PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle)	Date of Birth	Marital Status (circle)	Primary Care Physician
M / F		*Divorced - Married - Separated - Single - Widowed - Other*	

Preferred Language (circle)	Race (circle)	Ethnicity (circle)
English - Spanish - ________________	*Asian - Black - White - Other: ____________________*	*Hispanic - Not Hispanic - Unknown*

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party
Check if same as: [ ] Patient

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Responsible Party?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact
Check if same as: [ ] Responsible Party

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact
Check if same as: [ ] Responsible Party [ ] Emergency Contact

Last Name	First Name	Gender (circle)	Date of Birth	What is Patient's Relationship to Guardian?
		M / F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information
Check if: [ ] Self Pay

Check if same as: [ ] Responsible Party			Check if same as: [ ] Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender (circle) *M / F*	What is Patient's Relationship to Subscriber?		Gender (circle) *M / F*
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature ______________ Date ______

Patient/Legal Guardian Print ______________

IPM 2012 v1

Manatee
Weight Loss Center

Name: ____ **DOB:** __________________

REASON FOR VISIT: ____

DO YOU HAVE ANY ALLERGIES: ____

List of Medications **CURRENTLY** taking: Prescribed, over the counter and vitamins

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

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Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

Name: __________________________ Strength: _______________ How Often: ____________________

If you have additional medications please list below:

Pharmacy Name: ________________________ **Location:** ___________________________________

Name: ____ DOB: __________________

Medical History:

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bladder Cancer
- ☐ Bowel Problems-explain:
- ☐ Breast Cancer
- ☐ Breast Lumps
- ☐ Cancer-list type:
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes-Type 1 or 2
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ GERD/Heartburn
- ☐ Gout
- ☐ Heart attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney problems-explain:
- ☐ Liver Problems-explain:
- ☐ Lung Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pancreatic Cancer
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Prostate Cancer
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Sleep Apnea
- ☐ Stroke/CVA
- ☐ Other not listed: __________________________

Surgical/Procedures:

- ☐ Adenoids removed
- ☐ Appendix Removal
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Breast Biopsy
- ☐ Cardiac Bypass Surgery
- ☐ Cardiac Catheterization
- ☐ Cataract Surgery
- ☐ Colon resection
- ☐ Colostomy/Reversal
- ☐ C-Section
- ☐ D&C (Dilation & Curettage)
- ☐ Defibrillator Implant
- ☐ Gallbladder Removal
- ☐ Hernia Surgery–List type:________________
- ☐ Hysterectomy
- ☐ Lumpectomy
- ☐ Lymph node biopsy
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ PTCA (Angioplasty)
- ☐ Shoulder Surgery
- ☐ Splenectomy
- ☐ Tonsils removed
- ☐ Joint Replacement: knee, hip, shoulder, ankle
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other Not Listed:_____________________

Name: ____ DOB: __________________

Health Maintenance:	**YEAR:**	**Results:**
MRI	_____________	Normal Abnormal
Cat Scan	_____________	Normal Abnormal
Colonoscopy	_____________	Normal Abnormal
Ultrasound	_____________	Normal Abnormal
Blood Work	_____________	Normal Abnormal
EGD	_____________	Normal Abnormal

Social History:

Alcohol use: Never Daily Social
Estimated Daily Consumption: _______________

Smoker: Never Formerly Currently
If YES- circle which: Cigarettes Cigars Chewing/Dipping Tobacco Electronic Cigarettes
How much per day: ____________ How many years:____________ Quit When: ___________________

Street drug use: Never Previous Currently Type of Drug(s):______________________

Do you feel safe at home? Yes No

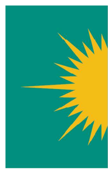
Living Will/POA: Do you have a living will? Yes No
Do you have Durable Power of Attorney for healthcare? Yes No

Family History: **Adopted** **Unknown**

Mother Living: Yes No Age of Death: _______ Cause of Death:_____________________
Father Living: Yes No Age of Death: _______ Cause of Death:_____________________

(Please list any serious medical history that runs in your family)

