GRAND HEALTH PARTNERS
TRANSFORMATIONS HAPPEN DAILY

Patient Information

Legal Name: _____
First Middle Last

Home Address: _____
Street City State Zip

Gender: (circle one) Male Female

Date of Birth: _____
mm / dd / yyyy

Social Security #: _____ – _____ – _____

Email: _____@_____._____ **Used for our patient portal/Billing Dept.*

Marital Status: Single Married Divorced Widowed

Primary Phone: _____ OK to leave a detailed message? Yes / No

Secondary Phone: _____ OK to leave a detailed message? Yes / No

Ethnicity: Non-Hispanic Hispanic African American Caucasian

Primary Language: _____

How did you hear of us? Online / GHP Patient / PCP Physician / Other: _____

Emergency Contacts

Emergency Contact 1: _____ (Name) _____ (Relationship) _____ (Phone #)

Emergency Contact 2: _____ (Name) _____ (Relationship) _____ (Phone #)

May we discuss private medical information with Emergency Contact 1 (HIPAA)? (Circle one) Yes / No

May we discuss private medical information with Emergency Contact 2 (HIPAA)? (Circle one) Yes / No

Primary Health Insurance

Name of Primary Insurance: _____ **Member ID/Contract Number:** _____

Policy Holder's Full Name: _____ **Group ID:** _____

Policy Holder's Date of Birth: _____ **Specialist Copay:** _____

Relationship to Policy Holder _____

Secondary Health Insurance

Name of Secondary Insurance: _____ **Member ID/Contract Number:** _____

Policy Holder's Full Name: _____ **Group ID:** _____

Policy Holder's Date of Birth: _____ **Specialist Copay:** _____

Relationship to Policy Holder: _____

2060 East Paris Avenue SE, Suite 100 Grand Rapids, MI 49546
Phone: 616-956-6100 | Fax: 616-956-6637 |Toll Free: 888-691-0050
www.grandhealthpartners.com

PATIENT LAST NAME: _____

History & Physical Information

Physicians + Pharmacy

Full Name of Primary Care Physician: _____
Did this physician refer you to us? Yes / No (Circle one)

PCP Address: _____
Street City State Zip

Physician Phone #: _____ **Physician Fax #:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____ **Fax #:** _____

Pharmacy Address: _____
City State Zip

Other Physician(s) (i.e., Cardiologist, GI, etc.)
Please use back of paper if you need more space

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Provider Name: _____ **Office Phone #:** _____

Weight + Dietary History

Total number of years overweight: _____

Please list all weight loss programs and/or attempted methods to lose weight in the past.

Name of Program:	**Date(s):**	**Name of Program:**	**Date(s):**
1) _____	_____	**2)** _____	_____
Name of Program:	**Date(s):**	**Name of Program:**	**Date(s):**
3) _____	_____	**4)** _____	_____

Past + Current Medical Diagnosis

*Check all that apply

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Diabetes Mellitus Type 2
- ☐ Arrhythmia
- ☐ Lung Disease
- ☐ Seizures
- ☐ Polycystic Ovarian Disease
- ☐ Diabetes Mellitus Type 1
- ☐ Congestive Heart Failure
- ☐ Liver Disease
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anxiety
- ☐ Reflux Disease/GERD
- ☐ Obstructive Sleep Apnea
- ☐ Bleeding Tendencies
- ☐ Peptic Ulcer Disease
- ☐ Hypothyroidism

Other: _____

Other: _____

Other: _____

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PATIENT LAST NAME: _____

Prior Surgeries

Have you ever had prior *bariatric surgery*? If YES, please list the type of operation/date performed.

