

BARIATRIC CONSULT PACKET

Welcome Letter

Patient Enrollment Form

Confidential Patient Information

Authorization Form Release of Protected Health Information

Hospital Care Consent

Patient Rights and Responsibilities

Authorization To Release Medical Information to Family

Members Bariatric Charge List

Mental Health Evaluation

Provider Based Clinic (effective October 21....)

Participating Provider Status

CHRISTUS Disclaimer Notice For Uninsured Patients

Understanding Your Hospital Bill

Notice of Privacy Practices

Financial Policy and Patient Financial Responsibility

Cancellation Fee Letter

Collated and stapled.

Reorder # 0244225 rev. 2/19



Dear _____,

The staff and surgeons at the CHRISTUS Southeast Texas Bariatric Center St. Elizabeth would like to extend a warm welcome to you and congratulate you on your decision to learn more about weight loss surgery. Thank you for giving us the opportunity to share with you our knowledge and expertise on this important topic.

You consultation with Dr. Jerome Schrapps / Dr. Kevin Dean is scheduled for:

We have enclosed the required registration forms for your appointment. Please complete these front and back prior to your appointment to help reduce any unnecessary wait time.

We look forward to meeting you and being part of your journey to better health! Please feel free to visit our website at www.setxweightloss.org to view video presentations of our procedures, read patient testimonials, and meet our staff.



PATIENT ENROLLMENT INFORMATION

PERSONAL INFORMATION:		DATE:
NAME:	HEIGHT:	WEIGHT:
DATE OF BIRTH:	AGE:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE SOCIAL SECURITY #:
DAY PHONE:	EVENING PHONE:	E-MAIL:
HOME ADDRESS:	CITY/STATE/ZIP:	
EMPLOYED BY:	POSITION:	
EMPLOYMENT ADDRESS:		
CITY/STATE/ZIP:	EMPLOYER PHONE:	
EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	
PHONE:	ADDT'L PHONE	PATIENT'S MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW/WIDOWER

INSURANCE INFORMATION:		
INSURANCE CARRIER:	POLICY #:	GROUP #
SUBSCRIBER:	SUBSCRIBER DATE OF BIRTH:	AGE:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY #:	RELATIONSHIP TO PATIENT:
EMPLOYED BY:	POSITION:	
EMPLOYMENT ADDRESS:		
CITY/STATE/ZIP:	EMPLOYER PHONE:	

PROTECTED HEALTH INFORMATION:
<p>I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information (PHI). I have had an opportunity to review this information before signing this form. I consent to CHRISTUS Southeast Texas Bariatric Center and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) to carry out treatment, payment, or health care operations. This includes any medical misinformation (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV-related information including HIV test result, if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to participation in this program (including pre-certification and verification, if necessary), or which may be needed to conduct continued care planning.</p>
Patient Signature: _____ Date: _____

- How did you hear about us?**
- Newspaper Billboard Radio Television Mail
 Family/Friend Attended Seminar Referred by Physician
Internet – which search engine or Website led you to us?
 Went directly to CHRISTUS Southeast Texas Bariatric Center's Website
 Google Yahoo! AOL MSN Ask.com
 Other _____



3030 North Street | Suite 340 | Beaumont, TX 77702
 409.839.LOSE (5673) | 409.839.5699 fax

02-2008

NAME:			DATE:		BMI
DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:		

PAST MEDICAL / SURGICAL HISTORY

PREVIOUS SUGERIES / PROCEDURES

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

HOSPITALIZATIONS

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

ILLNESSES: Describe illnesses not requiring hospitalization, list all health conditions you are currently being treated for (ie. Diabetes, sleep apnea, high blood pressure, etc.)

1	
2	
3	
4	
5	
6	
7	

ALLERGIES: List all

SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:

CURRENT MEDICATIONS: Include daily medications as well as those used as needed

MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:

PATIENT INFORMATION – 2

PHYSICIANS NAME:	PHONE	FAX
Primary Care:		
Pulmonologist:		
Gastroenterologist:		
Orthopedist:		
Neurologist:		
Cardiologist:		
Psychiatrist:		
Endocrinologist:		
Gynecologist:		
Other:		

SOCIAL HISTORY

Your occupation:	Spouse's occupation:
List any hobbies or volunteer work in which you participate:	
Number of children:	General health of children:

PERSONAL HABITS

Do you smoke? Y / N	How much?	How long have you smoked?	When did you quit smoking?
Do you drink alcohol? Y / N	How much?	How long have you drank?	When did you quit drinking?
Do you use illegal substances? Y / N	Ever used illegal substances? Y / N	What kind?	How often?
Do you exercise? Y / N	What kind of exercise?	How often do you exercise?	
Do you have any limitations to exercise?			

FAMILY HISTORY

RELATIONSHIP	AGE	HEALTH	IF DECEASED CAUSE	WEIGHT STATUS	RELATIONSHIP	AGE	HEALTH	IF DECEASED CAUSE	WEIGHT STATUS
Father		Good/Fair/Poor		Thin/Avg/Overweight	Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight
Mother		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight
Brother / Sister		Good/Fair/Poor		Thin/Avg/Overweight	Son / Daughter		Good/Fair/Poor		Thin/Avg/Overweight

Do you know of any blood relative who has had any of these conditions (If yes, give relationship of relative)

Stroke: Y / N _____	Heart Disease: Y / N _____	Tuberculosis: Y / N _____	Problems with Anesthesia : Y / N _____
High Blood Pressure: Y / N _____	Cancer: Y / N _____	Bleeding Tendencies: Y / N _____	Other: _____
Diabetes: Y / N _____	Overweight (20-99 lbs.): Y / N _____	Severely Obese (> 100 lbs.): Y / N _____	Other: _____

Reviewed with patient by _____

 Nurse Signature Date



CHRISTUS[®] SOUTHEAST TEXAS
 Bariatric Center - *St. Elizabeth*

AUTHORIZATION FORM RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize my physician(s):