Mother	Father	Sibling	Sibling	Maternal Grandparent	Paternal Grandparent



Patient Name: ______________________

Constitutional Symptoms	Yes	No	Head & Neck	Yes	No
Weight gain/loss *(circle one)*			Dizziness/vertigo		
Fatigue			Vision changes		
Loss of appetite			Nose bleeds		
Night sweats			Hearing loss		
Fever			Pain/difficulty swallowing		

Cardiac	Yes	No	Respiratory	Yes	No
Chest pain/heaviness			Shortness of breath		
Irregular heart/palpitations			Wheezing		
Lightheadedness/fainting			Coughing		
Shortness of breath at rest			Blood in sputum		
Shortness of breath w/activity			Snoring		

Gastrointestinal	Yes	No	Genitourinary	Yes	No
Abdominal pain			Pain/difficulty when voiding		
Nausea/vomiting			Frequency voiding		
Diarrhea/constipation (circle)			Blood in urine		
Heartburn			Sexual dysfunction		
Blood in stools			Groin pain		

Endocrine	Yes	No	Hematologic	Yes	No
Heat/cold intolerance *(circle)*			Abnormal bleeding/bruising		
Excessive thirst			Clotting problems		
Excessive voiding			Anemia		
Excessive appetite			Transfusion problems		
Excessive hair growth			Blood clots formation		

Musculoskeletal	Yes	No	Neuro-psychiatric	Yes	No
Joint pain/swelling *(circle)*			Depression		
Stiffness			Anxiety		
Weakness of limbs			Seizures		
Gout			Weakness		
Back pain			Numbness		

Women Health	Yes	No	Breast Health	Yes	No
Menstrual period regular			Breast lumps		
Menopause			Breast skin changes		
# Pregnancies __________			Nipple discharge		
# Live births __________			Breast pain		
Last pap smear __________			Last mammogram __________		

Physician List:

Primary Care Physician: ____________________ Cardiologist: ____________________

Gastroenterologist: ____________________ Oncologist: ____________________

Psychiatrist: ____________________ Endocrinologist: ____________________

Pulmonologist: ____________________ Gynecologist:____________________

Other: ______________________________

Manatee
Weight Loss Center

►Weight History:

Obesity has been a problem for ________ years, since: ❑ Childhood ❑ Teenage Years ❑ Adult ❑ Pregnancy
Highest weight as an adult: ___________________ Year: ___________
Lowest weight as an adult: ___________________ Year: ___________
In the last 6 months, have you gained or lost weight? ________________ How many pounds? ________________

►Activity Level: (Please check the one level that most accurately describes your activity.)

❑ Sedentary (very little exercise)
❑ Mild exercise (stairs, walk over three blocks without becoming short of breath, golf)
❑ Occasional vigorous exercise (work or recreation – less than 30 minutes/4 times a week)
❑ Regular vigorous exercise (work or recreation – more than 30 minutes/4 times a week)

What types of exercise programs have you tried? ____
What prevents you from exercising now? ____

►Weight Loss Surgery History:

Have you ever had bariatric surgery? ❑ Yes ❑ No If yes, what kind? ____
▪ When? __________________ Where? ________________________ Name of the doctor? ________________________

►Lap Band Patients Only:

What was your weight when the band was placed? _______________
How much weight were you able to lose with the band?___________________
Has it ever been too tight? ❑ Yes ❑ No
Have you ever had to have fluid removed? ❑ Yes ❑ No When? ___________________________
Has anyone ever had a problem accessing your band in the past? ❑ Yes ❑ No
Have you ever had revisional surgery for flipped port? ❑ Yes ❑ No Slipped band? ❑ Yes ❑ No
▪When? _____________________
Have you had recent x-rays of your chest or abdomen? ❑ Yes ❑ No Where? _______________________________

►Current Swallowing Problems:

Do you have GERD/Acid Reflux? ❑ Yes ❑ No
Do you have trouble swallowing solids? ❑ Yes ❑ No
Do you have trouble swallowing liquids? ❑ Yes ❑ No

►Diet History:

How would you describe your current diet? ❑ Good ❑ Bad ❑ Ugly ❑ Fair

► Physician Supervised Diet:

Insurance companies' definition of Physician Supervised Diet means that you have gone monthly to your physician, specifically for weight loss. If you have participated in this type of diet, please check how long you did a program.