Type: _____ **Date of Operation:** _____

Name of Surgeon: _____ **Facility:** _____

Other Surgeries

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Type: _____ **Date of Operation:** _____

Any past problems with Anesthesia? Please describe in detail: _____

_____

If necessary, will you accept a blood transfusion? (Circle one) Yes / No

Medications

List all current prescriptions

		Frequency
1. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
2. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
3. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
4. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
5. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
6. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
7. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
8. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
9. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**
10. _____	**Dose:** _____	**#** ___ **AM** **#** ___ **PM**

Please list any dietary supplements, herbs, or vitamins you are currently taking:

1. _____ **2.** _____

3. _____ **4.** _____

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PATIENT LAST NAME: _____

Medication Allergies	Food Allergies
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Family Medical History

Describe Family Medical Diagnosis

Father: Alive / Deceased (Circle one) Medical Problem (s):

Mother: Alive / Deceased (Circle one) Medical Problem (s):

# of Brothers: _____ Medical Problem (s):

# of Sisters: _____ Medical Problem (s):

# of Children: _____ Medical Problem (s):

Social History

Are you currently employed? Yes / No (Circle one)

Current Employer:_____ **Position:** _____

Are you currently disabled? Yes / No (Circle one)

If yes, please explain: _____

_____

Caffeine Consumption: (Per day) **Regular Pop/Soda: Quantity**_____ **Diet Pop/Soda: Quantity**_____

Coffee: Quantity_____ **Tea: Quantity**_____

Alcohol Consumption (# of drinks per week)**:** ☐None ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20

Smoking: ☐ Never ☐ Former ☐ Current **How often** _____

Chewing Tobacco: ☐ Never ☐ Current

Nicotine: ☐ Patches ☐ Gum ☐ Vaporizer / E-cigarette

Drug Use: ☐ Never ☐ Current ☐ Past

If current, what type: _____ **Medical Marijuana Card?** (Circle one) Yes / No

Are you currently involved in an exercise program? Please describe:

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PATIENT LAST NAME: _____

Previous Medical Testing

Have you had any recent labs done? (Circle one) Yes / No **If yes: Date:** _____ **Location:** _____

Sleep Study	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
C-pap? (circle one) Yes / No	**C-pap setting:** _____		
Echocardiogram	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Heart Stress Test	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Heart Catheterization	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Breathing Test (PFT's)	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Upper Endoscopy (EGD)	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Colonoscopy	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Ultrasound of Gallbladder	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
DEXA Scan	**Date:** _____	**Doctor/Location:** _____	**Results:** _____

Women only

Mammogram	**Date:** _____	**Doctor/Location:** _____	**Results:** _____
Pap & Pelvic Exam	**Date:** _____	**Doctor/Location:** _____	**Results:** _____

Men only

Prostate Exam	**Date:** _____	**Doctor/Location:** _____	**Results:** _____

Current Medical Conditions

***Check all that apply**

General	**Neurological**	**Genitourinary (GU)**
☐ Fever	☐ Numbness	☐ Urine Incontinence
☐ Chills	☐ Tingling	☐ Painful Urination
☐ Night Sweats	☐ Weakness	☐ Blood in Urine
☐ Fatigue	☐ Fainting	☐ Hesitancy
HEENT	**Hematological**	☐ Night-time Urination
☐ Headaches	☐ Easy Bruising	**Gastrointestinal (GI) / Abdominal**
☐ Vision Changes	☐ Easy Bleeding	☐ Pain
☐ Dizziness	☐ Blood Clots	☐ Nausea
Skin	**Musculoskeletal**	☐ Vomiting
☐ Rash	☐ Joint Pain or Swelling	☐ Diarrhea
☐ Jaundice	☐ Muscle Pain	☐ Constipation
☐ Ulcers (leg or sacrum)	**Cardiac**	☐ Bloody Stool
Pulmonary	☐ Chest Pain	☐ Heartburn/Reflux
☐ Cough	☐ Palpitations	☐ Difficulty Swallowing
☐ Wheezing	☐ Shortness of Breath w/ Activity	**Endocrine**
☐ Snoring	☐ Shortness of Breath w/o Activity	☐ Abnormal Hair growth
☐ Daytime Sleepiness	☐ Waking up short of breath	☐ High Blood Sugar
☐ Stop breathing in sleep	☐ Leg Swelling	☐ Thyroid Problems

