INFINITY SURGICAL ASSOCIATES

GHIATH ALSHKAKI, MD, FRCSI.

For Office Use Only

RX	Pre-op To be done within 60 days of surgery date
	Cardiac Clearance
	EKG
	Split Night Polysommography (sleep study)
	Ultrasound of Gallbladder
	Ultrasound of Pelvis
	EGD
	Colonoscopy For are more that 50 or 45 w/ family history of colon cancer
	Psychiatric Clearance
	Bone Density Scan of Hip/ EXA Scan
	Nutrition consult
	Seminar Attendance
	Letter of Medical Necessity for weight reduction Surgical procedure from PCP (she/he was under supervised weight reduction follow up)
	Education Material Given to the patient

Please coordinate with your PCP to complete all the above tests and to fax all the tests reports to us all at once.

	Pre-op Blood work to be done within 30 days of surgery date
	CBC, CMP, Lipid Panel, PT, INR, PTT
	Hepatitis B Surface Antigen, Hepatitis C Antibody
	Ceruloplasmin, Iron, Ferritin, Total Iron Binding Capacity
	Pregnancy Test (female only) Quantitative / PSA Level (males only)
	Urinalysis
	TSH
	H Pylori Test

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	TSH
	H Pylori Test

INFINITY SURGICAL ASSOCIATES

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BARIATRIC OUTPATIENT TREATMENT PROCEDURE LOG

PATIENT NAME: _____ Tel: _____

P.C.P.:_____ Tel: _____

Tests Ordered:	Date Completed:	Filed in Medical Record:
Cardiac Clearance:	_____	_____
Sleep Apnea Study:	_____	_____
Ultrasound of Abdomen/Pelvic	_____	_____
EGD/Colonoscopy:	_____	_____
Bone Density Study:	_____	_____
Psychiatric Clearance:	_____	_____
Letter from PCP*:	_____	_____
Blood Work:	_____	_____

***Letter of medical necessity for weight reduction surgical procedure (She/he was under supervised diet)**

INFINITY SURGICAL ASSOCIATES

4660 Kenmore Ave, Suite 600
Alexandria, VA 22304

Tel: 703-888-0731
Fax: 703-888-0791

PATIENT'S CALL LOG

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

TYPE OF SURGERY TO BE SCHEDULED: _____

HOSPITAL: ALEXANDRIA FAIRFAX GEORGE WASHINGTON

DATE OF SURGERY: _____

INFINITY SURGICAL ASSOCIATES

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PATIENT FLOW CHECKLIST

Patient Name: _____ DOB: _____

Seminar

→ Date _____ → Date _____

→ Quiz _____ → Date _____

☐ Bariatric Patient Education Syllabus given to patient

☐ Health Questionnaire collected

☐ Signed Bariatric Patient Education Seminar Acknowledgement collected

Consultation Appointment

→ Date: _____

→ Weight: _____ Height: _____ BMI: _____

→ Target weight: _____ Excess Weight: _____

HR: _____ B/P: _____ Temp: _____

→ Preoperative laboratory testing given to patient

→ Expected surgical method: ☐ Lap ☐Open

→ Expected surgical procedure: ☐ D/S ☐R NY

→ VBG with Sleeve ☐LAP BAND® ☐ _____

Insurance / Financial:

☐ Self Pay

☐ General insurance information foe the prospective patient signed by patient:

☐ Authorization letter/ package sent to insurance → Date: _____

☐ Authorization number: _____

☐ Hard Copy Authorization received

☐ Financial responsibility explained to patient: $_____

☐ Patient payment received

☐ Insurance status verified 24 hours prior to surgery

Surgery:

☐ Surgery scheduled with OR

→ Date: _____ Time: _____

☐ Weight, BMI, and special instructions given to OR

☐ Lap Versus open instructions given to OR

☐ Patient notified of surgery date by telephone

☐ Bariatric surgery guide package sent to patient

☐ Preoperative appointments checklist sent to patient

☐ Bariatric follow-up guide for PCP sent to PCP

Preoperative Appointment:

→ Date: _____

☐ Preoperative instructions given to patient

☐ RX given to patient

☐ LGB Blood product release signed by patient

☐ Bariatric surgery patient contracts.

