

*Welcome!*



We are so excited to have you join our family here at Blossom Bariatrics. Helping people regain their health and improve their lives is our passion! Our practice is devoted to surgical weight loss and helping people regain a higher quality of life by losing their excess weight. With the weight loss, people are able to start enjoying the simple pleasures of life again; such as playing with their children or grandchildren, riding a roller coaster for the first time, or starting to date and travel.

Our practice at Blossom Bariatrics views the physician-patient relationship as critical to our ability to provide you with appropriate care and treatment. We will have many discussions regarding the need for various treatments and the importance of following particular medical recommendations.

From the onset of your care with us here at Blossom Bariatrics, the seriousness of your disease should be clear to both you, as the patient, and to our doctors. Successful weight loss surgery can only take place when delivered in careful coordination with your surgeon, your regular physician, and other health care providers such as dietitians. We will provide clear explanations for your surgery. Because bariatric surgery is more of a journey rather than a stand alone operation, it is necessary to follow-up with regularly scheduled appointments. Please understand that continued, regular appointments are essential to your success.

Many of our patients suffer from other serious medical problems. Please continue to receive regular care from your other health care providers. Failure to follow the recommendations of your health care providers could lead to serious health complications. I understand and agree that care which is beyond the scope of Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center's services, as determined by Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center, will be coordinated by and through my primary care doctor or specialists. I have disclosed all known medical conditions and records to Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center and I understand that Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center is relying on my disclosures and medical records.

At Blossom Bariatrics, we truly want to be a partner in your health! To that end, it is critical that patients provide all of their medical history in a correct and complete manner to the best of their knowledge. Please help us here, at Blossom Bariatrics, to help you regain your health and your life back.

A handwritten signature in black ink, appearing to read 'Thomas W. Umbach'.

Thomas W. Umbach  
MD, FACS, FASMBS - Surgeon

I, \_\_\_\_\_, have read the above and understand the implications

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Patient Information

Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Email Address: \_\_\_\_\_

Medication Allergies \_\_\_\_\_ Who referred you to us: \_\_\_\_\_

**Nearest relative/friend not living with you for emergency contact:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## PRIMARY INSURANCE

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

## SECONDARY INSURANCE

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

## Authorization to Release Information & Obtain Insurance Benefits & Criteria

The above information is complete and correct. I authorize release of information necessary to get pre-authorization for a consultation with Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center and to obtain insurance benefits & criteria for Bariatric Surgery. **If the above information is incorrect, you may be held responsible for the full amount of your office visits and/or surgeries.** I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records when necessary. Signature is to remain in full force and effect until said time that it is revoked in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Office and Financial Policies

### Welcome to Our Office

We appreciate you selecting Blossom Bariatrics (BB), Blossom Medical Group (BMG) and Warm Springs Surgical Center (WSSC) to serve your weight loss needs. We are committed to caring for you and to helping you achieve the finest bariatric care possible. We welcome the opportunity to work with you to create a happier and healthier life. Please review this document to become familiar with our procedures.

### Office Hours

BB/BMG regular office hours are Monday through Thursday, 8:00 am to 5:00 pm. WSSC regular office hours are Monday through Friday, 7:00 am to 3:00 pm. The offices are closed on weekends, major holidays, and at times the doctor/staff are attending continuing education programs.

### Fees and Payment Policy

In an effort to keep our fees down while maintaining the highest level of professional care, we have established our financial policy as follows:

*Self-paying patients:* The consultation is \$150; the consultation fee will not be taken off the price of surgery. Any additional appointments will incur a charge of \$150 per visit. We offer financing through various finance companies. Any finance fees charged by these companies will be in addition to those charged by BB/BMG /WSSC.

*Insured Patients:* Co-pays are due at the time of the appointment. Any co-pays outstanding will be collected prior to the patient's surgery.

For your convenience, we offer Visa, MasterCard, and Bank Card debit service.

BB/BMG/WSSC cannot and does not guarantee insurance coverage and its participation in any coverage dispute or appeal will be limited to the provision of legible, accurate, and complete medical records in accordance with NRS 629.061.

Professional care is provided to you, the patient, and not the insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and handling your insurance questions from our office on your behalf. However, ultimately the patient must pay for their medical care if the insurance company refuses payment.

