STERLING SURGICARE, INC.
DR. AYOTUNDE ADEYERI
670 N. Beers St., Bld 2 Suite 4, Holmdel, NJ 07733
3 Hospital Plaza, Suite 206 Med Arts Bldg., Old Bridge, NJ 08857
Phone #: 732.217.3897 Fax #: 732.739.9094

Today's Date _____

Patient Name: _____
Last First M.I.

DOB: ___/___/____ SS#: _____ Sex: M F Age: _____
Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____ Domestic Partner _____

ADDRESS: _____
HOME #: _____ CELL #: _____ WORK #: _____
If we need to call you, which phone # should we call first? _____ EMAIL: _____

EMPLOYER: _____ POSITION: _____
WORK ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: _____
Relationship to Patient: _____

PRIMARY INSURANCE: _____
ID #: _____ GRP #:_____ COPAY AMOUNT: $_____
NAME OF INSURED: _____ DOB: _____
RELATIONSHIP TO PATIENT: _____ REFERRAL REQUIRED: YES NO If YES, REF #: _____

SECONDARY INSURANCE: _____
ID #: _____ GRP #:_____ COPAY AMOUNT: $_____
NAME OF INSURED: _____ DOB: _____
RELATIONSHIP TO PATIENT: _____ REFERRAL REQUIRED: YES NO If YES, REF #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____
ADDRESS: _____

Reason for Current Visit:

_____
_____
_____
_____
_____
_____
_____

Are you **Allergic or sensitive** to any medication or any radiographic dye? (List medication & reaction)

☐ I have no allergies

_____
_____

List all your **current medication** and dosages including supplements. (Example: Lipitor 10 mg daily, Saw Palmetto Herbs)

☐ I take no medications

Name	Dosage	Frequency

Past Medical History

List All Illnesses

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bladder Cancer
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer (List) _____
☐ Crohn's Disease
☐ Cirrhosis
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Diverticulitis
☐ Emphysema
☐ Fatty Liver
☐ Fibromyalgia
☐ Gastritis/ Ulcer
☐ GERD
☐ Glaucoma
☐ Gout
☐ Heartburn
☐ Heart Murmur
☐ Heart Attack
☐ Hepatitis
☐ Hiatal Hernia
☐ High Cholesterol
☐ HIV/ AIDS
☐ Hypertension
☐ Hypothyroidism
☐ Incontinence
☐ Irregular Rhythm
☐ Kidney Cancer
☐ Kidney Disease
☐ Kidney Stones
☐ Lung Cancer
☐ Lupus
☐ Multiple Sclerosis
☐ Parkinson's
☐ Polycystic Ovarian Syndrome
☐ Prostate Cancer
☐ Pseudotumor Cerebri
☐ Reynaud's
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep Apnea
☐ Stroke/TIA
☐ Tuberculosis
☐ Ulcerative Colitis
☐ Urine Infections
☐ Vascular Disease

☐ I HAVE NO MEDICAL PROBLEMS

Past Surgical History

List all your operations (include dates) (example: hernia repair 1991 etc.)

☐ I have had no surgery

_____
_____
_____
_____
_____

Previous Problems with anesthesia ☐ Yes ☐ No

If yes, please describe

_____
_____
_____
_____
_____

Family History

List all serious illnesses in your immediate family which started at age of 70 or younger. Include grandparents, parents, siblings, and children but not your spouse. (Example: Diabetes, colon cancer, etc.)

	Age	**Significant Illness**	**Deceased?**	**Cause of Death**
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Siblings				

Diet/Weight Loss History

When did you first start to have a weight problem? _____

Why did you start to worry about your weight? _____

In your opinion, what contributes to your excess weight?

_____

_____

_____

What Diets have you tried?

Name of Program/Medication	Date Started	How Long	Weight Loss	How Much Weight Regained

Review of Systems

Do you now or have you recently have any of the following problems? (Please Circle Yes or No)

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Weight Change Y N
Night Sweats Y N
Other _____

Gastrointestinal

Abdominal Pain Y N
Nausea/vomiting Y N
Heartburn Y N
Constipation Y N
Blood in Stool Y N
Diarrhea Y N
Other _____

ENT

Ear Infection Y N
Sore Throat Y N
Sinus Problem Y N
Hay Fever Y N
Other _____

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

Cardiovascular

Chest Pain Y N
Swelling of Feet Y N
Circulatory Prob. Y N
Irregular Heartbeat Y N
Palpitations Y N
Other _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Choking at Night Y N
Daytime Drowsiness Y N
Shortness of Breath Y N
Snoring Y N
Frequent Waking Y N
Other _____