_____ at the following address(es):
(Patient Primary Care Physician(s) Name)

(Patient Primary Care Physician(s) Address)

to use and disclose to the following party:

CHRISTUS Southeast Texas Bariatric Center – St. Elizabeth,
 3030 North St., Suite 340, Beaumont, Texas 77702
Fax (409) 839-5699 Phone (409) 839-5673

The use and disclosure will be made by the office staff of this facility. The health information to be used and/or disclosed is specifically described as follows (check all information to be released):

- | | |
|--|--|
| <input type="checkbox"/> Doctor's Office Notes and Reports | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Lab/X-Rays | <input type="checkbox"/> Psychiatric Notes |
| <input type="checkbox"/> Communication Notes between Staff & Patient | <input type="checkbox"/> HIV/Drug Screen |
| <input type="checkbox"/> Other Specific Testing: _____ | |

This authorization shall be in force and effective until the following event and/or date: _____, at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the aforementioned facility. I understand that a revocation is not retroactive to the extent that the facility has already used/disclosed information based on this current authorization. Also, a revocation is not effective if this authorization was a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure, I understand I have the right to: 1) Inspect or have a copy of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent state law provides greater access rights), 2) Refuse to sign this authorization; in which case we will be unable to process this request.

 Signature of Patient or Personal Representative

 Date

 Date of Birth

 Social Security #

 Printed Name of Patient or Personal Representative

 Relationship of Personal Representative

STATE OF TEXAS
HOSPITAL CARE CONSENT

- 1. General Consent:** I consent to CHRISTUS Southeast Texas Health System (the "Facility") giving me medical services and treatment that my doctor or other medical staff have ordered. My consent includes diagnostic testing (such as labs and x-rays), injections, immunizations, medications, and other medical treatment. I have the right to make decisions about my care. I know that I have the right to discuss treatment and procedures with the doctor beforehand. I also have the right to consent or refuse any treatment. Where appropriate, I consent to delivery of care utilizing interactive video conferencing thereby enabling a provider at a distant location to provide treatment to me and/or consult and advise my local healthcare provider in making decisions about the care provided to me. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Facility is under the direction of an independent provider, who is not an employee of the Facility. The Facility is not responsible for the medical care, medical judgment, and plan of care provided by non-employees. I recognize that services rendered in the hospital, including but not limited to, in the emergency department, inpatient, outpatient, SDC, etc. are admissions to the hospital for the purposes of, among other things, the Texas Property Code, Section 55.
- 2. Personal Property:** I understand that I am responsible for my personal property while at the Facility. The Facility is not responsible for keeping my property safe.
- 3. Financial Assistance:** If I cannot afford my Facility medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Facility's plain language summary of its Financial Assistance Policy. The full policy and more information is available at www.christushealth.org/charitycare.
- 4. Release of Information:** I allow the Facility to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Facility's Notice of Privacy Practices. I agree that all records about my treatment are the Facility's property. I understand that medical records and billing information created or maintained by the Facility are available to Facility workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.
- 5. Medicare/Medicaid Benefits:** If applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.
- 6. Communication:** I authorize the Facility (including any billing service, collection agency, agent, or contractor on the Facility's or contractor's behalf) to contact me by phone at any number that I have provided to the Facility at any time. The Facility may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Facility may use pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Facility may send me voicemail messages, text messages, or e-mails. I allow the Facility to contact me using any e-mail address that I have given it or any e-mail addresses that the Facility may obtain for me in the future.
- 7. Testing After Accidental Exposure and State Reporting:** If a healthcare worker accidentally touches my blood or other body fluids, state law allows the Facility to test me for certain diseases. These diseases include human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Facility is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or Centers for Disease Control.
- 8. Photography:** I consent to the Facility videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for medical education, quality improvement, research, or for other reasons related to treatment or operations. If the recordings or images are used, my identity will not be revealed. I will talk with my doctor if I do not want my recordings used for these purposes.
- 9. Ethics:** The Facility is a Catholic health ministry dedicated to helping the sick and injured in compliance with the *Ethical and Religious Directives for Catholic Health Facilities*. The Facility may not be used for procedures that violate the directives.

PERMANENT PART OF MEDICAL RECORD

HOSPITAL CARE CONSENT



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STATE OF TEXAS
HOSPITAL CARE CONSENT

- 10. Teaching and Observation:** I understand that the Facility may be a teaching facility. I consent to allow medical residents, students, and fellows who have a formal affiliation with the Facility to participate in my care as supervised by the treating physicians and permitted by Facility policy. Students, residents, and fellows from other non-affiliated programs as well as vendors may observe my care consistent with Facility policy and as approved by my treating physician.
- 11. Assignment of Benefits:** In consideration of services rendered and to be rendered, the sufficiency of which is hereby acknowledged, I hereby **irrevocably assign and transfer to** CHRISTUS Southeast Texas Health System Hospital (hereinafter referred to as the "Hospital") all right, title, and interest in all claims or benefits payable for hospital services rendered in the past or future, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity (hereinafter referred to as "Benefits") from whom my dependents or I may be entitled to recover. I further hereby irrevocably assign and transfer to the Hospital all right, title, and interest in any and all causes of action against all insurance companies, employee benefit plans, liability carriers, third party administrators, tortfeasors, and/or all other persons or entities responsible for payment (hereinafter referred to as "Responsible Parties") of Benefits and I hereby appoint the Hospital as my attorney in fact, with power of substitution, to sue or otherwise obtain payment of Benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of irrevocably granting the Hospital an independent right of recovery of Benefits against any Responsible Parties, at its option, but shall not be construed to be an obligation of the Hospital to pursue any such right of recovery. I hereby direct and irrevocably authorize all Responsible Parties to pay directly to the Hospital all Benefits and amounts due for services rendered by the Hospital without further request or written authorization from me. I further irrevocably authorize and direct that any Responsible Parties furnish copies of any insurance policies, employee benefit plans or any other document requested by the Hospital without further request or written authorization from me. I understand that in the event that the Hospital is not paid in full by proceeds of my insurance policies, this assignment does not release my obligation and liability to the Hospital for payment of the services and items provided to me by the Hospital. I agree to pay the Hospital for all charges incurred by me, or in the alternative, for all charges in excess of the sums actually paid by my insurance policies. We have the right to apply available funds in any or all of your accounts with us and our affiliates otherwise payable to you to any prior existing or future debt that you owe us. When we set-off a debt that you owe us, we reduce the funds in your account(s) by the amount of the debt. We are not required to give you any prior notice to exercise our right of set-off. The effect and consequences of this irrevocable assignment and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement.
- 12. Balance Billing Disclosure:** Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually be seen, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services. We encourage you to contact your health plan to determine whether the independent healthcare professionals are participating with your health plan. In order to obtain the most accurate and up-to-date information about in-network and out-of-network independent healthcare professionals, please contact the customer service number of your health plan or visit its website. Your health plan is the primary source of information on its provider network and benefits. To help you determine whether the independent healthcare professionals who provide services at this facility are participating with your health plan, this healthcare facility has provided you with a complete list of the names and contact information for each individual or group.

