M.P. VEERA MD PA

NON SURGICAL BARIATRIC PATIENT WELCOME SHEET

BOARD CERTIFIED IN GASTROENTEROLGY & INTERNAL MEDICINE

M.P. VEERA MD PA
DR. M.P. VEERABAGU, M.D
130 PERPETUAL SQUARE, ANDERSON, SC 29621

OFFICE HOURS: MONDAY-FRIDAY: 8 AM-12 NOON
MONDAY-THURSDAY: 1 PM -5 PM/CLOSED FRIDAY 12 NOON
PHONE:(864)224-8689 FAX:(864)222-1303

PATIENT NAME: _____

NON SURGICAL BARIATRIC INITIAL CONSULT APPOINTMENT DATE/TIME: _____

*****WELCOME TO OUR GASTROENTEROLOGY PRACTICE. YOUR ENTIRE VISITS, PROCEDURE AND FACILITY COSTS ARE NOT COVERED BY INSURANCE. THIS IS A CASH PAY PACKAGE, DETAILS AS SHOWN BELOW.**********

CASH PAY PACKAGE COSTS FOR NON SURGICAL BARIATRIC PROCEDURE:_____

*_____Our Provider/Practice initial consult Fees/Collected at check in

The following cash payments are collected a week prior to procedure:

*_____Our Provider/Practice Professional Procedure Fee

*_____Outside Facility/Anmed Charge where procedure performed. Anmed Financial Clearance Usually within a day or two prior to procedure date. (Facility & Anesthesia)

*_____**Grand Total**

YOUR DESIGNATED TIME SLOT IS TO MEET OUR PROVIDER. PLEASE BE CONSIDERATE TO OTHER PATIENTS WAITING TO SEE OUR PROVIDERS AND CALL US IMMEDIATELY TO CONFIRM, RESCHEDULE OR CANCEL AT 864.224.8689. PLEASE BRING:

- **FILLED OUT ATTACHED FORMS**
- ALL CURRENT MEDICATIONS-BOTH PRESCRIPTIONS AND OVER-THE-COUNTER
- **FOR MAIL ORDER PHARMACIES WE NEED: NAME, ADDRESS,PHONE NUMBER, FAX AND ANY OTHER DETAILS TO SEND IN YOUR ORDERS FOR YOUR OFFICE VISIT TO BE SUCCESSFUL**
- THE LABORATORY NAME AND PHONE # WHERE YOUR INSURANCE COMPANY IS IN NETWORK

MEDICATION REFILLS MAY REQUIRE EXTRA AUTHORIZATION PAPERWORK AND TIME. SO PLEASE PLAN AHEAD. REQUEST REFILLS WELL BEFORE YOU RUN OUT OF YOUR MEDICATION. IT IS THE RESPONSIBILITY OF EACH PATIENT TO ASK FOR REFILLS AND UPDATE THEIR MEDICATION LIST AT EACH OFFICE VISIT. **REFILLS ON MAINTENANCE MEDICATIONS** CAN BE OBTAINED BY CALLING YOUR PHARMACY. THE PHARMACY WILL THEN CONTACT US. WE ARE NOW SUBMITTING MOST PRESCRIPTIONS ELECTRONICALLY TO PHARMACIES. **THIS INCLUDES SOME MAIL ORDER COMPANIES AS NOTED ABOVE. CONTROLLED SUBSTANCES** FOR PAIN, ANXIETY ETC WILL BE REFILLED ONLY DURING REGULAR OFFICE HOURS. PRIOR AUTHORIZATIONS FOR MEDICATIONS REQUIRES US TO REVIEW YOUR CHART AND SUBMIT INFORMATION TO YOUR INSURANCE COMPANY FOR APPROVAL AND HENCE MAY TAKE SEVERAL DAYS TO GET A RESPONSE.

TEST RESULTS: THE NATURE AND COMPLEXITY OF THE RESULTS WILL DETERMINE HOW THEY WILL BE REPORTED TO YOU. POSSIBILITIES INCLUDE: OFFICE VISITS, MAIL, TELEPHONE CALL OR PATIENT PORTAL.
OCCASIONALLY, WE ORDER LABS **WHICH ARE DONE AT OTHER FACILITIES THAT MAY BE OUT-OF-NETWORK** WITH YOUR INSURANCE. PLEASE DISCUSS THIS WITH THE FACILITY AND INSURANCE COMPANY BEFORE YOUR LABS ARE DRAWN.

