Advanced Weight Loss Surgery/Maryland Bariatrics

Barry S. Greene, MD
Joseph A. Greene, MD, MBA

PATIENT REGISTRATION

Today's date: Primary Care Physician:

Patient's Legal Name (Last, First, Middle):_____ Date of Birth _____

Patient's Street Address: _____ City_____ State_____ Zip _____ SS # _____

Home Ph: _____ Cell Ph: _____ Email _____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated **Sex** ◯ Male ◯ Female Race _____

Employer: _____ Occupation: _____

Employer Address: _____ City _____ State_____ Zip_____

Who referred you to us? _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance**:** _____

Member ID # _____ Group # _____ Insurance Phone # _____

Insurance Address: _____ City _____ State _____ Zip _____

Policyholder's name (if different from patient) (Last, First, MI) _____ DOB_____

Relationship to Patient: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Employer: _____ Employer 's Address: _____

City _____ State_____ Zip ____ Employer's phone _____

SECONDARY INSURANCE INFORMATION

Name of Primary Insurance**:** _____

Member ID # _____ Group # _____ Insurance Phone # _____

Insurance Address: _____ City _____ State _____ Zip _____

Policyholder's name (if different from patient) (Last, First, MI) _____ DOB_____

Relationship to Patient: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

PREFERRED PHARMACY

Address: _____ Phone: _____

EMERGENCY CONTACT Name (Last, First, MI) _____ Home Ph: _____ Cell: _____

Relationship to Patient: ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all c0-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date (Month/Date/Year) _____/_____/_____

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AUTHORIZATION/RELEASE

I hereby give permission for my clinical information to be shared with Shady Grove Adventist Hospital/Holy Cross Hospital and the surgical review corporation for quality assurance purposes and possible data publication provided that I am not identified in any publication.

☐ YES ☐ NO

AUTHORIZATION/RELEASE

I hereby authorize the following person(s) to receive medical information, make appointment(s)/appointment changes, receive results, and have communications on my behalf.

LAST NAME: FIRST NAME:

NOTICE OF PRIVACY PRACTICES

By signing below, I am verifying that I have reviewed a copy of Advanced Weight Loss Surgery/Maryland Bariatrics "Notice of Privacy Practices", that I have had the opportunity to review the notice and ask any questions regarding the information provided within the notice, that I understand the information contained within the notice document, and that I may obtain a copy of the document upon request at any time.

PATIENT/GUARDIAN SIGNATURE: DATE:

PATIENT FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible care and service. If you have medical insurance, we are happy to assist you receive your maximum allowable benefits. In order to achieve these goals, you will need to remit all relevant insurance policy information to the provider at the time of service.

Please understand:

-Your insurance is a contract between you and the insurance company.
-You are responsible for whatever portion of our charges your insurance does not pay.
-Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These charges are your responsibility.

Unless otherwise agreed upon by the provider, payment for services is due at the time the services are rendered. We accept cash, checks, and all major credit cards. We will be happy to help you process and/or directly submit your insurance claim-form for reimbursement.

We will gladly discuss your proposed treatments and charges and will answer any questions relating to your services.
A copy of this form may be used in place of the original for proof of signature for insurance companies.

Returned checks will be subject to a $35.00 bad check fee. A $30.00 charge will also be applied for missed appointments and appointments canceled without 24 hours advance notice. In the unfortunate event that collection procedures are required to collect an outstanding account balance, the patient shall be responsible for all collection fees in addition to the past due balance.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are happy to help you.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Weight Loss Surgery/Maryland Bariatrics, or insurance company to release any information required to process my claims.

By my signature, I indicate that I have read, understand, and do hereby accept the terms of this agreement.

PATIENT/GUARDIAN SIGNATURE: DATE:

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Weight Loss Surgery/Maryland Bariatrics, for any services furnished by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Advanced Weight Loss Surgery/Maryland Bariatrics for any services furnished by that physician. I authorize any holder of medical information about me to release to the above named Medigap insurer, any information needed to determine these benefits payable for related services.