INFINITY SURGICAL ASSOCIATES

Office Use Only

Insurance Verification Form

Date: _____

Patient: _____ Birth date: _____

Insurance: _____ Id #:_____

Group #: _____ Subscriber: _____

Primary Insurance_____ Secondary Insurance;_____

Claims and Benefits Phone: _____

Mail Pre D Letter to: _____

_____

_____

Fax to: _____

Attention: _____

Is Patient eligible? ☐ Yes ☐ No Effective Date: _____

Does the patient have benefits for Lap Band (CPT 43846)	☐ Yes ☐ No
Does the patient have benefits for Lipectomy (CPT 15831)	☐ Yes ☐ No
Does the patient have benefits for VBG	☐ Yes ☐ No
Does the patient have benefits for Gastric By Pass	☐ Yes ☐ No
Does the patient have benefits for Sleeve	☐ Yes ☐ No

Phone to Pre- Cert: _____

Pre-Existing Period? ☐Yes ☐No Met? _____

Person at insurance company I spoke to: _____

INFINITY SURGICAL ASSOCIATES

Office Use Only

Initial Diagnosis Form

Patient Name: _____

Date: _____

Height _____ Weight _____

BMI_____

This is a _____ year old male / female with history of long standing morbid obesity. Developed co-morbidities associated with morbid obesity status.
The patient has attempted to reduce weight by conventional methods for an extended time with failed results and is considering bariatric surgery as the treatment of last resort. The surgical procedure (
) was explained to the patient in length. Benefits and potential complications were fully discussed (staple line leak, obstruction, infection, pulmonary embolism, pneumonia, hair loss, gastric or duodenal ulcer, dumping syndrome, vomiting, etc, and death). The success rate of this procedure is 75-80%
(weight loss ranging between 50% to 90%). The patient's commitment to attend post operative aftercare behavior modification program with a psychologist and a dietitian was emphasized. Life long follow-up and increase in exercise activities were stressed. The success of the operation depends heavily on the understanding of the surgery and the motivational level of the patient.

The patient understood everything and has consented to _____
Patient will be cleared for surgery according to protocols.

Diagnosis: _____

_____

_____

_____

_____

Signature _____

THE FOLLOWING PAGES MUST BE COMPLETED BY THE PATIENT

INFINITY SURGICAL ASSOCIATES

Reason for Visit: _____

PATIENT NAME: FIRST M.I. LAST		DATE OF BIRTH	SOCIAL SECURITY #			MALE / FEMALE? M or F
HOME ADDRESS APT #		CITY	STATE	ZIP	HOME PHONE	
EMPLOYER ADDRESS					WORK PHONE	
OCCUPATION		REFERRED BY: FIRST and LAST NAME			CELL PHONE	
ALLERGIES TO MEDICATIONS	PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)				MARITAL STATUS _____S _____M _____W _____D	
SPOUSES NAME		WORK PHONE:		OCCUPATION		
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)					TELEPHONE	
POLICY HOLDER NAME	SOCIAL SECURITY NUMBER		DATE OF BIRTH	FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT __OTHER		
EMPLOYER ADDRESS					WORK PHONE	

Primary Insurance Billing Information

Ins. Co. Name_____
Address:_____
City, State & Zip:_____
ID.No:_____
Group Name:_____**Group #**_____
Subscriber:_____
(Person's Name)
Subscribers Date of Birth:_____
Subscriber's Social Security #

Secondary Insurance Billing Information

Ins. Co. Name_____
Address:_____
City, State & Zip:_____
ID.No:_____
Group Name:_____**Group #**_____
Subscriber:_____
(Person's Name)
Subscribers Date of Birth:_____
Subscriber's Social Security #

Patient Full Name_____ **Signature/date**_____

INFINITY SURGICAL ASSOCIATES

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Giath Alshkaki, MD, to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

The information I provided above in the previous page
(Insurance and personal demographic information page) are correct.