❑ 3 months ❑ 6 months ❑ 9 months ❑ 12 months ❑ More than a year

Did you participate in this Physician Supervised Program within the last two years from today's date? ❑ Yes ❑ No

Manatee
Weight Loss Center

► Food Habits:

I am satisfied when I finish eating a meal.	❑ Yes	❑ No	I snack between meals.	❑ Yes	❑ No
I use food as a source of comfort.	❑ Yes	❑ No	I eat some sweets every day.	❑ Yes	❑ No
I am not concerned about how much I eat.	❑ Yes	❑ No	I binge eat.	❑ Yes	❑ No
I am not concerned about the types of food I eat.	❑ Yes	❑ No	I snack all day long.	❑ Yes	❑ No
I think a lot about food during the day.	❑ Yes	❑ No	I go without then gorge myself.	❑ Yes	❑ No
How many times per day do you eat?	____________		I eat normal size meals 3x daily.	❑ Yes	❑ No

► Weight Loss Drugs:

Please indicate all weight loss drugs you have used in the past including herbal/homeopathic and over-the-counter:

Fen-Phen	❑ Yes	❑ No	Xenecal®	❑ Yes	❑ No
Phentermine (Fastin®)	❑ Yes	❑ No	Pondimin®	❑ Yes	❑ No
Meridia®	❑ Yes	❑ No	Others (include all): ____________________________		

► Please indicate which diet programs you have tried by answering NO or YES to each of the diet programs listed

Book Diets	❑ Yes	❑ No	Self-Imposed Fasts	❑ Yes	❑ No	The Diet Center	❑ Yes	❑ No
Magazine Diets	❑ Yes	❑ No	Herbal Life	❑ Yes	❑ No	Curves	❑ Yes	❑ No
Over-the-Counter	❑ Yes	❑ No	High Protein	❑ Yes	❑ No	Hypnosis	❑ Yes	❑ No
Air Force Diet	❑ Yes	❑ No	Liquid Protein	❑ Yes	❑ No	Inches-A-Weigh	❑ Yes	❑ No
Dr. Atkins	❑ Yes	❑ No	Low Carbohydrate	❑ Yes	❑ No	Jenny Craig	❑ Yes	❑ No
Pritikin Diet	❑ Yes	❑ No	Low Calorie	❑ Yes	❑ No	LA Weight Loss	❑ Yes	❑ No
Personal Trainer	❑ Yes	❑ No	Medifast	❑ Yes	❑ No	Overeaters Anon.	❑ Yes	❑ No
Athletic Club	❑ Yes	❑ No	Nutri-System	❑ Yes	❑ No	TOPS Club	❑ Yes	❑ No
Bally's Program	❑ Yes	❑ No	Optifast	❑ Yes	❑ No	Virginia Mason	❑ Yes	❑ No
LA Fitness Club	❑ Yes	❑ No	Slim Fast	❑ Yes	❑ No	Weight Watchers	❑ Yes	❑ No
Living Well Lady	❑ Yes	❑ No	Subway	❑ Yes	❑ No	Mayo Clinic	❑ Yes	❑ No
Toppfast	❑ Yes	❑ No						

► PERSONAL GOALS: (Please summarize.)

Why do you want weight loss surgery?	What do you think your ideal weight and size should be?	What do you think you need to do to reach your goal?

I have answered the above questions to the best of my ability, and declare that I am not withholding any information which could be detrimental to my health or well-being, or impact the outcome of my medical treatment

____ ________________________

Patient's Signature Date

OFFICE POLICIES

Welcome to Manatee Surgical Alliance. We are thankful that you have chosen us as your healthcare provider. We are committed to providing the highest quality care to our patients.