PERMANENT PART OF MEDICAL RECORD

HOSPITAL CARE CONSENT



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**STATE OF TEXAS
HOSPITAL CARE CONSENT**

13. Patient Rights and Advance Directives: The Facility provided me a copy of the Patient Rights and Responsibilities when I arrived to the hospital. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Facility an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order, I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.

_____ (Initials) I have declined a copy of the Patient Rights and Responsibilities, and understand I can request a copy at any time.

14. Notice of Privacy Practices: I have received a copy of the Facility's Notice of Privacy Practices at this or an earlier visit. The Facility will give me a copy of the Notice of Privacy Practices any time I ask for one.

_____ (Initials) I acknowledge receipt of the CHRISTUS Notice of Privacy Practices

15. Facility Directory: Unless I object, the Facility will include my name, location in the facility (room number), and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to Facility) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Facility Directory.

(If you object, initial below.)

_____ I **DO NOT** want any information about me to be included in the Facility Directory. I understand that mail, flowers, telephone calls, and visitors will be refused on my behalf because hospital staff cannot acknowledge my presence in the hospital. If I make phone calls from the hospital, caller ID may show call recipients that I am calling from the hospital.

16. Insurance Information:

Primary Insurance: _____

Secondary Insurance: _____

Tertiary Insurance: _____

_____ (Initials) I acknowledge that I have provided the Facility with complete and correct insurance information in the appropriate filing order listed above.

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient or I am the patient's legally authorized representative and/or guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature of Patient / Legally Authorized Representative

Date

Patient's Name

Name of Legally Authorized Representative (if not Patient)

Relationship to Patient

Facility Representative

Date

PERMANENT PART OF MEDICAL RECORD

HOSPITAL CARE CONSENT



PATIENT RIGHTS & RESPONSIBILITIES

CHRISTUS Southeast Texas Health System is committed to providing care and service of the highest quality and to assuring that the basic human rights of expression, decision making, and personal dignity are preserved.

CHRISTUS Southeast Texas Health System respects the inherent dignity of each person and recognizes the rights of patients regardless of their race, creed, color, religion, gender, age, disability, national origin, orientation or source of payment.

The following statements summarize your rights and responsibilities as a patient. You will receive a copy of these rights and responsibilities for your records. Keep this information for reference; review it carefully and share it with those involved in your care. If you are unable to exercise any or all of these rights, your legally authorized representative may exercise these rights on your behalf.

YOUR STAY

Respect, Compassion and Dignity. You have the right to considerate, compassionate and respectful care at all times in an environment that promotes positive self-image.

Access to Care. You have the right, within the hospital's capacity, policies, mission statement and applicable law, to a reasonable and impartial response to your request for treatment or services that are available and medically indicated.

Communication. You have the right to effective communication and the right to unrestricted access to communication within the capacity of the hospital unless restrictions are necessary for your care. Such restrictions, if necessary, will be fully explained to you and your family with your participation.

Identity. You have the right to know the identity and professional status of the person(s) responsible for the delivery of your care, treatment and services. You also have the right to know the relationship between the hospital and other health care providers involved in your care.

Information. You and, when appropriate, your family, have the right to be involved in decisions about your treatment and care; and, to be informed about outcomes of care, including unanticipated outcomes.

Notification of Family and Physician. You have the right to have a family member or representative of your own choice, and your own physician notified promptly of your admission to the hospital.

YOUR CARE

Pain Management. You have the right to management of your pain with assessment and treatment.

Refusal of Treatment. You have the right to refuse treatment, including life-sustaining procedures, to the extent permitted by law and the Ethical and Religious Directives for Catholic Health Care Services, and should be informed of the medical consequences of this action.

Advance Directives. You have the right to create or present Advance Directives (such as a Directive to Physicians and Family or Surrogates, a Medical Power of Attorney or a Living Will) and to know that the terms of your directives will be followed in accordance with the law and the *Ethical and Religious Directives for Catholic Health Care Services*. Your Advance Directives shall be placed in your medical record and may be reviewed periodically by you or your designated decision maker. You are not required to have an Advance Directive in order to receive care.

Informed Consent. You have the right to reasonable, informed participation in decisions involving your health care. You have the right to give informed consent prior to the start of any procedure or treatment.

Filming and Recording. You have the right to give informed consent, authorization or the right to refuse prior to filming or recording of your care uses other than for treatment, payment, or health care operations.