PATIENT/GUARDIAN SIGNATURE: DATE:

Advanced Weight Loss Surgery/Maryland Bariatrics

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Page 1 of 2	Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY

GENERAL

Please answer the following questions by checking the appropriate box and provide DETAILS for each item where you checked YES.

			DETAILS
☐ YES	☐ NO	Have you had any change in appetite or any weight loss or gain not attributed to dieting?	
☐ YES	☐ NO	Have you ever had cancer? If so, please describe how it was treated.	
☐ YES	☐ NO	Have you or any blood relative ever had an adverse reaction to or problem with anesthesia?	
☐ YES	☐ NO	Have difficulty with hearing, sinus problems, post-nasal drip, ringing in the ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness?	
☐ YES	☐ NO	Have you had heart disease (e.g. rheumatic fever, heart attack, abnormal rhythm, heart murmur, mitral valve prolapses)?	
☐ YES	☐ NO	Have you had high blood pressure?	
☐ YES	☐ NO	Have swelling of feet or legs, pain in legs with walking?	
☐ YES	☐ NO	Do you routinely take antibiotics before dental work or surgery?	
☐ YES	☐ NO	Have you had lung disease (e.g., asthma, emphysema, tuberculosis, pneumonia)?	
☐ YES	☐ NO	Have shortness of breath, prolonged cough, coughing up blood, use home oxygen?	
☐ YES	☐ NO	Have you had gastrointestinal problems (e.g., heart burn, ulcer, chronic diarrhea or constipation, hemorrhoids, piles)?	
☐ YES	☐ NO	Have you had any recent change in bowel habits or blood in stools?	
☐ YES	☐ NO	Have you had any jaundice or liver disease?	
☐ YES	☐ NO	Have you had urinary tract problems (e.g., infection, kidney stones, bloody urine, incontinence, prostate problems, impotence)?	
☐ YES	☐ NO	Have you ever had any venereal or sexually transmitted disease?	
☐ YES	☐ NO	Have you had arthritis? Do you have any pain, stiffness or swelling in any muscles or joints?	
☐ YES	☐ NO	Have you had head trauma, broken bones, and accidents?	
☐ YES	☐ NO	Have you ever had a stroke or any other neurological disease?	
☐ YES	☐ NO	Have you ever had any fits, convulsions or seizures? Have you ever fainted?	
☐ YES	☐ NO	Do you have numbness, tingling or weakness in any part of your body?	
☐ YES	☐ NO	Have persistent rash, itching, new or change in skin lesion, hair loss?	
☐ YES	☐ NO	Do you have a history of depression or other psychiatric illness? Insomnia, irritability, anxiety, recurrent bad thoughts, mood swings, hallucinations?	
☐ YES	☐ NO	Have you had any endocrine disorder (e.g., thyroid or adrenal gland problems)?	
☐ YES	☐ NO	Do you have diabetes?	
☐ YES	☐ NO	Have you had any clotting or bleeding abnormalities (e.g., anemia, sickle cell anemia, leukemia) or lymph gland disorders? Do you bruise or bleed easily?	

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DATE		*NAME:*	
☐ YES	☐ NO	Have you ever had a blood transfusion?	
☐ YES	☐ NO	Are you currently taking Aspirin or blood thinners?	
☐ YES	☐ NO	Are you infected with HIV (the AIDS virus)?	
☐ YES	☐ NO	Have you ever used IV drugs?	
☐ YES	☐ NO	Have you had any exposure to HIV or Hepatitis?	

WOMEN ONLY			
Age at onset of menstruation:		Date of last menstruation:	
Number of pregnancies		Number of live births	Age at first pregnancy
☐ YES	☐ NO	Are you pregnant or breastfeeding?	
☐ YES	☐ NO	Did you ever Nurse? How Long?	
☐ YES	☐ NO	Have you ever taken birth control pills or hormone therapy? When?	
☐ YES	☐ NO	Are you taking hormone therapy now? What kind?	
Have you ever had: ☐ breast Surgery, ☐ breast implants, ☐ breast reduction or ☐ breast biopsy? Please Describe.			
Have you ever had: ☐ breast tenderness, ☐ lumps, ☐nipple discharge or ☐ any other breast problems? Please Describe.			

