MEETING HOUSE LANE
MEDICAL PRACTICE
AFFILIATED WITH SOUTHAMPTON HOSPITAL

Patient Name: _____ **INS Carrier:** _____

Date Seen: _____ **Provider:** Dr. Kathryn Saxby

ADVANCE BENEFICIARY NOTICE OF NON COVERAGE (ABN)

Note: You are receiving this notice because your insurance carrier may not pay for all services that you receive during your visit to our office. Please read this notice so you can make an informed decision about your care.

Services Rendered at Visit	Estimated Cost
Nutritional Weight Loss Counseling	$50 - $250

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose and option below about whether to receive said services above.

☐ Option 1: I want the abovementioned service listed above. I may be asked to be pay now, but I also want my insurance carrier billed for an official decision on payment, which is sent to me on an explanation of benefits (EOB). I understand that if insurance doesn't pay, I am responsible for payment.

☐ Option 2: No, I have decided not to receive these services.

☐ Option 3: Should I decide to request these services in the future, and they have previously been denied I understand I will be charged and am responsible for payment in full

By signing below you have received and understand this notice in its entirety. You also will receive a copy.

Signature:	Date:

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Nutritional Weight Loss Counseling below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Nutritional Weight Loss Counseling below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Nutritional Weight Loss Program	Services Not Covered	$50.00 - $250.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Nutritional Weight Loss Counseling listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Nutritional Weight Loss Counseling listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Nutritional Weight Loss Counseling listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** Nutritional Weight Loss Counseling listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Stony Brook Southampton Hospital

To ensure the efficacy and quality of our program, please note the following expectations for all patients enrolled in The Physician Supervised Weight Loss Series with Dr. Kathryn Saxby.

- ALL patients will be expected to have filled out and returned the required paperwork within 7 days of the start of the program.
- Please keep in mind that this program is a 5 week commitment. Any patient enrolled in the program who fails to show, shows up 15+ minutes late, or cancels without at least a 24 hours' notice will be considered a **No Show** and will be charged a **$25.00 fee per occurrence.** You must let the **front desk staff** know if you will not be in class in order to avoid a no-show fee.
- In order for us to enforce the No Show Policy, participants will be required to provide us with a valid payment card at the time of enrollment.
- The Physician Supervised Weight Loss Series is intended to accommodate patients with a BMI of 30 higher. Individuals who do not meet this criteria will not reap the full benefits of this program.

I have read and completely understand the conditions of this form. I understand that I am required to fill out the required paperwork within 7 days of the start of the program, and if not, my spot may no longer be reserved. I also understand that this program is a 5 week commitment, intended for individuals with a BMI of 30 or higher. I consent to allow the Ed and Phyllis Davis Wellness Institute to charge the card that I provided them with at the time of enrollment a fee of $25 when/if I am considered a No Show.

_____ _____

Patient's Signature **Date**

Intake Questionnaire

General Information

Name: _____ Age:____ Date of Birth:_____

Address:_____ City:_____ State:___ Zip:_____

Phone:_____ Email:_____

Genetic Background:☐African American☐Hispanic ☐Mediterranean ☐Asian

☐Native American ☐Caucasian ☐Northern European☐Other: _____

Emergency Contact: _____ Phone:_____ Relationship:_____

When, Where, and from Whom did you last receive medical or health care? Any recent hospitalizations?

_____

_____

Allergies (w/reaction):_____

Current Health Concerns/Medical History:

Problem/Diagnosis	Severity (mild-severe)	Treatment

Current Medications (including prescription and over the counter)

Medications	Dosage	Start Date	Reason for Use

Nutritional Supplements (Vitamins/Minerals/Herbs, etc)

Medications	Dosage	Start Date	Reason for Use

Family History

Maternal:_____

Paternal:_____

Detailed Social History

Sleep

How many hours each night on average?_____

Do you have problems falling asleep? Y or N . Staying asleep? Y or N

Do you snore? Y or N . Do you feel rested upon awakening? Y or N .

Do you use sleeping aids? ___ If Yes, explain:_____

Substances

Do you currently smoke? ____ What type and how much?_____

How many times have you attempted to quit?____ What methods?_____

If you previously smoked, how many years?

Do you use recreational drugs? ___ If so which ones/how often_____

Alcohol

How many alcoholic beverages in a week? ( ) None ( ) 1-3 ( ) 4-6 ( ) 7-10 ( ) >10

Previous intake? ___ Any problems with alcohol? _____

Exercise

Do you feel motivated to exercise?☐Yes ☐A little☐No

Are there any problems that limit exercise?☐Yes ☐No. Explain: _____

Do you feel unusually fatigued or sore after exercise?☐Yes ☐No

Activity	Type (Cardio/Strength/etc)	Length of time (min)	Times per week

Nutrition

Have you ever been in a formal nutrition program before?____ How many times?__

What program?_____

Do you currently follow a specific diet?☐Vegetarian/Vegan☐Elimination☐Low Fat ☐Low carb☐Low sodium☐No Dairy☐Gluten Free☐Other: _____