Research and Clinical Trials. You have the right to be informed if your physician proposes to engage in or perform research, investigational studies or clinical trials affecting your care or treatment. You have the right to refuse to participate in such research projects and refusal will not affect your access to care or treatment.

Ethical Issues. You and your designated representatives have the right to participate in the consideration of ethical issues that arise during your care. If you or your family need help making difficult decisions, counselors, chaplains and others are available to help in consideration of your physical, mental, social, spiritual and cultural diversity that influence your illness.

Transfer and Continuity of Care. You have the right not to be transferred to another facility or organization until you have received a complete explanation of the need for the transfer and of the alternatives to such a transfer. Any transfer of patients must be acceptable to the other facility or organization. You have the right to be informed of continuing health care requirements that your physician feels you may need after you leave the hospital.

PERMANENT PART OF MEDICAL RECORD

PATIENT RIGHTS & RESPONSIBILITIES



YOUR SAFETY AND SECURITY

Privacy, Security and Confidentiality. You have the right to personal privacy, security and confidentiality of information. State and federal laws and hospital operating policies protect the privacy of your medical information. You will receive a Notice of Privacy Practices that describes the way the hospital safeguards and may use or disclose your information. The Notice of Privacy Practices also explains how you may obtain a copy of your health care information from the Hospital Health Information Management (HIM) Department.

Personal Safety. You have the right to receive care in a safe setting and to be free from all forms of abuse or harassment.

Protective Services. You have the right to access protective services and authorized individuals or agencies. For those wishing more information on these services, a hospital representative is available to assist you at (409) 892 - 7171 or you may call the Texas Abuse Hotline at 1-800-252-5400 or Louisiana Protective Services at 1-800-898-4910.

Restraints and Seclusion. You have the right to be free from restraints or confinement of any form that is not medically necessary or is used as a means of coercion, discipline, convenience, or retaliation.

HOSPITAL SERVICES

Hospital Charges. Regardless of the source of payment for your care, you have the right to request and receive an itemized and detailed explanation of your total hospital bill for services rendered.

Interpretive Services. You have the right to qualified interpretation services free of charge if you have special communication needs due to deafness, blindness and/or limited English proficiency.

Complaint Resolution. You have the right to register a complaint concerning any aspect of your care and receive follow-up from a hospital representative to clarify policies and procedures pertaining to hospital services, including your rights and responsibilities as a patient. You may also place a complaint with the following entities:

- Louisiana Department of Health, DHH/Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821, Phone: (225) 342-0138
- New Mexico Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110, Phone: (505) 827-2613
- Texas Department of State Health Services, P.O. Box 149347, Austin, TX 78714-9347, Phone: (888) 973-0022
- The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, complaint@jointcommission.org

Organ or Tissue Donation. You have the right to accept or decline the opportunity to become an organ or tissue donor. You may make your wishes known to a hospital representative.

PATIENT RESPONSIBILITIES

Consideration. You are responsible for following hospital rules and regulations affecting patient care and comfort and for being considerate of the rights of others while in the hospital. Please help us by controlling noise, observing our no-smoking policy, and limiting the number of your visitors.

Giving Information. You are responsible for providing accurate and complete information about your health and for reporting changes in your condition.

Pain Management. You are responsible, in consultation with your physician and nurse, in assisting them in measuring the amount of pain you experience. You are responsible for telling a member of your health care team if your pain is not relieved and of any concerns you may have taking pain medications. You are also responsible for following the prescribed and agreed upon pain management plan.

Following Instructions. You are responsible for following the treatment plan recommended by your doctors, nurses, and other caregivers and for reporting to your doctor the side effects of any treatments. You should also make it known if you do not clearly understand a course of action in your treatment. If you refuse treatment or fail to follow the directions of your physicians and other health care providers, please understand that you assume full responsibility for the consequences of your decision.

Financial Responsibility. You are responsible for ensuring that the financial obligations of your health care are fulfilled at time of service.

These rights and responsibilities are to promote a better hospital/patient relationship in keeping with the Mission, Vision and Core Values of CHRISTUS Health.

[References: 42CFR§482.13; TJC RI 01.01.01- 02.01.01; NMAC§7.11.2.26; TAC§133.42]

PERMANENT PART OF MEDICAL RECORD

PATIENT RIGHTS & RESPONSIBILITIES





CHRISTUS® SOUTHEAST TEXAS

Bariatric Center - *St. Elizabeth*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____ Date of Birth: _____

I hereby authorize medical providers and personnel of the CHRISTUS Southeast Texas Bariatric Center to discuss my protected health information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ I **DO NOT** authorize the CHRISTUS Southeast Texas Bariatric Center to release **ANY** medical or appointment information to anyone.

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires.

- Unless specified above, this authorization will expire 365 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Center has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

Signature of Patient/Personal Representative

Printed Name of Patient/Personal Representative

Date

Description of Personal Representative's Authority



CHRISTUS® SOUTHEAST TEXAS

Bariatric Center - *St. Elizabeth*

Patient Name _____ **Date of Birth** _____

Dietitian Charges

Initial Dietitian Assessment	\$ 60.00
Follow Up Dietitian Assessment	\$ 30.00
Group Classes (per person)	\$ 20.00
Bariatric Preoperative Kit	\$125.00-160.00

Mental Health Assessment

Physician Charges for Lap Band Fills/Unfills: Fill/Unfill - S2083

Initial Assessment	\$250.00
CHRISTUS Southeast Texas St. Elizabeth	110.00
Physician Charge	150.00
CHRISTUS Southeast Texas St. Elizabeth	110.00
(filed on insurance as applicable)	

******THESE FEES WILL NOT BE FILED ON YOUR INSURANCE******

I am aware that these services are not filed on my insurance and therefore, I am responsible for payment when services are rendered.