Neurological

Tremors Y N
Dizzy Spells Y N
Numbness Y N
Tingling Y N
Hearing Loss Y N
Vision Loss Y N
Migraines Y N
Other _____

Skin

Rash Y N
Boils Y N
Itching Y N
Skin Ulcers Y N
Cellulitis Y N
Skin Fold Irritation Y N
Other _____

Hematology

Swollen Glands Y N
Bleeding Problems Y N
Anemia Y N
Other _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other _____		

Musculoskeletal

Joint Pain	Y	N
Back Pain	Y	N
Weakness	Y	N
Difficulty Walking	Y	N
Limited Mobility	Y	N
Other _____		

Psychologic

Depression	Y	N
Anxiety	Y	N
ADD/OCD	Y	N
Sexual Abuse	Y	N
Obsession	Y	N
Hyperactivity	Y	N
Alcoholism	Y	N
Other _____		

Social History

Do you smoke?

☐ Y If yes, how many packs/day? _____ ____ # of years smoked

☐ N

☐ USED TO, STOPPED _____ packs/day for ____ years Year Quit _____

☐ Never

Do you drink alcohol ☐ Y ☐ N How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

If yes, how many glasses per week? _____

Do you use drugs ☐ Y ☐ N ☐ Used to If yes, which ones? _____

_____

Advance Beneficiary Notice

In the event that I lose my health insurance benefits and become a self-paying patient, I acknowledge and understand that I am responsible for all medical services rendered to me by the physicians of Endo-Surgical Associates of Central Jersey, LLC/ Central Jersey Bariatrics, LLC, as well as for any unpaid cash balances to my account.

_____

Patient

_____ _____

Signature of Patient/Guarantor Date

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COMPLIANCE AGREEMENT FOR BARIATRIC PATIENTS

The decision to have bariatric surgery is a very serious one and I understand the commitment and sacrifices I must make to have a successful outcome.

I also understand and agree that I will not gain any additional weight from the date of my initial consultation to my scheduled surgical date. If I fail to keep this agreement, I understand that my surgery may be postponed or even cancelled.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Witness Signature: _____

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PHOTO AUTHORIZATION AND RELEASE

I hereby authorize STERLING SURGICARE, INC. to display my photographs and statements on their website and other avenues.

Patient's Name: _____

Patient's Signature: _____

Date: _____

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EMAIL AND TEXT POLICY

I, _____, (patient/guardian) hereby voluntarily provide my email and cell telephone number to Sterling Surgicare.

I agree to permit Sterling Surgicare and their Authorized Representatives to communicate with me by e-mail and text message with respect to the medical claims submitted to my health plan and with respect to any balances due to Sterling Surgicare after health plan and other payments received by Sterling Surgicare and for balances not covered by my health plan, coinsurance, deductibles or any other balance deemed client responsibility.

To be clear, I am consenting to communication by email as required by 15 U.S.C. §7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify Sterling Surgicare in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to e-mail communication in writing to Sterling Surgicare there are no hardware or software requirements needed to receive e-mail communication from the Sterling Surgicare or their authorized representatives other than an active e-mail account obtained from a vendor that provides such e-mail accounts.

I understand Sterling Surgicare and their Authorized Representatives will not sell, share, or rent my e-mail address or any other personal information collected on this consent.

Date: _____

Email address: _____

Cell phone #: _____

Patient/Guardian Signature: _____

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Medical Records Request

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____
_____

I hereby authorize STERLING SURGICARE, INC. to obtain any and/or all of my medical records pertaining to my care and treatments from _____ to _____.

( ) Please fax to 732.739.9094

( ) Please mail medical records to 670 N. Beers St., Bld 2 Suite 4, Holmdel, NJ 07733

I release you from all legal responsibility that may arise from this authorization

Signature: _____ Date: _____

Witness: _____ Date: _____

STERLING SURGICARE, INC.
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RELEASE OF MEDICAL INFORMATION CONSENT FORM

Due to new HIPPA (Health Insurance Portability and Accountability Act), we are limited as to what information in your medical records can be shared with any other person except you. BY INITIALING THE APPROPRIATE LINES BELOW, YOU ARE ALLOWING OUR OFFICE TO RELEASE YOUR HEALTHCARE INFORMATION IN LIMITED CASES. You may revoke your consent at any time, in writing to our office.