FOR OFFICE USE ONLY

Examination: Height	Weight	BMI				
Lungs	☐ Clear	☐ Other				
Heart	☐ RRR	☐ Neck				
Abdomen	☐ Soft	☐ Non tender	☐ Non Distended	☐ No Masses/Hernias present	☐ Umbilical Hernia	☐ Ventral Incisional Hernia
Extremities	☐ NO clubbing, cyanosis, or edema			☐ Trace Edema ☐ Moderate Edema		☐ Extreme Edema

Cardiac Clearance Required ☐ NO ☐ YES

	Patient Discussion		**Depression Questionnaire Score =**	
Risks	☐ Bleeding	☐ Infection	☐ Weight Loss Pre- Op	☐ Lifestyle Change
	☐ Injury to Organs	☐ Clot leading to PE	☐ Exercise Pre and Post OP	☐ Vitamins for Life
	☐ Leak	☐ Stricture	☐ Hair loss/Thinning	☐ B-12
	☐ Ulcer	☐ (if applicable) Band slippage / erosion	☐ Malabsorption	☐ Iron

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Date:

Surgery you are interested in: ☐ **Sleeve Gastrectomy** ☐ **Roux-en-Y Gastric Bypass** ☐ **Lap Band**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		***DOB:***	**AGE:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary Care Physician:		***Date of last physical exam:***	
Physician Address:			
City, ST, Zip:			

PLEASE CHECK ANY OF THE FOLLOWING DISEASES FOR WHICH YOU ARE TREATED		
☐ Arthritis: ☐ Ankles ☐ Back ☐ Knees	☐ Gall Bladder removed	☐ Pulmonary Disease
☐ Asthma	☐ Gastro esophageal Reflux Disease	☐ Sleep Apnea
☐ DVT (Deep Venous Thrombosis)	☐ Heart Disease	☐ Venous Stasis
☐ Depression	☐ Hyperlipidemia	☐ Urinary Stress Incontinence
☐ Diabetes	☐ Hypertension	☐ Other : (Please describe)
☐ Edema	☐ Fatty Liver	
☐ Gallstones	☐ Menstrual Abnormalities	

PLEASE LIST ANY PRIOR SURGERY, DATE, AND THE TYPE OF ANESTHESIA		
DATE	**TYPE OF OPERATION**	**TYPE OF ANESTHESIA**
Previous Abdominal Surgery: **yes** ☐ **no** ☐ **If yes, please describe**		

PLEASE LIST YOUR MEDICATIONS AND DOSAGES			
Medication Name	Strength (MG)	Times per day	Prescribing Physician

PLEASE LIST YOUR VITAMIN/SUPPLEMENT AND DOSAGES			
Vitamin/Supplement Name	Amount (MG)	Times per day	Prescribing Physician

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 NAME: ***DATE:***

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

PLEASE LIST ANY FAMILY HISTORY OF CANCER

FAMILY MEMBER	TYPE OF CANCER	Age:	☐ **Living**	☐ **Deceased**
		Age:	☐ **Living**	☐ **Deceased**
		Age:	☐ **Living**	☐ **Deceased**
		Age:	☐ **Living**	☐ **Deceased**
		Age:	☐ **Living**	☐ **Deceased**

WHICH DIETS HAVE YOU TRIED?