Patient's Signature: _____ **Date** _____



Mental Health Evaluation

Patient Name: _____

1. Are you currently being treated by a psychologist/psychiatrist? Y/N

If yes, please list who you see and date of last visit: _____

2. Are you on any prescription medications for a mental health disorder? Y/N

If yes, please list the name/dose of the medication: _____

3. Have you ever been hospitalized for a mental health disorder? Y/N

If yes, please give the date and reason for admission: _____

4. Do you drink? Y/N Use Nicotine? Y/N Use illegal drugs? Y/N

If yes, please explain type/amount/what age you started:

5. Who is your support system for surgery? _____

Reviewed by Surgeon: _____

Date: _____



PROVIDER BASED CLINIC

ATTENTION ALL PATIENTS NEW AND ESTABLISHED

Effective October 1, 2013 the CHRISTUS Southeast Texas Bariatric Center St. Elizabeth will become a Provider Based Clinic. A Provider Based Clinic is a department of the hospital similar to how the Emergency Department, Imaging Center, or Laboratory is a department of the hospital. What this means to you is your insurance will be billed for services within the department by CHRISTUS Southeast Texas St. Elizabeth.

Your physician fees will remain the same. Under this arrangement you may be subject to out-of-pocket fees in the form of a co-payment or from your deductible. This will apply to physician office visits only at this time. This will be applicable to both new and established patients.

Please understand we will strive to keep your out-of-pocket costs to a minimum. However, you may receive a bill for services from CHRISTUS Financial Services.

Thank you for your cooperation and understanding during this transition.

Bill Klamfoth
Regional Director
Outpatient Operations

Patient Signature

Date

Participating Provider Status

Based on the information you provided us today, **CHRISTUS Southeast Texas St. Elizabeth Hospital** is is not a participating provider or is unable to confirm participating status under your third-party payor coverage with _____ on the date services are to be rendered.

If **CHRISTUS Southeast Texas St. Elizabeth** is a participating provider under your insurance plan's network, it is important to note other professional services provided at or through the facility by physicians and other health care practitioners may not be participating providers in your health plan. Therefore, their charges may not be covered by your health plan and you will be responsible for payment of the fees. Please contact your insurance provider for further information and to determine the participating status of your health care providers.

Please note that requesting an estimate may result in a delay in the scheduling and/or date of your inpatient admission, outpatient surgical procedure or other service.

The actual charges for your inpatient admission, outpatient surgical procedure or other service will vary based on your medical condition and other factors such as your recovery time, reaction to medications or treatment, etc.

The actual charges for your inpatient admission, outpatient surgical procedure or other service may differ from the amount paid by you or your insurance provider. You may be personally responsible for payment for your treatment, depending on your health benefit plan coverage.

For information regarding your health benefit plan, please contact your insurance provider directly. They can provide you with accurate information regarding your plan structure, benefit coverage, deductibles, co-payments, coinsurance and other plan provisions that may impact your liability for payment for your inpatient admission, outpatient surgical procedure or other service.

For more information about **CHRISTUS Southeast Texas St. Elizabeth** procedures regarding estimates and pricing policies, please visit us on the web at <http://www.christushealth.org>.



CHRISTUS DISCLAIMER NOTICE FOR UNINSURED PATIENTS

At this time, we can only estimate your charges, and you may incur additional charges resulting from your visit. All questions about your account should be directed to our business office 1-800-756-7999.

We appreciate your considering CHRISTUS Hospital for your health care services.

NOTE: Estimates are based on hospital charges for anticipated routine care and recovery. Actual charges on the final hospital bill may vary from the estimate, based on the patient's medical condition, unknown circumstances or complications, final diagnosis, and recommended treatment ordered by the attending physician(s).

This estimate covers hospital charges only. Professional fees for services such as those provided by a contracted or independently-practicing physician, surgeon, radiologist, pathologist, anesthesiologist, nurse practitioner or other independent practitioner are not estimated and may be billed separately.

Charges from providers of non-hospital services (e.g., home health, durable medical equipment, ambulance) are not included in this estimate.

If it is determined that you have or qualify for insurance coverage under a government-sponsored or other health insurance plan, then your charges will be based on the applicable plan health rates for covered services, and the level of insurance coverage, and applicable co-payments, deductibles, and coinsurance may affect your personal out-of-pocket costs.

Understanding Your Hospital Bill

At **CHRISTUS Health**, we are committed to fulfilling our mission to extend the healing ministry of Jesus Christ. We take a proactive approach to patient billing and collections, with respect and professionalism at the forefront of our transactions. We understand that billing and collection for health care services may be confusing. Our admitting and business office staff will work with you to answer your billing questions, set up a payment plan, or to assist you in applying for government-sponsored programs.

Your Hospital Bill As a routine practice and when appropriate, *the hospital expects payment of all known patient expenses at time of service*. Our initial request for payment may include deposits, deductibles, co-pays and coinsurance amounts. The amount of all charges may not be known or available at the time of admission or discharge, and it is possible that charges may be added to your bill after discharge. Therefore, *calculated deposits and coinsurance amounts* are based on estimated charges. Any overpayment will be promptly refunded, and we will not charge interest on any balance of your bill that remains after your insurance provider has provided us with their portion of the payment.

You may request an itemized copy of your bill after your discharge from the hospital. A copy of your bill will be provided to you as soon as it has been finalized or otherwise as soon as possible.

Discounts

CHRISTUS Health has initiated an updated uninsured discount policy for patients who do not have any type of insurance coverage, liability claims, or any other funds or means available to pay their hospital bill. We will discount bills under these circumstances for all patients who receive medically necessary services. Information about this program will be provided at the time of registration or during your visit. After your bill has been discounted, you will be asked to pay the remainder. If you are unable to pay your bill in full, we may ask you for a partial payment on your account. We will also work with you to see if you may:

- Qualify for programs like Medicaid or Medicare
- Set up a payment plan
- Apply for a charity discount

We also provide charity care discounts for patients whose family income is at 200 percent of the Federal Poverty level or less. A prompt pay discount may also be available if you pay your entire bill at the time of service. Please feel free to ask a CHRISTUS associate for more information about any of our discount policies.