THERE IS A $ 25.00 CHARGE FOR NO SHOW. ALLOW PLENTY OF TIME TO FIND OUR OFFICE. FOR EMERGENT MEDICAL NEEDS CALL 911.

PATIENT SIGNATURE:_____ **DATE:**_____

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MP VEERA MD PA

NON SURGICAL BARIATRIC WEIGHTLOSS CASH PAY PRICING ONLY

**********www.marvelousmeweightloss.com**********

ALL FEES NEED TO BE PAID IN FULL PRIOR TO PROCEDURE DATE - CASH PAY PRICING IS AS LISTED BELOW

DESCRIPTION OF SERVICES AND PARTIES	ESG	ORBERA	TORe
MP VEERA MD PA Professional Fees	Gastric Sleeve	Balloon	ByPass Revision
Initial Consult Visit	$ 150.00	$ 150.00	$ 150.00
Procedure with 3 visits as needed, includes one year weight loss support counseling with Restore Weightloss LLC*	3,150.00	2,150.00	2,150.00
Total MP VEERA MD PA cost	**3,300.00**	**2,300.00**	**2,300.00**
Third Party Fees/Estimate			
Anmed Anesthesia & facility charges	8,250.00	5,006.00	8,800.00
Psychologist Pre-Surgery Evaluation Estimate	100.00	100.00	100.00
Total Third Party Fees/Estimated cost	**8,350.00**	**5,106.00**	**8,900.00**
GRAND TOTAL COST FOR EACH PROCEDURE	$ 11,650.00	$ 7,406.00	$ 11,200.00

**Restore Weightloss, LLC (restore-weightloss.com) is an independent third party team of bariatric weight-loss lifestyle licensed professionals who provide post, 24/7 concierge service via unlimited texts, phone calls, and weekly one on one counseling for a period of one year/twelve months*

Updated March 1 2023

MP Veera MD PA

BARIATRIC INTAKE FORM

Teresa Moore, CMA AAMA
130 Perpetual Sq
Anderson, SC 29621
864-224-8689 Fax 864-222-1303

Name: _____

Phone #:_____

Address: _____

Age: _____ DOB: _____

Weight: _____ Height:_____

BMI: _____(optional)

Current Health Conditions (Check all that apply)

- ☐ Diabetes Medication: _____
- ☐ High Blood Pressure Medication: _____
- ☐ Sleep Apnea CPaP/ BiPaP
- ☐ Heart Disease
- ☐ Other _____

Have you had a weight loss surgery procedure in the past? Y/N Procedure:

_____

Surgeon/ Location of Previous Weight Loss Procedure:

_____

Primary Care Doctor/ Family Physician: _____

Name of Insurance Company: _____

How did you hear about us?

- o Doctor/Referral _____
- o Friend _____
- o Patient _____
- o Office/Staff/Flyers _____
- o Other (be specific): TV/Radio/Newspaper/Online _____

- **Insurance does not currently cover any cost for Endoscopic Procedures.**
- **Please ask your provider for Cash Pay Packages and Pricing**
- **All fees and incurred costs must be paid in full before procedure is done.**

Dietary Weight Loss Attempts after original Weight Loss Surgery

Program	Year	Months On Program	Pounds Lost	Pounds Regained	Cost ($)
Phentermine (Adipex)					
Medifast or Optifast					
Nutrisystem					
Weight Watchers					
Jenny Craig					
Atkins/ South Beach					
Other					

Exercise Weight Loss Attempts

Program	Year	Months On Program	Pounds Lost	Pounds Regained	Cost ($)
Jogging/Running					
Walking					
Bicycling					
Swimming					
Aerobics					
Trainer/Gym Membership					
Own Home Equipment					

What do you feel is the reason for your weight regain? _____

Do you have any medical causes for weight regain (any new issues)?