We will make every effort to work with patients in this situation. Should the patient default on a balance owed, the patient will be responsible for any and all legal, collection, and court fees incurred by BB/BMG/WSSC.

The surgeon's fee is due in full prior to the patient's operation.

Additional charges may apply, such as finance fees, transfer fees, program fees, transaction fees, or additional required appointments, etc. Checks returned for insufficient funds, stop payment, and/or account closed are subject to a \$35 fee. The interest rate on balances outstanding over 30 days is 18% annum.

Psychological Evaluations & Nutrition Class are located onsite for your convenience. The providers for these services are outside contractors to BB/BMG and are *not* "employee practitioners." The price of the Nutrition Class is \$350.

BB/BMG charges a \$50 fee for FMLA forms and \$25 fee for Disability forms. Surgical Clearance is available, please ask for pricing.

**Gastric Band Adjustments**

There is an office visit (copay or \$150 self-pay) and band adjustment charge for each and every gastric band adjustment/evaluation (\$150), *There is no guarantee on ANY band adjustment!* After clinic hours, emergency band adjustments will incur an additional fee of \$200.

**Pre-Operative Visit**

The pre-operative appointment will typically be held about 2 weeks before the surgery date. There will be a standard office charge for this visit. Also at this visit, all of the patients surgical responsibilities will be collected. These fees can include co-pays and deductible amounts.

**Treatment of Staff**

At the discretion of the physician, you will be discharged from our care if you act in an abusive manner to the staff. By signing this contract, you as our patient, agree to be an active participant in your care. In agreeing to do so, you acknowledge an understanding that you may be discharged from our care at the discretion of the physician if any of the above terms are not followed.

**Smoking:**

(initial) \_\_\_\_\_

Clients who smoke are at a **very high risk** for surgical complication and post-surgery healing. The sooner you quit smoking the better! Dr. Umbach, and his associates, requires all clients to be smoke-free for **FOUR WEEKS BEFORE** surgery and **FOUR WEEKS AFTER** surgery. Dr. Umbach reserves the right to cancel your surgery if smoking is suspected.

**Post-Operative Appointments**

The initial post-operative appointment, typically two weeks after surgery, is considered integral to the operation and therefore is included in the surgeon's fee for the surgery (excluding endoscopies/EGD). Any additional appointments that occur after surgery are new appointments and will be billed appropriately.

**Consults**

In order to provide the patient with optimum care at the initial visit, we require all patients to obtain a referral for consultations from their primary care physician prior that initial consult at BB/BMG. Those patients whose insurance requires a referral, one must be provided within 5 days of the appointment will be liable for the entire usual and customary cost of the consultation. Insurance companies do not typically pay for telephone consults. Therefore, all phone consultations will be billed as a cash basis which will be collected at that particular appointment.

**Appointments**

Patients are seen by appointment only. Please schedule in advance so that we may reserve a time for you. Appointment scheduling is available online through <https://blossombariatricsportal.patrx.com/Login>. The office telephone number is (702) 463-3300. We make every effort to be on time for our patients, and ask that you extend the same courtesy to us. If you cannot keep an appointment, please cancel or reschedule your appointment at least 24 hours in advance. Late cancellations (within 24 hours of appointment) or no shows to the appointment will be charged \$100. After 3 "No Shows" we have the right to discharge you from our practice.

**Wholly Owned Subsidiaries**

Dr. Thomas Umbach has an equity interest in BB/BMG (located at 7385 S. Pecos Rd., Las Vegas, NV 89120) and WSSC (3235 E. Warm Springs Rd., Las Vegas, NV 89120). The patient has a right to obtain services at these entities, and understands similar services can be obtained at North Vista Hospital (409 E. Lake Mead Blvd, N. Las Vegas, NV 89030) or at Henderson Hospital (1050 Galleria Dr., Henderson, NV 89011).

**Medical History**

I have disclosed all known medical conditions and records to BB/BMG/WSSC and I understand that BB/BMG/WSSC is relying on my disclosures and medical records. I understand and agree that care which is beyond the scope of BB/BMG/WSSC's services, as determined by BB/BMG/WSSC, will be coordinated by and through my primary care doctor or specialists.