I understand that I will be responsible for a charge of $25.00 for missed appointments without at least 24 hour prior cancellation notice and a charge of $100.00 for any missed procedure without at least 48 hour prior cancellation notice; and a $10 Processing fee will be charged if I don't pay my copay at the time of my visit. I certify that the information I provided above is correct.

_____ _____

Date *Signature of Subscriber or Beneficiary*

I acknowledge that I read and agree with the privacy notice of Giath Alshkaki, M.D.

_____ _____

Date *Signature of Patient*

4660 Kenmore Ave, Suite 600
Alexandria, VA 22304

Tel: 703-888-0731
Fax: 703-888-0791

Patient Name: _____ **Today's Date:** _____

Please present you insurance card(s) and your driver's license to the front office staff so they may make a copy to place in the medical record.

Insurance Waiver and Financial Notification Statement

All co-pays and deductibles are expected at the time of service by cash, or credit card. Insurance benefits applicable to this service will be filed by our billing office provided you furnish the necessary identification numbers with the mailing address. All referrals and pre-certification are the responsibility of the patient to make sure they are received by our office before being seen by the physician. If insurance payment is not received in 45 days from the date of filing, it become your responsibility to pay the account in full and look directly to the insurance company for resolution of the claim. Accounts that are not paid in full by 60 days are considered delinquent and are subject to collection by an outside agency. In the event this account is released for collection, any collection and/or attorney's fees will become the responsibility of the guarantor of the account.

- I agree that **Infinity Surgical Associates** are not to file a claim when the insurance information is given after the services are performed and the patient will be fully responsible to pay the amount due.
- I agree to pay for services for which I have not provided the correct insurance information prior to the service.
- I agree to pay for any services for which I have not obtained a proper referral.
- I agree to pay for non-covered services under my insurance plan.
- I agree to pay any deductibles, co-pays, or out of pocket expenses per my insurances policy as requested by **Infinity Surgical Associates** in a timely fashion.
- I agree to pay for any service for which I have not answered my own insurance company's inquires.
- I certify that I have provided complete, current and accurate information regarding my personal, medical and insurance information.

I take responsibility for understanding my coverage by communicating with my insurance company and/or benefits coordinator. Also, I agree that it is my responsibility to make sure that Infinity Surgical Associates are paid for this service.

Guarantor Signature: _____ **Date**: _____

Assignment of Insurance Benefits: I hereby authorize payment directly to Infinity Surgical Associates of any and all insurance benefits for this visit, hospital inpatient or outpatient stay, otherwise payable to or on behalf of the patient or to me, and authorize release of information requested by the patient's insurance company(ies).

Signature: _____ **Date**: _____

(Patient or authorized representative)

Assignment of Medicare and/or Medicaid Benefits: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.

Signature: _____ **Date**: _____

(Patient or authorized representative)

INFINITY SURGICAL ASSOCIATES

REQUEST FOR MEDICAL RECORDS/ RELEASE OF INFORMATION FORM

The undersigned patient or patient representative agrees to the following terms regarding all general and specific information transmission, and/or requests that medical records are delivered to the specified location. I understand that a fee may apply for specific requests.

Patient's Name_____ Date of Birth_____

Social Security Number_____

Records Requested:

Any records requested deemed necessary for the pre-operative and post-operative evaluation and management of a patient's case. Records may be sent to referring physicians, specialists, hospitals, pre-op centers, insurance or financing agencies, or any other entity that needs such information for the patient's care or other financial purposes. The modality of record delivery may include phone conversation, fax, e-mail, US mail, UPS, or other courier service. I understand that any of these delivery modalities is not perfect and that the records may reach persons or entities other than those requested. I understand that Dr. Alshkaki and his employees are acting in good faith and I certify that I will indemnify and hold Dr. Alshkaki and his employees harmless for any such delivery errors.

I agree to receive e-mail/faxes regarding my medical condition from my doctor or Dr. Alshkaki. I understand that when I communicate via e-mail, that response times may be significantly slow and delayed and that I will not depend on this modality for time sensitive communication or urgent problems.