Daily Diet Regimen	☐ **High calorie diet** ☐ **High Carbohydrate / Fast foods** ☐ **Large portion eater** ☐ **Other:**

☐ Atkins	☐ Phentermine ☐ Phen-Phen	☐ Fat Burners
☐ Jenny Craig	☐ South Beach	☐ Xenical
☐ Meridia	☐ T-Factor	☐ Optifast/Liquid Diet
☐ Nutrisystems	☐ Weight Watchers	☐ Other: (Please describe)

PHYSICIAN DIRECTED WEIGHT LOSS

Have you had Physician directed weight loss? ☐ NO ☐ YES Do you have **6** months of documented weight management ☐ NO ☐ YES

Name of Physician	Date(s)

PERSONAL SOCIAL HISTORY

Do you have a family history of obesity? ☐ NO ☐ YES

Exercise	☐ Sedentary (No exercise)	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# Of cups/cans per day?			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	
	If yes, what kind?			
	How many drinks per day? How many drinks per week?			
Tobacco	Do you use tobacco?	☐ Yes	☐ No	
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Other drugs used:	☐ None	Describe:		

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Beck Depression Questionnaire / Mental Health Evaluation

1. (0) I do not feel sad
   (1) I feel sad
   (2) I am sad all the time and I can't snap out of it
   (3) I am so sad or unhappy that I can't stand it

2. (0) I am not particularly discouraged about the future
   (1) I feel discouraged about the future
   (2) I feel I have nothing to look forward to
   (3) I feel the future is hopeless and that things cannot improve

3. (0) I do not feel like a failure
   (1) I feel I have failed more than the average person
   (2) As I look back on my life, all I can see is a lot of failures.
   (3) I feel I am a complete failure as a person

4. (0) I get as much satisfaction out of things as I used to
   (1) I don't enjoy things the way I used to
   (2) I don't get real satisfaction out of anything any more
   (3) I am dissatisfied or bored with everything

5. (0) I don't feel particularly guilty
   (1) I feel guilty a good part of the time
   (2) I feel quite guilty most of the time
   (3) I feel guilty all the time

6. (0) I don't feel I am being punished
   (1) I feel I may be punished
   (2) I expect to be punished
   (3) I feel I am being punished

7. (0) I don't feel disappointed in myself
   (1) I am disappointed in myself
   (2) I am disgusted with myself
   (3) I hate myself

8. (0) I don't feel I am any worse than anybody else
   (1) I am critical of myself for my weakness or mistakes
   (2) I blame myself all the time for my faults
   (3) I blame myself for everything bad that happens

9. (0) I am no more irritated now than I ever am
   (1) I get annoyed or irritated more easily that I used to
   (2) I feel irritated all the time now
   (3) I don't get irritated at all by the things that used to irritate me.

10. (0) I have not lost interest in other people
    (1) I am less interested in other people than I used to be
    (2) I have lost most of my interest in other people
    (3) I have lost all my interest in other people

11. (0) I make decisions about as well as I ever could
    (1) I put off making decisions more that I used to
    (2) I have greater difficulty in making decisions than before
    (3) I can't make decisions at all any more

12. (0) I don't feel I look any worse that I used to
(1) I am worried that I am looking old or unattractive
(2) I feel that there are permanent changes in my appearance that make me look unattractive
(3) I believe that I look ugly

13. (0) I can work about as well as before.
(1) It takes an extra effort to get started at doing something
(2) I have to push myself very hard to do anything
(3) I can't do any work at all

14. (0) I can sleep as well as usual
(1) I don't sleep as well as I used to
(2) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
(3) I wake up several hors earlier than I used to and I cannot go back to sleep

15. (0) I don't get more tired than usual.
(1) I get tired more easily than I used to
(2) I get tired from doing almost anything
(3) I am too tired to do anything

16. (0) My appetite is no worse than usual
(1) My appetite is not as good as is used to be
(2) My appetite is much worse now
(3) I have no appetite at all any more

17. (0) I don't have any thoughts of killing myself
(1) I have thoughts of killing myself but I would not carry them out
(2) I would like to kill myself
(3) I would kill myself if I had the chance

18. (0) I don't cry any more than usual
(1) I cry more now than I used to
(2) I cry all the time now
(3) I used to be able to cry, but now I can't even cry though I want to

19. (0) I am no more worried about my health than usual
(1) I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
(2) I am very worried about physical problems and it is hard to think about anything else
(3) I am so worried about my physical problems that I cannot think about anything else

20. (0) I haven't lost much weight, if any, lately
(1) I have lost more than 5 pounds
(2) I have lost more than 10 pounds
(3) I have lost more than 15 pounds