Scheduled Appointments

Every effort is made to keep your waiting time to a minimum. For all new patients we ask that you arrive 30 minutes prior to your scheduled appointment time. We ask that our established patients arrive 15 minutes prior to your appointment. Please bring with you a list of all prescribed and over the counter (OTC) medications you are presently taking to each office visit. Patients who arrive late for appointments will have to be worked in between patients who have arrived on time. This may extend your wait time. You may also be asked to reschedule your appointment for the next opening on the provider's schedule.

Same Day Appointments

If you have a medical problem that you believe requires a "same day" appointment, please call the office as early as possible during office hours to schedule an appointment with your provider. If your provider does not have an available appointment and if another physician has an opening, we may offer an appointment with another health care provider within our group.

After Hours

If you have a life threatening emergency, call 911, or go to the nearest emergency room. For non-life threatening emergencies you may leave a message with our answering service or proceed to one of our 4 Urgent Care Walk-In Clinics open 7 days a week 8am to 8pm. Prescription refills will not be handled after hours please call during normal business. Please refer to our prescription refill policy below.

Prescription Refills

Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy, and your provider, to receive and respond to your request before you run out of your medication. For maintenance medications, your healthcare provider will prescribe enough refills to last until your next office visit. If you are out of refills, this is an indication of the need to schedule a follow-up appointment with your provider. *****We do not manage chronic pain for long term, as chronic pain patients should be cared for by pain management specialists*****

Cancellation/No Show Policy

We make every effort to provide prompt medical care to all our patients. If you are unable to keep a scheduled appointment, we ask that you call us at least 24 hours in advance so that we may be able to accommodate another patient that may need immediate attention. **Multiple cancellations without notifications may result in termination from our practice.**

Medical Records

We assure the privacy and confidentiality of your medical records. No information will be released by our office without your consent to any parties other than your providers. HealthPort handles our medical record requests; however there may be a service fee for completing. HealthPort Customer Service: 1-800-367-1500.

Referrals

We require no less than 2 business day notifications to obtain referrals/authorizations from your primary care physician and or your insurance company. Additional processing time maybe required by your individual carrier.

Identification

The protection of your identity is important to us. You will be required to produce a government issued photo identification card along with your insurance cards electronic medical record to protect your identity. You consent for a photograph to be made of your face. You understand that the information will only be used for identification purposes and will be stored securely.

Forms

Some forms are extensive and will require a fee of $25 at the time of request. There are forms that may require an appointment prior to completion of the requested forms.

Financial Policy

Our group participates with most major insurance carriers. It is your responsibility to check with your insurance to find an in-network provider. *It is imperative that the office has your correct insurance information on file at all times.* ***It is ultimately your responsibility to know the benefits provided under your insurance plan.*** As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances greater than 90 days will be considered delinquent and placed in collection status. All costs associated with sending the patient to collections will be the responsibility of the Guarantor. Payment plans can be arranged by our office and/or contacting our billing department at 888-804-6274.

Payment

Payment will be required at the time the services are rendered. We will collect all outstanding balances within our group and for services performed at the time of service. Please note that your insurance company may process the claim with a higher patient responsibility. You may receive a statement for any balance billing. Methods of payment include Cash, Check, MasterCard, Visa, Discover Card, and American Express.

Non-Covered Services

Your insurance company may diem some services are non-covered by your policy. It is your responsibility to know what services are non-covered by your plan. You would be fully responsible for these services per your insurance company. Your insurance plan may determine that some services are not medically necessary and you may be billed for those services. Please check with your insurance with additional questions.

Self-Pay Uninsured Policy

We will gladly offer a self-pay **UNINSURED** discount rate for services rendered.

Cash Self-Pay Uninsured Statement

By accepting this discounted rate, you are stating you have no insurance and agree to the cash price as **PAID IN FULL** and will not seek reimbursement from any outside entity.

We appreciate your selection of our office to provide your care and we will work hard to serve your needs. At the conclusion of your visit a survey to the email you provided. Your satisfaction and experience in our practice is important to us. We would appreciate your feedback when you receive our M3 patient satisfaction survey.