_____

Do you have history of anorexia or bulimia? Y / N

Have you tried to go on a formal "diet" or exercise program to lose weight? Y / N

Current Exercise Habits (circle all that apply):

Sedentary Minimally active Moderate active Very active

Exercise Frequency: _____ times/week Type of exercise:_____

Eating Habits (circle all that apply):

Skips meals	Snack	Eat large portions	Binge eat
Eat out a lot	Eats sweets	Eat late at night	Eat fast food

Do you have medical records at another facility besides AnMed? If so please get a copy or sign a release for us to obtain your records from that facility

MP Veera MD PA

864.224.8689

Patient Information Sheet

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank you.

PATIENT INFORMATION

Full Name:		Social Security #:	
Date of Birth:		Name you wish to be called:	

Legal Sex: (as on your driver's license)

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Transgender Female (male-to-female)
- ☐ Transgender Male (female-to-male)
- ☐ Other

Sex at Birth:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Unknown
- ☐ Uncertain
- ☐ Not recorded on birth certificate

Sexual Orientation:
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Choose not to disclose
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else

Mailing Address:			
City, State, Zip:		County:	
Street Address:			
City, State, Zip:		County:	
Home Phone #		Work Phone #:	Mobile #:
Email Address:	I DON'T HAVE EMAIL NO THANKS		

Marital Status:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Significant Other
- ☐ Single
- ☐ Single
- ☐ Widowed
- ☐ Other
- ☐ Unknown

Do you need an Interpreter? YES NO

Language Preference:

Written Language Preference:

Religion:

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian Indian
- ☐ Asian
- ☐ Native Hawaiian / Other, Pacific Islander
- ☐ Black / African American
- ☐ White
- ☐ Unknown
- ☐ Declined

Ethnicity:
- ☐ Not Hispanic Latino/a or Spanish origin
- ☐ Colombian
- ☐ Cuban
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican, Mexican American or Chicano/a
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Declined to Answer
- ☐ Unknown

Primary Care Provider (PCP) Name:	
Emergency Contact Name and Relationship:	
Emergency Contact Phone #:	Is the Emergency Contact the Patient's Legal Gaurdian? Yes No
Employer Name:	

Employment Status:
- ☐ Full Time
- ☐ Part Time
- ☐ Self Employed
- ☐ Retired
- ☐ Disabled
- ☐ Not Employed
- ☐ Active Military Duty
- ☐ Other / Unknown

Student Status:
- ☐ Full Time
- ☐ Part Time

GUARANTOR INFORMATION

Who is financially responsible for this account? SELF EMPLOYER SPOUSE FATHER MOTHER OTHER

Primary Insurance Company:	**Secondary Insurance Company:**
Subscriber Name:	Subscriber Name:
Subscriber Social Security Number:	Subscriber Social Security Number:
Subscriber Sex:	Subscriber Sex:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Home Phone #:	Subscriber Home Phone #:
Subscriber ID #:	Subscriber ID #:
Subscriber Group #:	Subscriber Group #:

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

I authorize the following people access to my protected health or medical information (list name(s) and relationship(s) to patient):

Do you have Advanced Directives? YES NO If yes choose type: __ Health Care Power of Attorney/Living Will __DNR

Preferred Pharmacy Name and Location:

Signature of Patient of Legal Guardian | Printed Name of Patient or Legal Guardian | Date | Time

MP VEERA MD PA

YOUR AUTHORIZATION TO COMMUNICATE FORM

As stated in the HIPAA privacy laws, this authorization form permits MP VEERA MD PA to use or disclose protected health information listed in the **Description Section** to the Entity or Person listed in the **Receiving Entity section** below for the following patient/you:

Name _____ Birth Date _____
Address _____
City/State/ Zip _____

Description of information to be given to Entity or Person.	**Receiving Entity or Person Review & list if needed carefully**
*Appointment or absentee from work information/form *Return to work or school information/form	Employer _____ School _____
*Family billing information *Financial information *Medical/List separately or mark as "ALL" _____	Spouse (Provide full name) _____ Other (Provide full name(s)) _____
*Family billing information *Financial information *Medical/List separately or mark as "ALL" _____	Parent(s) (Provide full name) _____ _____ _____ _____
*Portal Log in/updates via email *Texting *Internet and social media (examples: google, facebook, instagram) viewing and communications/responses to you	Your Email _____ as updated by you Please provide updated cell number, if any_____ Internet and social media _____

Purpose

The purpose of this authorization is to meet your request for information disclosures and uses. ***(TURN PAGE TO COMPLETE FORM)***

**********TWO SIDED FORM→**

Expiration date or event: This authorization shall be in force until revoked by the patient or _____ date is the specific end date of this authorization.