_____ _____ _____

Patient's Printed Name Patient's Signature Today's Date

OR

I certify that I am legally entitled to sign on behalf of the patient.

_____ _____ _____

Representative's Printed Name Rep.'s Signature Date

INFINITY SURGICAL ASSOCIATES

4660 Kenmore Ave, Suite 600
Alexandria, VA 22304

Tel: 703-888-0731
Fax: 703-888-0791

PATIENT RESPONSIBILITY WAIVER
NON-COVERED PROCEDURES/SURGERY OR NO REFERRAL

I, _____ have been made aware

that my insurance company/ies_____
(NAME OF INSURANCE COMPANY/IES)

May not cover the following procedures:

1._____ 2._____

3._____ 4._____

I understand that I am and will be financially responsible for all charges/amounts due at the time of service unless other arrangements are made for a payment plan with our office manager and/or billing service.

_____ _____
Patient/ Guardian Signature Date

_____ _____
Office Personal Signature Date

Alternative Arrangements for Payment

Payment for services provided to the patient will be made as follows:
(Describe payment arrangements.)

PATIENT IS TOTALLY RESPONSIBLE FOR PAYMENT IF SEEN BY PHYSICIAN WITHOUT PROPER REFERRAL. PCP WILL NOT AND CANNOT BACKDATE REFERRALS FOR OFFICE VISITS/PROCEDURES/SURGER

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Probability and Accountability Act of 1996(HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF INFINITY SURGICAL ASSOCIATES) (ISA) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice describes ISA's privacy practices and those of:

- Any health care professional authorized to enter information into your ISA chart.
- All locations of ISA.
- All employees, staff and other ISA personnel.
- All of these locations follow the terms of this notice. They may share medical information with each other for treatment, payment or ISA operations purpose described in this notice.
- Any business associate of ISA that performs services for or on behalf of these entities is required by us to enter into a contact in which it undertakes to accord the same level of confidentiality to medical information that we afford.

OUR PRIVACY PRACTICES REGARDING MEDICAL INFORMATION

In order to provide you with quality care and to comply with legal requirements, we create a record of the care and services you receive from us. We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. This notice applies to all of the records of your care generated by us. We are required by law to:

- Make sure that medical information that identifies you is treated confidentially;
- Give you this Notice of Privacy Practice with respect to medical information about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use your medical information to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your medical information in order to write a prescription for you, or we might disclose your medical information to a pharmacy when we order a prescription for you. Many of the people who work for ISA including, but not limited to , our doctors and nurses may use or disclose your medical in order to treat you or to assist others in your treatment. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your medical information to others health care providers for purposes related to your treatment.

- **For Payment.** We may use and disclose your medical information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your medical information to bill you directly for services and items. We may disclose your medical information to other health care providers and entities to assist in their billing and collection efforts.

INFINITY SURGICAL ASSOCIATES

To be completed by the patient

MEDICAL QUESTIONAIRE

MEDICAL HISTORY	
Last name	First
Age	
Height (ft / in)	Current weight
Occupation	
How long at current weight?	
Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Hispanic	

Who is the first person to notify immediately following surgery?

Name_____

Relationship_____

Phone: (check where to call) Home_____ Work_____

Will she / he be waiting at the hospital during your surgery? ☐Yes ☐No

MEDICATIONS TAKEN

Current medications: Including vitamins, over the counter medications, and intermittently used drugs.

Name	Strength	How often taken	Purpose	When use started	Req.	As needed

Are you allergic to any medication or foods? ☐Yes ☐ No

Please list. _____

_____

List any major illnesses			
Illness	Date	Treatment	Outcome

List any Surgeries		
Surgery	Date	Reason

Have you ever had surgery to aid weight loss? ☐Yes ☐ No if yes, When? _____

FAMILY HISTORY Check all the applies								
Family Member	Age now or at death	Cause of Death	Thin	Normal Weight	Slightly Overweight	Moderately Overweight	Markedly Overweight	Health-Problems

Any other family members are obese (indicate Mother's / father's side of the family).

Breast, Colon or Prostrate Cancer?

