BARIATRIC ASSOCIATES of NEW ENGLAND, LLC

Patient Information Form

Patient Name: (Last)______________________________(First)_____________________________(MI)____

Name you prefer to be called: ____

Address: ____City: ____________State: ______Zip: _______

Home Phone: ____________________________________Beeper/Cellular: ________________________

Date of Birth: ___/___/____ Country of Birth:____________Country of Parents' Birth:___________

Education: (*Circle/Underline the highest level achieved*)

Elementary · High School/Technical School · 2yr College · 4yr College · Graduate School

Employment Information:

Patient Employer: _________________________________Occupation: _______________________________

Employer Address: ______________________________City: ____________State:_______ Zip: ______

Work Phone: ____________________________________Ext. ____

Social Security #: ______________________________Drivers License #: _________________________

In Case of Emergency:

Name: ___________________________________Relationship: ______________Phone: _______________

Family Physician: ____Phone: _______________

Referred by: ____

Insurance Information:

You are expected to pay your deductible and copayments at the time of service.

Missed Appointments/Late Cancellations:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge a fee of $50.00 for missed, late or cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Financial Policy:

Thank you for selecting BANE for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, AMEX, Discover and personal checks. Patients will be charged a fee of $50.00 for all personal checks returned due to insufficient funds.

All professional fees for services rendered are non-refundable. Supplements and meal replacements are non refundable due to safety concerns and consumable nature of the products.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

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Patient's Signature Date