Physician Billing

Professional services may be provided to you by independent physicians, including physician services in some hospital departments (for example ER or Radiology). These physician services will be billed separately and apart from the fees charged by the hospital. Please note that physicians and other health care providers who provide services for you may not be listed as participating providers or contracted with the same insurance plans as the hospital. We have contracts in place for many managed care networks, but not all. It is possible that these physician services may be provided to you "out of network". This means that their services may not be covered by your medical insurance provider even if the hospital is in your network. If you receive a bill from a physician and have questions, please call the telephone number listed on the bill or call the number listed at the bottom of this notice. Physicians that may bill you separately include, but are not limited to the following:

- Your personal physicians
- Pathologists
- Emergency Department physicians
- Cardiologists
- Anesthesiologists
- Radiologists
- Neonatologists
- Hospitalists

Processing Your Bill

If you have current insurance coverage, our hospital billing department will bill your insurance company shortly after your visit. When a claim is sent to your insurance company, an informational letter will be sent to you. Please note that this letter is NOT a bill. Your insurance company should pay your hospital bill within 60 days. The hospital may request your help in contacting your insurance company if payment is delayed. There may also be times when your insurance company needs additional information from you before they will pay your bill. Please respond to your insurance company as quickly as possible so payment is not delayed. Please note that you may be responsible for all or part of the remaining charges that are not paid by your health benefit plan, and payment will be due upon receipt of your bill.

Notice of Medicare Non-Covered Out Patient Drugs

Medicare does not cover "self administered drugs" in a hospital outpatient setting. If you get self-administered drugs that are not covered by Medicare, the hospital may bill you for the drugs. If you have Medicare supplemental coverage, your plan may or may not cover these drugs. Self-administered drugs are those that you would normally take on your own. Examples of these types of drugs are listed in your Medicare Handbook.

We're Here for You!

Please contact your local CHRISTUS Hospital billing office at 1-844-936-6009 if you have questions concerning your bill.
To pay your bill online, please visit www.christusepay.com

Patient Signature

Date

PERMANENT PART OF MEDICAL RECORD

UNDERSTANDING YOUR HOSPITAL BILL



* H S P B L *

CHRISTUS Southeast Texas St. Elizabeth and St. Mary
Notice of Privacy Practices
Effective 3/26/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, please contact the Privacy Office at the address or phone number at the end of this Notice.

Who will follow this Notice?

CHRISTUS Southeast Texas St. Elizabeth and St. Mary provides healthcare to our patients, residents and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- ❖ Any healthcare professional who treats you at any of our locations;
- ❖ All departments and units of our organization including all off-campus units or departments;
- ❖ All employed Associates, staff or volunteers of our organization, including Associates at our regional office and CHRISTUS Health, our parent organization, with whom we may share information as permitted within our organized healthcare arrangement.
- ❖ Any Business Associate or Business Associate sub-contractor, or any affiliate or partner of CHRISTUS Health with whom we share health information.

Our pledge to you:

- ❖ We understand that medical, billing and personal information is very important and we are committed to protecting the privacy of that information. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by our Associates or your personal physician. Your personal physician may have different policies or Notices regarding the physician's use and disclosure of medical, billing and personal information created in the physician's office.
- ❖ We will not sell your medical or personal information for direct or indirect payment without your authorization.

We are required by law to:

- ❖ Keep medical, billing and personal information about you private;
- ❖ Give you this Notice of our legal duties and privacy practices with respect to your protected health information;
- ❖ To notify you of an unauthorized disclosure of your unsecured medical, billing or personal information;
- ❖ Follow the terms of the Notice currently in effect.

Changes to this Notice:

We may change our policies and privacy practices at any time. Changes will apply to your protected health information we already have, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our Notice and post the new Notice prominently in waiting areas and on our website at www.christussetx.org. You can receive a copy of the current Notice at any time. The effective date is listed just below the title. You will be offered a copy of the current Notice each time you register at our facility for treatment. You will also be asked to acknowledge your receipt of this Notice in writing.

PERMANENT PART OF MEDICAL RECORD

NOTICE OF PRIVACY PRACTICES



How we may use and disclose your protected health information:

We may use and disclose medical, billing and personal information about you for:

- ❖ **Treatment** (such as sending medical information about you to another provider of healthcare as part of a referral);
- ❖ To obtain **payment** for care provided (such as sending billing information to your insurance company); NOTE: if you pay out of pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your insurance company;
- ❖ And to support our **health care operations** (such as comparing patient data to improve treatment methods).

We may use and disclose medical information about you without your authorization for:

- ❖ Public health purposes;
- ❖ Abuse or neglect reporting;
- ❖ Health oversight audits or inspections;
- ❖ Some research studies;
- ❖ Funeral arrangements;
- ❖ Organ donation;
- ❖ Worker's compensation purposes;
- ❖ During emergencies;
- ❖ When required by law, such as in response to a request from law enforcement officials in specific circumstances;
- ❖ In response to valid judicial or administrative orders.

We may contact you without authorization for:

- ❖ Appointment reminders;
- ❖ To inform you about possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

We may use certain demographic information without authorization:

- ❖ Such as name, address, telephone number or e-mail address, date of birth, health insurance status, gender, dates of service, department of service information, treating physician information or outcome information to contact you for the purpose of fundraising for CHRISTUS Southeast Texas St. Elizabeth and St. Mary. You have the right to opt-out of receiving future communications with each solicitation. Information on how to opt-out will be contained in each communication.
- ❖ We may provide your name to our institutionally related foundation. The money raised will be used to expand and improve the programs and services we provide to the community. Information on how to opt-out will be contained in each communication.
- ❖ Your decision to opt-out will have no impact on your treatment or payment for services at CHRISTUS Southeast Texas St. Elizabeth and St. Mary.