Any additional medical information you want GHP to know: _____

_____

_____

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PATIENT LAST NAME: _____

Online Seminar Viewer Contract

I _____ **(print name)**, have completed Grand Health Partners' online Bariatric Surgery seminar. I acknowledge that I have understood the information contained in that seminar regarding general information about Bariatric Surgery, Grand Health Partner's process for Bariatric Surgery, and the possible risks and benefits involved with Bariatric Surgery. I also understand that if I have any questions or concerns regarding the Bariatric Surgery seminar I viewed, now or in the future, I can call Grand Health Partners at 616-956-6100.

I acknowledge that I have had the opportunity to ask questions about the information contained in that seminar.

_____ _____

Patient Signature Date

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PATIENT LAST NAME: _____

Payment Policy & Agreement

Thank you for choosing Grand Health Partners for your surgical and medical weight loss needs. We are committed to providing you with quality and affordable health care. Please read the following agreement, ask us any questions you may have, and sign in the space provided.

1. Insurance: We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Grand Health Partners does offer a discount to self-pay patients who pay at the time of service.

2. Proof of insurance: Before seeing a Provider, all patients must complete our Patient Information (page 1) form which includes listing insurance carrier details. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance; you are responsible for providing these and keeping the information current on GHP records. If not, you may be responsible for the balance of a claim. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Non-covered services: Please be aware that some – and perhaps all – of the services you receive may not be covered by Medicare or other insurers. You are responsible to pay for these services in full at the time of visit. Grand Health Partners does offer a discount to self-pay patients who pay at the time of service.

4. Co-payments and deductibles: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. **All co-payments are patient responsibility.** Most medical insurance policies have deductibles that must be met before your health insurance starts to cover a larger portion of your bills. If deductibles have not been met, you may ask our Billing Department to provide you with an estimated cost, prior to your appointment. Patients are expected to pay for services performed on the date of service. **For surgical patients, we cannot schedule your surgery until all balances due are paid in full.**

5. Food supplements for Surgical Patients: You will need to be on GHP food supplements for approximately 2 weeks before and 2 weeks after surgery, as determined by your Surgeon. Pricing will vary depending on which products you choose. The average total cost of food is $75 per week ($300 for 4 weeks). Payment is due at the time of purchase. Products are not returnable or exchangeable. We encourage you to pay towards your food at each visit so that the cost is more manageable than paying it all at the time of surgery. If you pay $15 to $25 per visit, the funds will be applied as Payer Credit. When you go to the GHP Store to purchase food, simply inform the cashier that you would like to use your Payer Credit to pay for your food. Any excess funds can be applied to outstanding balances or refunded to you via check.

6. Payment types: We accept Cash, Check, Debit and Credit cards (Visa, MasterCard, Discover, American Express). For your convenience, we can securely store your H.S.A., debit or credit card information within your account. You can assign a maximum charge amount to your card. Financing is available through www.MedLoanFinance.com

7. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Most insurance contracts only pay a percentage of your claim after your deductible is met and you are required to pay the remaining balance due which is called coinsurance*. Grand Health Partners will apply the insurance payment received to your account and any coinsurance due will be billed to you. Please be aware that the outstanding balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

8. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

9. Nonpayment: If your account is over 90 days past due, it may result in your account being transferred to a Collection Agency and/or you being discharged from our practice.

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10. Missed appointments: Please help us to serve you better by keeping your regularly scheduled appointments! Our policy is to charge $25 for missed appointments that are not canceled at least 24 hours prior to the appointment. These charges will be your responsibility and billed directly to you.

Definitions

In general, it works like this: You pay a monthly premium just to have health insurance. When you go to the doctor or the hospital, you pay either full cost for the services, or copays as outlined in your policy. Once the total amount you pay for services, not including copays, add up to your deductible amount in a year, your insurer starts paying a larger chunk of your medical bills, typically 60% to 90%. The remaining percentage that you pay is called coinsurance. You'll continue to pay copays or coinsurance until you've reached the out-of-pocket maximum for your policy. At that time, your insurer will start paying 100% of your medical bills until the policy year ends or you switch insurance plans, whichever is first.