**Credit Transactions**

We are constantly on guard to prevent identity theft and fraud for our customers at BB/BMG/WSSC. As such we follow the red flag rules as stated in the FACTA (Fair and Accurate Credit Transactions Act of 2003) guideline. Common procedures used to verify patient identities include requesting copies of driver's license, current health insurance card, and verifying personal identifying information. The practice manager will be notified immediately of any suspicious behavior or documents.

**Please sign below that you have read and understand the above procedures and policies.**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Thomas W. Umbach**  
MD, FACS, FASMBS



7385 S. Pecos Rd.  
Suite 101  
Las Vegas, NV 89120  
office: (702) 463-3300  
fax: (702) 441-0251



**WARM SPRINGS**  
SURGICAL CENTER  
3235 E. Warm Springs Rd.  
Suite 110  
Las Vegas, NV 89120  
office: (702) 802-5200  
Fax: (702) 802-5201

# Authorization for Disclosure of Medical Information

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Patient's Phone #: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_

I authorize Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center to **release information to:**  
**OR**

I authorize Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center to **obtain information from:**

Name of Provider/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Purpose for this request:**  Healthcare Treatment  Insurance Coverage  Personal  
 Transfer of Care  Other

**Type of Records Authorized:**

Immunization History  
 All medical records related to a specific illness or injury:  
Specify illness/injury: \_\_\_\_\_  
Date(s) of treatment: \_\_\_\_\_

Treatment summary (including history/physical, laboratory tests & x-ray reports, pathology)

Specific information:  
 Procedure report  History & Physical  Physical Therapy  X-ray reports  
 Laboratory test results  Other: \_\_\_\_\_

Copy of the entire medical record, as allowed by law.

**Voice Mail**

In the event we have to contact you and you are not available, may we leave a message on your machine/voicemail box or leave a message with your contact person/family member?

Yes  No

(initial) \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

*Please note that unless revoked by patient in writing, this authorization release shall remain valid indefinitely.*

**I understand that:**

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information state above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Mutual Binding Arbitration Agreement

Patient's Name: \_\_\_\_\_

This mutual binding Arbitration Agreement constitutes an integral part of a contract for medical services by and between **Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center** and Patient who agree to be bound as described hereunder:

1. Any dispute, claim or controversy arising out of or relating to any Consent for Treatment or Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this Arbitration Agreement, shall be determined by arbitration in Clark County, Nevada before one arbitrator with at least 10 years of active litigation experience, unless otherwise directed herein. If the amount claimed is less than \$250,000, the arbitration will be administered by JAMS in accordance with JAMS' Streamlined Arbitration Rules and Procedures. Claims brought under the Streamlined rules will have the damages capped at \$250,000. For claims in excess of \$250,000, the Comprehensive Arbitration Rules and Procedures will apply.

2. This Arbitration Agreement expressly applies to any claims for medical malpractice as defined by Nevada law. Any medical malpractice claims must be arbitrated before a panel of three arbitrators. NRS 41A will apply to any such arbitration proceedings, with the arbitration panel taking the place and stead of the district court. NRS 41A.071 specifically applies to any arbitration proceeding, which requires a malpractice claim to be filed with an affidavit supporting the claims by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice of Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Within 15 days after the commencement of arbitration, each party shall select one person to act as arbitrator. The parties will communicate their selected arbitrator to the JAMS Case Manager. If a party fails to select an arbitrator within 15 days, JAMS will appoint an arbitrator. The two party-determined arbitrators will select a third arbitrator to serve as panel chair within 30 days of the commencement of the arbitration. The panel must be chaired by an attorney with at least 20 years of active litigation experience or a retired judge from a court having jurisdiction in Nevada. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator within the allotted time, the third arbitrator shall be appointed by JAMS in accordance with its rules and the criteria set forth above. All arbitrators shall serve as neutral, independent, and impartial arbitrators.

3. This Arbitration Agreement applies to any claim against Dr. Thomas W. Umbach individually, Blossom Bariatrics and/or Blossom Medical Group, and/or Warm Springs Surgical Center, and/or any employees or contracted staff. This Arbitration Agreement and the rights of the parties in relation to any claims shall be governed by and construed in accordance with the laws of the State of Nevada.