PERMANENT PART OF MEDICAL RECORD

NOTICE OF PRIVACY PRACTICES

If you are admitted as a patient:

- ❖ You have the option of not being listed in the facility patient directory.
- ❖ If you do chose to be listed in the directory, the following information will be listed and may be released to anyone who asks for you by name, except religious affiliation:
 - Your name
 - Your location in the facility
 - Your general condition (good, fair, guarded, critical, etc.)
 - Your religious affiliation (your religious affiliation may be disclosed to a facility employed clergy member, even if they do not ask for you by name).
- ❖ We may disclose medical and billing information about you to a friend or family member who is involved in your medical care; or
- ❖ To disaster relief authorities so that your family can be notified of your location and condition.

Other uses of your medical information:

- ❖ Other than face-to-face conversations about services and treatment alternatives we will not use your protected information for marketing purposes without your authorization.
- ❖ In any other situation not mentioned in this Notice, we will ask for your written authorization before using or disclosing your medical, billing or personal information.
- ❖ If you choose to authorize the use or disclosure of your medical, billing or personal information, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding your medical and billing information:

- ❖ In most cases, patients have the right to look at or obtain a copy of their medical and billing information contained in the designated record set used to make decisions about their care.
- ❖ You may request this information in a printed format or if the information is maintained electronically you may request an electronic copy of the information.
- ❖ There may be a fee charged for the cost of supplies and labor for creating the paper or electronic copy.
- ❖ If you believe that information in your designated record set is incorrect or that information is missing, you have the right to request that we correct the records. Your request must be submitted in writing and include the reason you are requesting the change. We can deny your request to change a record if the information you are requesting to be changed was:
 - not created by us,
 - is not part of the medical or billing information maintained by us, or
 - if we determine that the record is accurate.
- ❖ You may appeal, in writing, a decision by us not to amend a record.
- ❖ You have the right to a list of those instances when we have disclosed medical, billing and personal information about you, for reasons other than treatment, payment or healthcare operations or without your authorization. Your written request must identify a time period, which must be less than a six (6) year time period and after April 14, 2003. You may receive the list in a printed format or, if available, in an electronic format. There may be a cost associated with your request. You will be informed of the cost before any charges are incurred.
- ❖ If you initially received this Notice electronically, you have the right to a paper copy.
- ❖ You have the right to request that your medical and billing information be communicated to you in a confidential manner, such as sending mail to an address other than your home.

PERMANENT PART OF MEDICAL RECORD

NOTICE OF PRIVACY PRACTICES

You must notify us in writing of the specific manner or location for us to use to communicate with you.

- ❖ You may request, in writing, that we not use or disclose your medical, billing or personal information for treatment, payment or healthcare operations to persons involved in your care except when specifically authorized by you, or when required by law, or in an emergency. We will consider your request but we are not legally required to honor the request.
- ❖ Where you pay for service out-of-pocket in full, you have the right to restrict certain disclosures of protected health information to your insurer or health plan.

Complaints:

- ❖ If you are concerned that your privacy rights may have been violated or if you disagree with a decision made about access to your records, you may:
 - contact the Privacy Office listed in this Notice;
 - call the CHRISTUS Health Integrity Line, available 24 hours a day, 7 days a week at 1-888-728-8383 or access it electronically at <https://christus.alertline.com/gcs/overview>;
or
 - file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights (OCR) at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>.
- ❖ If you need help filing a complaint or have a question about the complaint or consent forms, you may e-mail OCR at OCREmail@hhs.gov or request help from the Privacy Office listed in this Notice.
- ❖ We will not retaliate against you for filing a complaint.

PRIVACY OFFICE CONTACT INFORMATION:

Privacy Officer
c/o CHRISTUS Health
Compliance Department
919 Hidden Ridge
Irving, TX 75038
1-844-444-8440 (toll-free)
privacy@christushealth.org

PERMANENT PART OF MEDICAL RECORD

NOTICE OF PRIVACY PRACTICES



Patient Name: _____ Date of Birth _____
Please print

Guarantor if other than Patient _____ Relationship to patient _____
Please print

LETTER OF EXPLANATION – PROVIDER-BASED CLINICS

Thank you for choosing CHRISTUS Southeast Texas Health System as your health care facility to assist with your health care needs.

We share this notice to inform you of our billing policies for the **CHRISTUS Southeast Texas Bariatric Center St. Elizabeth**. Jerome Schrapps, MD and Kevin Dean, MD although independent of CHRISTUS, treat their clinic patients in the CHRISTUS facility.

Under Provider Based billing, physician offices are considered to be departments of the hospital. Patients visiting a provider-based clinic may receive a bill from the hospital for facility-related fees, and a separate bill from either Jerome Schrapps, MD, LLC or Kevin Dean, MD of Southeast Texas Surgical Associates, P.A. for any professional services (physician services) they receive. The provider-based status essentially separates the fees out and they are billed separately. That is why patients will receive a separate bill from the hospital and another from the physician. There is no difference from the way CHRISTUS bills for other hospital based services like the Emergency Department, Therapy Services, Lab services and surgical procedures.

In the provider based model in physician office locations, the total out-of-pocket expense for a visit could be more, could be the same, or could be less depending on the type of visit and individual's insurance coverage. Depending on one's insurance, this may mean that a patient will pay an additional co-pay and/or deductible (one for the hospital charges and one for the physician). The majority of our Medicare patients carries supplemental insurance and will not see a change in their total out of pocket.

As your health care provider, we are committed to offering you the best care possible. We are also committed to helping you understand our financial and billing policies; so if you have questions regarding these billing policy changes, please feel free to call our **CHRISTUS Health Customer Service Center at 1-800-756-7999 or locally 409-839-5673, if you have questions regarding Provider-Based Billing.**

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

Patient responsibility: You as the patient are ultimately responsible for all fees. All payments, co-payments, co-insurances, and deductibles are due at the time of service, including Physician charges. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary payments, co-payments, co-insurances, and deductibles at the time of service.