21. (0) I have not noticed ay recent change in my interest in sex
(1) I am less interested in sex than I used to be
(2) I am much less interested in sex now
(3) I have lost interest in sex completely

22. YES NO Are you currently being treated for depression?

23. YES NO Do you have a history of depression?

24. YES NO Are you in a stable relationship?

25. YES NO Do you have support at home or among friends?

26. YES NO Do you have a history of sexual abuse?

Are there any issues you can think of that you may have to deal with after surgery that would make it more difficult to follow the guidelines to lose weight such as:

27.	YES	NO	Food addiction
28.	YES	NO	Fear of weight loss
29.	YES	NO	Fear of looking better
30.	YES	NO	People in your life who don't want you to lose weight

_____
Barry S. Greene, M.D.

_____
Joseph A. Greene, M.D.

Advanced Weight Loss Surgery/Maryland Bariatrics

Barry S. Greene, MD
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Financial Policy

Thank you for choosing AWLS/Maryland Bariatrics as your healthcare provider. We realize that the cost of healthcare is a concern for our patients, and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. ***Patients are responsible for understanding their health insurance coverage(s) and benefits. There may be limitations and exclusions to coverage. You are responsible for any charges not covered by your plan.***

Insurance Accounts: We ask that you present your insurance card at every visit. If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- We will file claims to insurance companies provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information within 30 days of the original date of service a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. Self-pay patients are responsible for paying 100% of charges at the time services are rendered.

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney. If your account is referred to an outside collection agency/attorney, you will be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, Discover, Care Credit, HSA, and FSA. Cash, check or money orders are also acceptable methods of payment. If your check is dishonored (returned for non-sufficient funds) you will be required to pay an additional fee of $35.00.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voicemail. ***Your failure to appear for a scheduled appointment or to cancel an appointment at least 24 hours prior to the visit will result in a missed appointment fee of $30.*** This policy is aimed at minimizing waiting time and ensuring availability of medical care for all our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice, but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

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Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, photocopying medical records, producing narrative reports, personal letters, etc.) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Insurance Deductible Fees: All patients that have a deductible to meet based on their specific insurance provider and plan will be subject to a $100 deductible copayment at the time of their scheduled appointment. This will prevent the acquisition of large outstanding account balances with Advanced Weight Loss Surgery/Maryland Bariatrics.

Medicaid: Dr. Tuesday Cook and Dr. Joseph Greene are not in-network with Maryland Medicaid. All patients under the care of Dr. Tuesday Cook and Dr. Joseph Greene agree to pay all remaining coinsurance fees accrued during treatment with Maryland Bariatrics.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

By signing below, I fully understand and agree to the terms of the AWLS/Maryland Bariatrics Financial Policy.

Patient Name: _____

Signature: _____

Advanced Weight Loss Surgery/Maryland Bariatrics

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DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Barry S. Greene MD is an owner of Surgery Center of Rockville, LLC.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Surgery Center of Rockville, LLC.

3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Surgery Center of Rockville, LLC.

   If you have any questions concerning this notice, please feel free to ask your physician or any representative of Surgery Center of Rockville, LLC. We welcome you as a patient and value our relationship with you.

   By signing with Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Surgery Center of Rockville, LLC.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Type or Print Name of Patient

_____
Type or Print Name of Parent or Guardian
(if applicable)

_____
Date

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	PATIENT NAME	DOB	DATE
	SPECIALTY	PHYSICIAN NAME	TELEPHONE NUMBER
1	REFERRING PHYSICIAN		
2	PRIMARY CARE PHYSICIAN		
3	CARDIOLOGY		
4	PULMONOLOGY		
5	NEPHROLOGY		
6	PSYCHOLOGY		
7	SLEEP MEDICINE		
8	NEUROLOGY		
9	GASTROENTEROLOGY		
10	PAIN MANAGEMENT		
11	ENDOCRINOLOGY		
12	RHEUMATOLOGY		
13	ORTHOPEDICS		
14	OB/GYN		
15	OTHER		