Verification method or code: This practice will verify the identity of any entity or individual requesting protected health information by asking the your full name, date of birth and may request for the last four digits of your social security #

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to MP VEERA MD PA, 130 Perpetual Square Dr., Anderson, SC 29621 Attn: HIPAA Officer. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only (Employee please sign, scan and give back this original to patient):

Employee _____Date received _____

☐ Copy given to patient by receiving employee

MP VEERA MD PA
CONTROLLED MEDICATION
AGREEMENT
130 PERPETUAL SQ. ANDERSON, SC 29621
864.224.8689 FAX 864.222-1303

AS A GENERAL RULE WE DO NOT WRITE CONTROLLED SUBSTANCES

The purpose of this agreement is to prevent misunderstandings about certain controlled substance medications, referred to as controlled medication, and to help both you and your provider comply with the state and federal laws regarding controlled medication. Because these medications have high potential for misuse, their administration is strictly controlled by local, state and federal governments. They include such classes of drugs as narcotics (for pain management, such as OXYCONTIN, HYDROCODONE, CODEINE, and STADOL), depressants (barbiturates), anti-anxiety medications (such as XANAX and ATIVAN), sedatives (such as AMBIEN) and stimulants (such as ADDERALL, ADIPEX-P and DIDREX). Their administration is intended to relieve, but not eliminate various symptoms, often pain; and is not simply to mask an underlying problem. Overdoses of controlled medications can cause serious illness or death.

Because your provider is prescribing a controlled medication for the management of your condition, you must agree to abide by the following guidelines. Please initial beside each statement. Once read a full signature at bottom of page is required.

1. I understand that I am responsible for my controlled medication. If the medication is lost, misplaced, or stolen, or if I do not follow the prescribed directions and I use all of the medication before I am eligible for a refill, I understand it will not be replaced.
2. I will not request or accept a controlled medication from any other physician or individual while I am receiving such medication from any of MP VEERA MD PA medical providers. Not only is it illegal to do so, but it may also endanger my health. The only exception is in the event that I am admitted to a hospital and a controlled medication is prescribed for me during my stay. (Please note that hospital admission does not include visits to an emergency department or an urgent care/minor care facility.)
3. Refills of my controlled medication:
   a. Will only be given during normal office hours. Refills will not be given at night, during office holidays or on weekends.
   b. Will not be given if I use all of the medication before I am eligible for a refill. I am responsible for taking my medication according to the prescribed directions, as well as for keeping track of the remaining amount.
   c. Will only be considered with at least seventy-two (72) hours advance notice. This holds true for requests submitted prior to the weekend.
4. I understand that if I violate any of the above conditions, my controlled medication prescription and/or treatment by MP VEERA MD PA providers may be terminated immediately. If the violation involves obtaining a controlled medication from another physician or individual, I may also be reported to the prescribing physician, corresponding medical facilities, and other necessary authorities.
5. I agree to abide by my physician's judgment regarding the necessity for controlled medication and the amount/frequency of medication that is best suited to the treatment plan as it is made, as well as when to cease the use of the medication.
6. I understand that if I am pregnant or become pregnant while taking controlled medication, my child could be physically dependent on the controlled medication and withdrawal can be life-threatening for the baby.
7. I understand that unannounced drug screens may be requested, and I will be in full cooperation with the administration of these tests.
8. I agree to fill all of my controlled substance prescriptions at the same pharmacy, and to provide my pharmacy information to MP VEERA MD PA. Any change of pharmacy will be promptly reported to the office.
9. I agree not to sell, lend or in any way give my controlled medication to any other person.
10. I understand that I will attend all required follow up visits with the physician to monitor the controlled medication and that failure to do so will result in discontinuation of this treatment.
11. I understand that there is a risk of addiction from controlled medications. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment facility.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE OF WITNESS

DATE