4. Judgment on the arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

5. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Blossom Bariatrics/Blossom Medical Group/Warm Springs Surgical Center. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.

6. The Arbitration Agreement shall bind the parties hereto, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns. All parties to the arbitration will bear their own attorney's fees and costs, and an equal share of the arbitration fees.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: \_\_\_\_\_

# HIPAA Privacy Practices Notice

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## **Your Information. Your Right. Our Responsibilities.**

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.**

## **Your Rights**

This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address and we will accommodate all reasonable requests.
- You can ask us to not contact you in a specific way (for example, email, voice/voicemail, text and/or postcards).

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. We will review requests for information and respond within 30 days.

### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will take reasonable efforts to ensure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not take any adverse action against you for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will strive to follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission: marketing purposes, sale of your information, or most sharing of psychotherapy notes.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.  
*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.  
*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues**

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you for workers’ compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order or subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**Other Instructions for Notice**

- This Notice is effective as of June 1, 2015.
- Any questions or concerns regarding privacy or security may be addressed to:  
*Janelle Molina, Office Manager, 7385 S. Pecos Rd, Las Vegas, Nevada 89120*

***All medical records are electronic.  
Any paper records are scanned and destroyed by intra-office shredding.***

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Assignment of Insurance Payments

Blossom Bariatrics/Blossom Medical Group bills your insurance as a courtesy for all in network and out of network policies. Occasionally the insurance company will send payment directly to the patient. If this does happen with your policy, simply sign the back of the check "Pay to the order of Blossom Bariatrics" then you sign underneath. Be sure to send a copy of all correspondence that comes with the check.

(initial) \_\_\_\_\_

I understand and acknowledge that I have a legal obligation to pay for the services I have received or will receive from Blossom Bariatrics/Blossom Medical Group.

(initial) \_\_\_\_\_

I also acknowledge that if my health insurance company covers the medical procedures I have received or will be receiving, that payment from my health insurance company should be paid to Blossom

Bariatrics/Blossom Medical Group. ***Under no circumstances am I entitled to receive and keep any payments from my health insurance company. These payments are rightfully owed to Blossom Bariatrics/Blossom Medical Group in payment for the services I have received from them.***

THEREFORE, I hereby assign to Blossom Bariatrics/Blossom Medical Group any and all sums of money which I have received to date or which I may receive in the future from my health insurance company.

I HEREBY authorize and instruct \_\_\_\_\_ Insurance Company, Policy # \_\_\_\_\_ to pay all sums which it has paid or would pay to me directly to Blossom Bariatrics/Blossom Medical Group at the following address:

Blossom Bariatrics  
7385 S Pecos Rd  
Suite 100  
Las Vegas NV 89120

Blossom Medical Group  
7385 S Pecos Rd  
Suite 101  
Las Vegas NV 89120

This Assignment is to remain in full force and effect for all claims submitted and all payments made from the date this Assignment is executed below until it is revoked in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_





# Assignment of Insurance Payments

Warm Springs Surgical Center bills your insurance as a courtesy for all in network and out of network policies. Occasionally the insurance company will send payment directly to the patient. If this does happen with your policy, simply sign the back of the check "Pay to the order of Warm Springs Surgical Center" then you sign underneath. Be sure to send a copy of all correspondence that comes with the check.

(initial) \_\_\_\_\_

I understand and acknowledge that I have a legal obligation to pay for the services I have received or will receive from Warm Springs Surgical Center.

(initial) \_\_\_\_\_

I also acknowledge that if my health insurance company covers the medical procedures I have received or will be receiving, that payment from my health insurance company should be paid to Warm Springs Surgical Center. ***Under no circumstances am I entitled to receive and keep any payments from my health insurance company. These payments are rightfully owed to Warm Springs Surgical Center in payment for the services I have received from them.***

THEREFORE, I hereby assign to Warm Springs Surgical Center any and all sums of money which I have received to date or which I may receive in the future from my health insurance company.