Patient Signature: ______________________________ Date: ____________________

Patient Printed Name: ______________________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Birth Date: __________________________
Maiden/Prior Names: ____ Current Phone #: _____________________
Current Address: ____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination
☐ Legal Investigation ☐ Other: _____________________

I **authorize the release of the following:**

☐ Provider office note
☐ Lab results
☐ Diagnostic Reports
☐ Other: __________________________________

Items below will not be included unless checked:
☐ Psychological Evaluation
☐ Alcohol and Drug Abuse Treatment Records
☐ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

☐ ___________________________ (____)______________ _____________________________________
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

Release my health information to:

☐ ___________________________ (____)______________ _____________________________________
Facility/Provider's Name Telephone or Fax Number Address City State Zip Code

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

______________________________________ ___________________________________ ___________________
Patient's signature (required for ages 12 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

______________________________________ ______________________
Witness signature Date Signed

This authorization is intended to allow The Pavilion to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. ***FACILITY*** is not liable for such re-disclosures.

NOTICE of PRIVACY PRACTICES

A copy of ***Facility's*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Facility*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: ____ **Relationship** __________________________

Name: ____ **Relationship**__________________________

I authorize ***Facility*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: ________________________________ **Phone number**________________________ **Relationship:** ______________

Email Address: ____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Facility strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Facility*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Facility*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***facility*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Facility*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Facility***. Any photographs or other images taken will become part of my medical record. ***Facility*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Facility*** will provide me with information and forms prior to such procedures. . I grant ***Facility*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***facility*** to search for and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***facility***.

____ ____

Patient's Name (Please Print) Signature

____ ____

Patient Representative (If patient is unable to sign) Signature

PATIENT AUTHORIZATION FOR PHOTOGRAPHY, VIDEOTAPE, AUDIOTAPE AND INTERVIEW USE AND RELEASE

I authorize Manatee Weight Loss Center and/or its subsidiaries, partnerships, limited partners, general partners, parent companies or affiliates including but not limited to Universal Health Services, Inc. and UHS of Delaware, Inc. (collectively referred to throughout this document as “Manatee Weight Loss Center”) to photograph, videotape, audiotape or interview me, and I authorize Manatee Weight Loss Center to publish and use such materials or any portions thereof in its sole discretion and in any manner it desires including but not limited to informing and educating the public as well as to commercially promote, advertise and/or market the services of the hospital. I hereby waive any right to compensation for Manatee Weight Loss Center’s use such materials which may display my likeness, photographs, image, voice, statements and name and release Manatee Weight Loss Center and its employees and agents from liability for any causes of action or claims of damages relating to Manatee Weight Loss Center’s use of such materials including but not limited to any claims of invasion of privacy, defamation, infringement of my right of publicity, copyright infringement. I understand and acknowledge that any photograph, videotape, audiotape or printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent.

I recognize and understand that I may be providing and disclosing my protected health information of which I would have the right to full confidentiality and privacy. I authorize Manatee Weight Loss Center to publicize and/or reproduce such protected health information as referenced above and release and waive any claims against Manatee Weight Loss Center, its employees, agents, officers and directors from any causes of action or claims of damages relating to the disclosure of such information and the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) or any other law. As referenced below, I have the right to revoke this authorization. However, I acknowledge and agree that any revocation of this authorization will not change any actions that Manatee Weight Loss Center took before I did so and it will be able to use and disclose the information I provided prior to the revocation.

___________________________________ ________________

(Name-Please Print) (Date of Birth)

___________________________________ ________________

(Signature) (Date of Authorization)

Patient – Please Note

1. You have the right to request cessation of recording or filming.
2. You may revoke your authorization at any time by sending notice, in writing, to the Marketing Department of this center.
3. Your authorization will expire within 3 years of the date you entered above.
4. Treatment, payment, enrollment and eligibility for treatment in this hospital are not affected by your agreement or refusal to give your authorization.
5. You are entitled to have a copy of your signed authorization.
6. Disclosure of a videotape, photograph, audiotape or interview to the general public could result in their republication by unknown persons without your/our knowledge or consent and federal privacy laws will not protect it.