Do you have any food allergies or sensitivities? _____

How many meals do you eat a day? ___ How many meals do you eat out a week? ___

Would you describe yourself as a picky eater?_____ Do you cook? _____

Who does the grocery shopping?_____

Check all the factors that apply to your current lifestyle and eating habits:

☐Love to eat ☐Fast easter ☐Eat too much ☐Binge Eating ☐Late night

☐Dislike healthy foods ☐Time constraints ☐Travel Frequently ☐Poor snack choices

☐Eat more than 50% of meals away from home ☐Do not plan meals or menus

☐Don't care to cook ☐Confused about nutrition advice ☐Eat out of convenience

☐Emotional eater ☐Eat too little under stress ☐Eat too much under stress

The most important thing I should change about my diet to improve my health is:

_____

_____

List the three worst foods you eat during the average week:

1._____

2._____

3._____

List the three healthiest foods you eat during the average week:

1._____

2._____

3._____

Weight

Height (feet/inches) _____ Current Weight (lbs) _____ BMI _____

Usual weight range? +/- 5lbs _____ Desired weight range _____

Highest adult weight _____ Lowest adult weight _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Stress

Do you feel like you have an excessive amount of stress in your life? _____

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other

Do you feel like you can easily cope with your stressors? _____

What are your coping mechanisms? _____

Psychosocial

Are you happy? _____ Do you feel your life has meaning and purpose? _____

Readiness Assessment

On a scale from 1-5, how willing 5 (very willing) to 1 (not willing) are you to make changes:

Significantly modify your diet	1.☐ 2.☐3.☐4.☐5.☐
Modify your lifestyle (i.e. sleep habits, stress reduction, etc).	1.☐ 2.☐3.☐4.☐5.☐
Engage in regular exercise	1.☐ 2.☐3.☐4.☐5.☐
Daily journal during your modifications	1.☐ 2.☐3.☐4.☐5.☐
Follow up regularly with your physicians	1.☐ 2.☐3.☐4.☐5.☐

How supportive do you think the people in your household will be to the above changes? 5 (very supportive) to 1 (not supportive) 1.☐2.☐3.☐4.☐5.☐

How confident are you of your abilities to make changes in your life and stick to them?

5 (very confident) to 1 (not confident) 1.☐2.☐3.☐4.☐5.☐

Please list your top biggest goals of this program?

1._____

2._____

3._____

4._____

5._____

Meeting House Lane Medical Practice, PC

Acknowledgment of receipt of Privacy Notice

Today's Date: _____

I, _____ DOB: _____

(PLEASE PRINT PATIENT NAME\ GUARDIAN NAME) (DATE OF BIRTH)

Acknowledge that I have received a copy of:

Meeting House Lane Medical Practice Privacy Notice

Please check one of the following:

(_____) I authorize MHLMP to leave messages regarding appointments, test results, and/or medical treatment.

(_____) I authorize MHLMP to leave messages regarding appointments only.

(_____) I do NOT authorize MHLMP to leave messages regarding appointments, test results and\or medical treatment.

Disclaimer: MHLMP will still call in the event of a care coordination or billing question.

Please list anyone besides doctors that you allow us to release any medical information to. Under **NY State Law**, substance use, mental health and HIV information are considered confidential. Please put a check mark next to those we are able to discuss this information with.

Name:	Relationship:	Clinical Information	Substance Use	HIV	Mental Health
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

☐ I do not wish to share any information with anyone

Patient/Guardian Signature: _____

Meeting House Lane Medical Practice, PC
Patient Registration

Patient Information **Date:**

Patient Name: (Last) (First) (Middle)			Date of Birth:
Social Security Number:	Marital Status: **S M D W**	Driver's License:	Sex: **M F**
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home Work Other
Primary Care Physician:		Referring Physician:	
Employer Name:	Address:	Business Phone:	Type of Work:
Emergency Contact:	Relationship:	Phone:	
Race:	Preferred Language:	Religion:	

Guarantor Information (Responsible Party, spouse or parent)

(Last) (First) (Middle)		Relationship to Patient:	Date of Birth:
Street Address: (City) (State) (Zip)			Phone: Cell Home Work Other
Mailing Address (If different than above) (City) (State) (Zip)			Additional Phone: Cell Home ☐ Work Other ☐
Social Security Number:		Drivers License:	
Employer Name:	Address:	Business Phone:	Type of Work:

Insurance Information

Primary Insurance Name:	Claims Address:	(City)	(State)	(Zip)	Phone:
Policy Holder (Name):	Policy Number	Group Number:		Policyholder Date of Birth:	

Secondary Insurance Name:	Claims Address:	(City)	(State)	(Zip)	Phone:
Policy Holder (Name):	Policy Number:	Group Number:		Policyholder Date of Birth:	

I hereby authorize Meeting House Lane Medical Practice, PC for treatment and the release of any medical information to the insurance carriers to process claims. I also authorize all payments for medical services to the patient to be assigned to the supplier of services. I understand that I am responsible for all amounts not covered by my insurance company, including deductibles and co-insurance.

X_____

Patient or Responsible Party's Signature **Date**

MEETING HOUSE LANE
MEDICAL PRACTICE
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New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form
Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:
1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating
physician; OR
2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____
Signature of Patient **Date of Signature**