_____

_____

_____

FAMILY HISTORY CONTINUED. . .

Cancer (specifictype):

_____

_____

_____

Diabetes:

_____

_____

_____

Heart attack:

_____

_____

_____

Stroke:

_____

_____

_____

High Blood Pressure:

_____

_____

_____

Arthritis:

_____

_____

_____

Back Trouble:

_____

_____

SHORTNESS OF BREATH

Do you experience shortness of breath with physical activity? ☐Yes ☐ No

How long have you been aware of this (be specific)? _____ Months _____ years

When walking up stairs, how many steps can you climb before noticing shortness of breath?

_____ steps / flights. (Please circle one and indicate how many).

Do you exercise regularly? ☐Yes ☐ No

If yes, complete the following:

What type of exercise: _____ How often? _____

What prevents you from exercising now? _____

UNINARY PROBLEMS (Females)

Do you ever involuntarily lose your urine? ☐Yes ☐ No

If yes, what causes you to loose urine? ☐ Coughing ☐ Jumping ☐ Sneezing ☐ walking ☐bending forward ☐ laughing

Do you experience pain when urinating? ☐Yes ☐ No

Do you wear pads for protection? ☐Yes ☐ No How often must you change pads? _____

How often do you wet your clothing? _____

Any history of bladder surgery? ☐Yes ☐ No

In what position do you sleep? Sitting up Lying flat on back Lying on side lying on stomach

How many pillows do you use under your head? _____

Do you awaken from sleep to catch your breath? _____

Do you snore? ☐Yes ☐ No

Do you ever stop breathing while asleep? ☐Yes ☐ No

Do you doze off when you're talking to someone? ☐Yes ☐ No

Have you ever had a sleep study done? ☐Yes ☐ No

Do you have or ever had asthma? ☐Yes ☐ No How long? _____

Do you experience swelling of the ankles? ☐Yes ☐ No How long? _____

What do you do to decrease the swelling? _____

Do you experience chest pain with exercise or activity? ☐Yes ☐ No

How long? _____ (yrs / mos)

What do you take to relieve the pain? _____

Thyroid problem? ☐Yes ☐ No Describe _____

Are you Diabetic ☐Yes ☐ No How long? _____

What are you taking for diabetes? _____

Do you monitor your blood sugar? ☐Yes ☐ No

How often? _____

Do you have high blood pressure? ☐Yes ☐ No

How long? _____

What are you taking for your high blood pressure? _____

HEARTBURN AND / OR INDIGESTION

Do you have indigestion or heartburn? ☐Yes ☐ No

If so, for how long? _____years / months

What food or drinks cause digestive problems for you? _____

Do you ever have any type of pain in the abdomen? ☐Yes ☐ No

If yes, give details_____

What relieves the pain? _____What have you tried that did not relieve the pain?

_____

Any changes in bowel movements? ☐Yes ☐ No Explain: _____

Any bloody stools? ☐Yes ☐ No History of hemorrhoids? ☐Yes ☐ No External / Internal

BONE OR JOINT PROBLEMS

Do you have the following:

Locations	Swelling	Pain	Stiffness	Popping
Ankles				
Knees				
Hips				
Back				
Other				

Have you ever sought treatment for bone or joint problems or injuries? Give details.
(Including physical therapy and chiropractic)

Doctor	Date of Treatment	Diagnosis / Treatment

Have you taken any medications for this problem? If so what? _____

Have you consulted a chiropractor? ☐Yes ☐ No

Have you ever been told you have degenerative changes or early arthritic changes in your joints? ☐Yes ☐ No

To be completed by the patient

REVIEW OF SYMPTOMS

Unless otherwise specified. Answer the following referring to your current status.

