Welcome Back

We are so excited to have you join us for another year. Please complete the following packet to ensure we have the most up to date information.

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Main Phone : _____ Alt Phone : _____

Email: _____

Medication Allergies _____

Primary Insurance: _____ Policy #: _____

Policy Holder: _____ Date of Birth: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder: _____ Date of Birth: _____

Please initial stating you have read and understand the following:

(initial) _____ I understand that I am responsible for all charges not covered or reimbursed by the above agents. I also agree that in the event on non-payment I assume the costs of interest, collections and legal action ifrequired.

(initial) _____ I authorize the release of information that is necessary to obtain prior authorization for a consultations, surgery and aftercare with Dr. Umbach and his associates. **I understand that if the information is incorrect, I may be held responsible for the full amount of my office visit and/or surgeries.**

(initial) _____ I authorize the release of all medical records to my referring doctors and the insurance companies as applicable. I authorize a facsimile transmission when necessary.

(initial) _____ I have read and understand the Financial Policy. I understand that a copy has been available to me.

(initial) _____ According to HIPAA of 2003, my health information is to remain confidential. I understand that Blossom Bariatrics and/or Blossom Medical Group and/or Warm Springs Surgical Center will not disclose any of my information to any outside organization with the exception of the following: * Professional referral to another provider, hospital or clinic for the diagnosis, assessment or treatment * Collection of payment for services rendered (insurance company, collection activity) * Office administration including phone calls. If I am not available to receive calls, a message will be left on my machine. I understand that a full disclosure of the HIPAA law is available upon request at the front desk.

I have read and received a copy of the above statements and accept the terms.
A duplicate of the statement is considered the same as original.

Signature: _____ Date: _____

THIS CONSENT/AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY PATIENT IN WRITING

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: _____

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 that $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 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

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/.
- 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.

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**.**

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:** _____

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 heather 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.pattrax.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:** _____

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

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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:** _____

Blossom Bariatrics

Thomas W. Umbach
MD, FACS, FASMBS

BLOSSOM MEDICAL GROUP
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:** _____