Houston Surgical Weight Loss office will refund me any overpayment that is due to me.

I agree that if assigned insurance benefits owed to Dr. Irfan Wadiwala/ Alez Tse M.D or Wifumam PA, or Houston Surgical Weight Loss are paid to me by the insurance company, I shall immediately notify the office of such, and immediately endorse benefits check to the provider. I understand that, if I do not fulfill any of the above obligations, I will remain personally liable for payment for the services to the furthest extent of the law.

I understand that I am being charged based on my insurance benefits and verification.

_____	_____	_____
Patient Name/ Guardian	Patient Signature/ Guardian	Date

Houston Surgical Weight Loss

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

How did you Hear about us?

Please circle one

GOOGLE

FACEBOOK

INSTAGRAM

REFERRED BY DOCTOR

OTHER

NAME: _____ DATE: _____

Houston Surgical Weight Loss

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

Pharmacy Information Sheet

Patient Name: _____ Patient DOB:_____

Pharmacy Name: _____

Pharmacy Phone#: _____

Pharmacy Fax # (optional): _____

Pharmacy Address:

_____

_____

_____

DR. IRFAN I. WADIWALA / DR. ALEX TSE

Board Certified General Surgeon
& Weight loss Surgery
www.info@houstonweightlossdr.com

5220 FM 2920, Suite 120,
Spring, Tx, 77388
Ph. (281) 653-6544 Fax (281) 807-9702

GERD QUESTIONNAIRE

Patient Name: _____ DOB: _____ DATE: _____

Do you have any of the following symptoms:

Please answer the following questions with: **YES/NO** & frequency **3 MO/ 1YR/ 3 + YEARS**.

Questions	Yes	No	Frequency
Q1 Do you get heartburn [dyspepsia] or reflux?			
Q2 Do you have difficulty swallowing?			
Q3 Do you burp/belch a lot?			
Q4 Do you experience chest pain/or chest discomfort?			
Q5 Do you have poor dentition caused by acid reflux?			
Q6 Do you clear your throat often?			
Q7 Do you have trouble sleeping or difficulty breathing?			
Q8 Do you have chronic bad breath?			
Q9 Do you have persistent vomiting?			
Q10 Have you experienced hematemesis?			
Q11 Any evidence of Gastrointestinal (GI) bleeding or anemia?			
Q12 Have you experienced unintentional weight loss > 5%?			
Q13 Have you ever been treated for H-Pylori or ulcers?			

Q14- If you answered YES to Q13 what's the name of the prescription for treatment:
_____?

Q15- Have you had an EGD (Esophagogastroduodenoscopy)?
Circle: YES / NO *write in YES or NO below*
Doctor's Name: _____?

Q16- Please circle which PPI's (Promotion Pump Inhibitor) you've been prescribed or taken OTC (over the counter)
PRILOSEC / PREVACID / NEXIUM / PROTONIX / ZEGERID / ACIPHEX / DEXILANT / OTHER:
_____?

Q17- Please circle which antacids you have taken: *write in below*
TUMS / PEPTO-BISMOL / AMPHAJEL / ALKA-SELTZER / OTHER: _____

Q18- Please circle which H-2 Receptor antagonists you have taken: *write in below*
ZANTAC / PEPCID / TAGAMENT / OTHER: _____

_____ _____

Patient Signature Witness