I, _____, give my consents to STERLING SURGICARE, INC. to:

___ Speak with my family members/spouse about my Medical Condition, Labs, Radiology Results, AND/OR Treatment Plans. (Please list person/s who are to release information to and their relation to you on the provided line below)

_____ _____

_____ _____

_____ _____

___ Fax my test results to other physicians who are participating in my care.

___ Telephone my phone to confirm appointments

___ Telephone my work to confirm appointments

___ Leave messages on my answering machine with regards to test results

___ Other (please specify)

Patient's Name (PRINT): _____

Patient's Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has rights to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain my current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that required that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operation** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures or protected health information, including those related to disclosures to family members, other relatives close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

Consent for the Release of Confidential Information

Insurance

I,_____ hereby consent to communication between Sterling Surgicare and my Insurance Company to communicate with and disclose to one another the following information:

( ) My name and other identifying information

( ) My status as a patient at Sterling Surgicare

( ) Initial Evaluation

( ) Attendance

( ) Summary of Treatment Plan, Progress and Compliance

( ) Date of Admission

( ) Urine Analysis Results

( ) All

( ) Other_____

( ) Progress Report

( ) Discharge Summary

( ) Treatment Plan(S)

( ) Legal Information

( ) Court/DCFS Records

( ) Date of Discharge

( ) Psychiatric Evaluation

The purpose of the disclosures authorized in this consent is to: Doctors & Insurances.

It may be transmitted in the following forms:

( ) Written ( ) Verbal ( ) Electronic ( ) Audio ( ) Video

Term of Consent:

This consent automatically expires at the end of;

( ) Six Months ( ) One Year ( ) Other Date _____

I understand that alcohol and/ or treatment records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Resident Records, 42C.F.R.pt 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts 160 &164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties.

I understand that Sterling Surgicare may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the patient is prohibited.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA OR OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Insurance Benefits – Appointment as 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 Sterling Surgicare, and their authorized representative Mary Ellen Byrne ("My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)

I certify that the health insurance information that I provided to Provider is accurate as of 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 to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

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: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of 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; and (2) 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. This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims. I authorize communication with the Provider and its authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

STERLING SURGICARE, INC.
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BALANCE BILL POLICY – OUT-OF-NETWORK CLAIMS ONLY

We are out-of-network healthcare providers with most health plans. This means that we are a non-participating providers with most health plans meaning we have no contract with health plans to participate in their Network of Participating Providers.

In many instances, the health plans do not pay our charges for medical services in full. We recognize that, as a result, we have an obligation to bill our out-of-network patients the difference between our charges and all payments received. This is commonly referred to as a "Balance Bill". The Balance Bill amount owed by the patient in some cases is not properly stated on the health plan's EOBs and remittances. We do not balance bill patients until all medical claims are billed to your health plan and we take all necessary steps to ensure that your claims are paid at rates set forth in your health plan, which, in many cases, includes our filing appeals with your health plan on your behalf.

We have created this Balance Bill Policy to comply with state and federal laws which require the Balance Bill of clients for out-of-network claims. This Policy apply to all of our facilities that you may encounter during your complete course of treatment.

Once we feel confident that no further payment will be made by the health plan, we will balance the patient the difference between our charge and all payments received.

We recognize that not all of our patients will be able to afford their patient responsibility for the balance bill, their deductibles, copayments and coinsurance. As a result, we have created a financial hardship policy which legally permits us to reduce and, in some cases, waive your patient responsibility. Many of you will be offered financial assistance prior to your first visit. **If you believe you might qualify for financial assistance due to financial hardship, please ask our staff for a copy of our Financial Hardship Policy.**

Balance Bill Letters will not be sent to patients who have health plans that we participate with as in-network providers.

The statute of limitations for debt collection in the State of New Jersey is six (6) years for contracts in writing. Accordingly, we will only seek collection of the Balance Bill that were incurred no more than six (6) years from the date of the balance bill statement was sent. Thank you for being our patient.

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OUT-OF-NETWORK DISCLOSURE FORM AND FINANCIAL AGREEMENT

We are out-of-network healthcare providers with most health plans. This means that we are a non-participating providers with most health plans meaning we have no contract with health plans to participate in their Network of Participating Providers.

In many instances, the health plans do not pay our charges for medical services in full. As a result, we have an obligation to bill our out-of-network patients their ordinary coinsurance, deductibles and cost share amounts.

We recognize that not all of our patients will be able to afford their patient cost share amounts. As a result, we have created a financial hardship policy which legally permits us to reduce and, in some cases, waive your patient cost share responsibility. **If you believe you might qualify for financial assistance due to financial hardship, please ask our staff for a copy of our Financial Hardship Policy.**

You agree by signing this document to be responsible for your patient cost share and that you will ultimately be responsible for our Practice's charge after all payments are received, unless you qualify for financial assistance under the Practice's Financial Hardship Policy. You agree to pay our invoices for coinsurance, deductibles and cost share amounts upon receipt of our invoice or statement. If you fail to pay your coinsurance, deductibles and cost share amounts upon receipt of our invoice or statement, you will be subject to collection activity and will be further responsible for interest on the balance owed the Practice at 3% per month.