Premium: A monthly payment you make to have health insurance. Like a gym membership, you pay the premium each month even if you don't use it, or you lose coverage.

Copay: Your copay is a predetermined rate you pay for health care services at the time of care.

Deductible: The deductible is how much you pay before your health insurance starts to cover a larger portion of your bills. In general, if you have a $1,000 deductible, you must pay $1,000 for your own care out-of-pocket before your insurer starts covering a higher portion of costs. The deductible resets yearly.

Coinsurance: Coinsurance is a percentage of a medical charge that you pay, with the rest paid by your health insurance plan, after your deductible has been met. For example, if you have a 20% coinsurance, you pay 20% of each medical bill, and your health insurance will cover 80%.

Out-of-pocket maximum: The most you could have to pay in one year, out of pocket, for your health care before your insurance covers 100% of the bill.

Grand Health Partners is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

By signing below, I acknowledge that I have read and understand the Payment Policy and agree to abide by its guidelines. I understand that if I have any questions or concerns, I can call Grand Health Partners at 616-956-6100 or toll-free at 888-691-0050. I understand that if GHP is unable to answer any questions that I may need to contact my insurance company. I also understand that I can request a copy of this agreement at any time.

Print Name	Patient Signature	Date

Legal Representative Section ***If Applicable***

Print Name of Legal Representative	Relationship	Signature of Legal Representative	Date

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PATIENT LAST NAME: _____

HIPAA Compliance

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, as part of my healthcare, Grand Health Partners (GHP) originates, obtains, and maintains health information and medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment or care. I was able to review Grand Health Partners *Notice of Privacy Practices* that provides a more complete description of how GHP uses and discloses my health information. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this and that I can ask for a copy of the *notice* to take with me. I understand that GHP reserves the right to change the *notice*, and prior to implementation, will post a copy of any revised *notice* in its waiting rooms and will provide me with a copy upon my request. I understand that I have the right to request restrictions as to how my health information is used, and or disclosed, to carry out treatment, payment, or healthcare options. I understand that GHP is not required to agree to the restrictions requested. GHP will consider my request, but I am aware that they are not legally required to accept it and will, given the complexity of multiple methods of dealing with information, most likely elect not to treat me or to disregard it in an emergency situation.

SIGNATURE BELOW INDICATES ACCURACY OF PATIENT INFORMATION, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, AND ACCEPTANCE OF THE FOLLOWING:

- Authorization for providers of Grand Health Partners to examine me and render medical treatment deemed necessary for evaluations, management and treatment of my medical conditions; and to share any information with my primary care physician, any physician to which a referral is made or any other provider of health care products or services.
- I understand that Grand Health Partners may collaborate with other health care providers to coordinate, manage, and provide health care to me and consent to Grand Health Partners (1) sharing my health information and records, whether electronically or otherwise, for the purpose of treatment, payment or operations, including improving the overall quality of health care services provided to me (example: avoiding unnecessary or duplicate testing, etc.), and (2) obtaining my health information and records, whether electronically or otherwise, from other health care providers to assist Grand Health Partners with my treatment (such as other lab test results, records from other physicians and from hospitals, etc.).
- Authorization for Grand Health Partners providers to release to my insurance carrier or benefit plan and its agents any information needed to determine my eligibility for payment or reimbursement for Grand Health Partners' services and for purposes of payment for those services.
- Authorization for direct payment to Grand Health Partners for services rendered by its providers. I understand I am financially responsible for any balance not covered by my insurance company/benefit plan.
- Authorization for Grand Health Partners to obtain pharmaceutical records from my pharmacy.

Print Name	Patient Signature	Date

Legal Representative Section ***If Applicable***

Print Name of Legal Representative	Relationship	Signature of Legal Representative	Date

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