I HEREBY authorize and instruct \_\_\_\_\_ Insurance Company, Policy # \_\_\_\_\_ to pay all sums which it has paid or would pay to me directly to Warm Springs Surgical Center at the following address:

Warm Springs Surgical Center  
3235 E Warm Springs Rd  
Suite 110  
Las Vegas NV 89120

This Assignment is to remain in full force and effect for all claims submitted and all payments made from the date this Assignment is executed below until it is revoked in writing

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

## Assignment of Benefits/ ERISA Authorized Representative Form

### FINANCIAL RESPONSIBILITY:

I have requested professional services from Blossom Bariatrics/Blossom Medical Group ("Provider") on behalf of myself and/or my dependents, and understand that by making the request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

### ASSIGNMENT OF INSURANCE BENEFITS - APPOINTMENT OF 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 their affiliated law firms and billing representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

(initial) \_\_\_\_\_ File medical claims with the health plan

(initial) \_\_\_\_\_ File appeals and grievances with the health plan

(initial) \_\_\_\_\_ Institute and necessary litigation and/or complaints against my health plan naming me as the plaintiff in such lawsuits and actions if necessary

(initial) \_\_\_\_\_ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to the Provider is accurate as 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 Provider 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 deductibles.

### AUTHORIZATION OF RELEASE INFORMATION:

I hereby authorize "My Authorized Representatives" to:

(initial) \_\_\_\_\_ Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments

(initial) \_\_\_\_\_ Process insurance claims generated in the course of examination or treatment

(initial) \_\_\_\_\_ Allow a photocopy of my signature to be used to process insurance claims

(initial) \_\_\_\_\_ This order will remain in effect until revoked by me in writing

**ERISA AUTHORIZATION:**

I hereby designate, authorize, and convey to "My Authorized Representatives" to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

(initial) \_\_\_\_\_ The right and ability to act as my authorized representative in connection with any claim, right, or cause in 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.

(initial) \_\_\_\_\_ The right and ability to act as my authorized representative to pursue 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 ability to act as "My Authorized Representative" with respect to a benefit plan governed by the provisions of ERISA 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. I authorize communication with Provider and his authorized representatives by email and my email address is: (email) \_\_\_\_\_

(initial) \_\_\_\_\_ I understand that I can revoke this authorization in writing at any time.

(initial) \_\_\_\_\_ A photocopy of this assignment/authorization shall be as effective and valid as the original.

**Print Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Assignment of Benefits/ ERISA Authorized Representative Form

### FINANCIAL RESPONSIBILITY:

I have requested professional services from Warm Springs Surgical Center (“Provider”) on behalf of myself and/or my dependents, and understand that by making the request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

### ASSIGNMENT OF INSURANCE BENEFITS - APPOINTMENT OF 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 their affiliated law firms and billing representatives (hereinafter, “My Authorized Representatives”) and I appoint them as my authorized representative with the power to:

(initial) \_\_\_\_\_ File medical claims with the health plan

(initial) \_\_\_\_\_ File appeals and grievances with the health plan

(initial) \_\_\_\_\_ Institute and necessary litigation and/or complaints against my health plan naming me as the plaintiff in such lawsuits and actions if necessary

(initial) \_\_\_\_\_ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to the Provider is accurate as 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 Provider 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 deductibles.

### AUTHORIZATION OF RELEASE INFORMATION:

I hereby authorize “My Authorized Representatives” to:

(initial) \_\_\_\_\_ Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments

(initial) \_\_\_\_\_ Process insurance claims generated in the course of examination or treatment

(initial) \_\_\_\_\_ Allow a photocopy of my signature to be used to process insurance claims

(initial) \_\_\_\_\_ This order will remain in effect until revoked by me in writing

**ERISA AUTHORIZATION:**

I hereby designate, authorize, and convey to "My Authorized Representatives" to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

(initial) \_\_\_\_\_ The right and ability to act as my authorized representative in connection with any claim, right, or cause in 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.

(initial) \_\_\_\_\_ The right and ability to act as my authorized representative to pursue 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 ability to act as "My Authorized Representative" with respect to a benefit plan governed by the provisions of ERISA 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. I authorize communication with Provider and his authorized representatives by email and my email address is: \_\_\_\_\_

(initial) \_\_\_\_\_ I understand that I can revoke this authorization in writing at any time.

(initial) \_\_\_\_\_ A photocopy of this assignment/authorization shall be as effective and valid as the original.

**Print Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_