Agreed to by: _____ (Patient) Date: _____

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INSTRUCTIONS FOR CLAIM CHECKS SENT TO CLIENT

Sterling Surgicare is "out-of-network", meaning they are not participating with your health plan. Many health plans send out-of-network claim checks, denials and other correspondence directly to the client.

If you receive a claims check, denial, explanation of benefits or other documentation from your health plan, you agree to immediately send that check/documentation to us directly. If you receive a claims check, please do the following immediately, within three (3) days of receipt:

- Endorse the check;
- Under your endorsement, write, "Payable to the order of "Sterling Surgicare"
- Under this write, "For Deposit Only";
- SEND THE CHECK and ALL CORRESPONDENCE AND DOCUMENTATION to us at:

Sterling Surgicare
P.O. Box 628
Holmdel, N.J. 07733

While any check must be sent via regular or expedited mail service, you can also forward any explanations of benefits or any other correspondence to us via email to our billing company at mbyrne@sterlingsurgicare.com. You can also fax them to (732) 739-9094.

I agree to return claims checks, denials, explanation of benefits or other documentation received from my health plan to Sterling Surgicare at the above address within ten (10) days of receipt. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for services from Sterling Surgicare are paid in full.

I also understand that I am responsible for all amounts not covered by my health insurance or health plan, including co-payments, co-insurance and deductibles. In the event Sterling Surgicare determines or becomes aware that I have failed to remit any payment received by me from my insurer within the ten (10) day period set forth above, I understand that Sterling Surgicare is entitled to treat this action as a failure to pay for services rendered, and take any and all action permitted by the Financial Agreement for such failure. If payment is not received by Sterling Surgicare within ten (10) days, then the Patient will pay a penalty of 3% of the full amount due. Each month an additional 3% of any remaining balance will be assessed until the debt is paid in full.

_____ _____
Patient Name (Print) Date

_____ (Guardian of Patient)

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PATIENT AUTHORIZATION TO OBTAIN

SUMMARY PLAN DESCRIPTION & 5500 FORM

I hereby direct you to forward to **Sterling Surgicare** the following governing plan documents for the purpose of applicability of compliance with PPACA:

- **Summary Plan Description (SPD)**
- **5500 Form (Plan Annual Report)**
- **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address I immediately:

Sterling Surgicare
P.O. Box 628
Holmdel, NJ 07733

DATED: _____ _____
Patient Name (Please Print)

_____
Patient Signature

OFFICE POLICIES

- There is a charge of $30 for all returned checks.
- There is a $25 charge for missed or canceled appointments less than 24 hours prior notice.
- Confirming appointments is only a courtesy on our part. If you did not receive a confirmation phone call because we cannot leave a message on your answering machine, non-existence of a voicemail or any other reason for that matter, you are still liable for $25 charge for a NO SHOW or CANCELING LESS THAN 24 HOURS PRIOR. Messages can be left on our answering machine.
- If you have more than one insurance (secondary & tertiary insurances), you must provide us with information for ALL insurances at the time of registration. Your primary insurance will only cover a portion of basic and major procedures/office visits. Your secondary and/or tertiary insurance will pick-up some of the difference. Therefore, if you do not provide all the information we need to bill, you will be liable for any balances.
- All copays are due at the time of visit. We are no longer allowed to bill copays.
- We reserve the right to transfer any outstanding accounts (90 days or more) to a collection agency unless prior payment arrangements were made. Additional fees may apply.

_____ _____

PATIENT SIGNATURE DATE

Sterling Surgicare

Please take a moment to tell us how you heard about us!

Why are you here today? ☐ Bariatric ☐ Surgery ☐ Other _____

What town do you live in? _____

Male ☐ Female ☐ Age _____

Referred by:

Were you referred by another doctor? If so, by whom? _____

Please identify any/all that apply:

Friend/Co-worker/Family Member _____
Dr. Adeyeri's Seminar _____

Internet

SterlingSurgicare.com _____
Facebook/Twitter _____
ObesityHelp.com Website _____
BariatricPal.com Website _____
General website search (Google) _____

Advertising

TV or Print Advertisement _____

Hospital

Raritan Bay Medical Center _____
CentraState Medical Center _____
Bayshore Community Hospital _____

Other

Insurance Referral _____
Other _____

THANK YOU!