Patients with healthcare coverage: We do accept insurance assignment and will file your insurance claims for you, if you have provided a copy of your insurance card at the time of service. You are responsible for all co-payments or balances as required by your specific insurance plan. You need to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If the initial given insurance coverage changes at any time during your care, immediately provide a copy of the new insurance card to a CHRISTUS Southeast Texas Bariatric Center patient representative or our insurance department. If your insurance plan requires a referral, this must be obtained from your primary care physician or specialist prior to coming in to the office. It is your responsibility to obtain this referral. If the referral is not received or obtained when you arrive for your visit your insurance company will not honor the visit so your appointment will be rescheduled.

Patients without insurance coverage: If you do not have healthcare coverage, you are required to make a \$200 payment prior to seeing the physician and you are responsible for any additional charges. The \$200 pre-payment is not the total for today's visit. Following your appointment, see the cashier to give you a total for the cost of the visit. If the charges exceed \$200 you will be asked to pay the remaining balance. If the total charge is under \$200 you will be refunded the difference.

CHRISTUS Southeast Texas Bariatric Center St. Elizabeth accepts the following methods of payment: Cash, check, money order, debit, MasterCard, Visa, Discover, American Express and CareCredit.

Signature _____ Date _____

PERMANENT PART OF MEDICAL RECORD

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY



What does "Provider Based" designation mean?

This is a Medicare status for hospitals and clinics that comply with specific Medicare regulations. Medicare has determined that CHRISTUS has met these regulations and has now been designated as such. This status requires that CHRISTUS bill Medicare in two parts.

How does "Provider Based" affect my billing?

When seeing a CHRISTUS healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under "Provider Based" status, Medicare requires Provider Based to bill all healthcare provider services in two parts. When your medical services are completed, CHRISTUS will submit one claim to Medicare, Facility Fee:

Facility Fee to Part A

When your medical services are completed, CHRISTUS Southeast Texas Bariatric Center St. Elizabeth will submit one claim to Medicare, Provider Fee:

Healthcare provider fee to Part B

You will receive two Medicare Summary Notices (MSNs) from Medicare. Once Medicare has processed their portion of the charges, the balance will be submitted to a secondary payer. If there is a balance after the secondary insurance processes the claim, or if you do not have secondary insurance, you will receive a bill for the remaining balance.

Medicare has designated CHRISTUS outpatient clinics as "Provider Based" facilities. As Medicare recipients, this designation affects the way your services are billed to Medicare. CHRISTUS is committed to providing you with the highest standard of medical care.

If you have any questions regarding **Provider Based Billing, please call us at 409-839-5673.**

If you have questions regarding your CHRISTUS bill, please feel free to call our **CHRISTUS Health Customer Service Center at 1-800-756-7999.**

Estimate of charges –

AFTER YOUR ANNUAL DEDUCTIBLE IS MET

Medicare requires that we provide you with an estimate of your Part A and Part B coinsurance amounts. These amounts will vary based on the type and number of services received.

Estimate of coinsurance amounts:

	<u>Part A</u>	<u>Part B</u>
Office Visit	\$14-\$15	\$2-\$40
Radiology	\$20-\$40	\$2-\$15
Minor Procedure	\$30-\$50	\$10-\$25

Why does the Medicare Secondary Payor (MSP) Questionnaire need to be completed?

As a participating Medicare provider, CHRISTUS is required to screen Medicare patients according to the Medicare Secondary Payor (MSP) rules. At each visit, business services representatives will ask you the MSP questions. These questions will help to confirm if Medicare or another payer should process the claim as primary.

Commercial Insurance

All pricing is an estimate **AFTER YOUR ANNUAL DEDUCTIBLE IS MET.** Your claim will be processed under the guidelines of your Insurance Company; for covered services and assignment of your out-of-pocket. Our price estimator tool will evaluate your insurance coverage based on the last time the insurance company updated their records with your current or previous claims.

Thank you for choosing CHRISTUS Southeast Texas Bariatric Center as your healthcare provider.

Please note: *The total cost of charges for Medicare patients will not exceed charges incurred by non-Medicare patients receiving the same services.*



CHRISTUS[®] SOUTHEAST TEXAS
Bariatric Center - *St. Elizabeth*



MEDICAL & DIETITIAN APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for choosing The CHRISTUS Southeast Texas Bariatric Center St. Elizabeth. When you schedule an appointment with our office we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please See our Appointment Cancellation/No Show Policy Below:

Effective January 1, 2018 we will not be charging for the first time that you do not show up for an appointment or reschedule within 24 hours of the visit. We understand that unforeseen events can make this necessary.

Any patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second Time will be charged a \$40.00 fee for physician visit or \$20.00 for dietitian visit. **The fee is the patient's responsibility and can't be billed to your insurance company. It is due at the time of your next office visit.**

As a courtesy, our office uses an automated system for appointment reminders. If you don't confirm your appointment via the automated system we make reminder calls. We want to do everything possible to help you make it to your scheduled visit. It will help us tremendously if you can make sure that we are updated regarding any changes to your phone numbers or email.

If you reach a point during the process of working towards surgery that you are no longer able to continue, or simply do not wish to continue, please contact our program coordinator and she will make sure that you do not receive unwanted correspondence.

You may contact our office 24 hours a day, 7 days a week at the Number below. Should it be after regular business hours Monday through Thursday 8am-4pm, Friday 8am-12 noon, or a weekend, you may leave a message on the office voicemail system. Messages are checked daily, except on weekends.

Thank you,

CHRISTUS Southeast Texas Bariatric Center
St. Elizabeth

I have read and understand the above policy x_____.