	NO	YES	Details or Comments
Frequent or severe fatigue……	___	___	_____
Frequent or severe Weakness……..	___	___	_____
Fever, chills, night sweats……	___	___	_____
Frequent or severe headaches……..	___	___	_____
Any history or head injury with loss of consciousness	___	___	_____
Nasal congestion……..	___	___	_____
Chronic sinus congestion……	___	___	_____
Wheezing……	___	___	_____
Coughing……	___	___	_____
Heart murmur…….	___	___	_____
Anemia……	___	___	_____
Any history of blood transfusion……	___	___	_____
Bleeding tendency……..	___	___	_____
Convulsions, seizures…….	___	___	_____
Paralysis……..	___	___	_____
Numbness or tingling……	___	___	_____
Memory loss…….	___	___	_____
Depression……	___	___	_____
Anxiety……	___	___	_____
Mood swings……	___	___	_____
Sleep problems……	___	___	_____
Drug or alcohol abuse…….	___	___	_____
Chronic skin rash or hives……..	___	___	_____
Hay Fever……	___	___	_____

Have you used tobacco products in the past? ☐ Yes ☐ No If yes, how long?_____

Do you now use any tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes or packs per day? _____

Do you ever drink alcohol? ☐ Yes ☐ No

If yes, what? _____ How many drinks per day___ Week_____

Do you use caffeine? (coffee, cocoa, cola, chocolates, No-Doz, Aqua Ban).

☐ Yes ☐ No If yes, in what form? _____

How much per day? _____

To be completed by patient

DIETARY HISTORY

Patients Name: _____ Current Weight _____

Please complete the form as precisely as possible

DIET PROGRAMS:	# Times Tried	Date(s) Tried	Of Time On Diet	# Lbs Lost	#Lbs Regained
Example:	3	1999/2002/04	2 – 3 mos ea	5-25 lbs ea	All+
Medi-Fast ……	_____	_____	_____	_____	_____
Opti-Fast ……	_____	_____	_____	_____	_____
Mayo Clinic…….	_____	_____	_____	_____	_____
HMR……	_____	_____	_____	_____	_____
_____.....	_____	_____	_____	_____	_____
Shots: ☐ B-6	_____	_____	_____	_____	_____
☐ B -12	_____	_____	_____	_____	_____
☐ Other____	_____	_____	_____	_____	_____
Phen-Fen	_____	_____	_____	_____	_____
☐Phentermine (only)	_____	_____	_____	_____	_____
☐ Fastin	_____	_____	_____	_____	_____

M.D. Name/Address_____

M.D. Name/Address _____

M.D./ Clinic Name _____

☐ Redux	_____	_____	_____	_____	_____
☐ Meridia	_____	_____	_____	_____	_____
☐ Xenical	_____	_____	_____	_____	_____
☐ Other	_____	_____	_____	_____	_____

M.D. /Clinic Name _____

NON M.D. SUPERVISED

Weight Watchers….	_____	_____	_____	_____	_____
Nutri-System……	_____	_____	_____	_____	_____
Jenny Craig……..	_____	_____	_____	_____	_____
Diet Center……..	_____	_____	_____	_____	_____
TOPS……	_____	_____	_____	_____	_____
Overeaters Anonymous	_____	_____	_____	_____	_____
Slimfast……	_____	_____	_____	_____	_____
Sweet Success…….	_____	_____	_____	_____	_____
Other……	_____	_____	_____	_____	_____

DIET PROGRAMS:	# Times Tried	Date(s) Tried	Length Of Time On Diet	# Lbs Lost	#Lbs Regained
MISCELLANEOUS DIETS					
Low Calorie Diet……	_____	_____	_____	_____	_____
Low Fat Diet……..	_____	_____	_____	_____	_____
High Protein Diet…..	_____	_____	_____	_____	_____
Self Imposed Diet…..	_____	_____	_____	_____	_____
Atkins Diet……	_____	_____	_____	_____	_____
Scarsdale Diet……..	_____	_____	_____	_____	_____
Pritikin Diet…….	_____	_____	_____	_____	_____
Richard Simmons…	_____	_____	_____	_____	_____
Susan Powter……..	_____	_____	_____	_____	_____
Herbal Life…….	_____	_____	_____	_____	_____
Cambridge Diet…..	_____	_____	_____	_____	_____
Other_____.....	_____	_____	_____	_____	_____
DIET PILLS (over the counter)					
Acutrim……..	_____	_____	_____	_____	_____
Dexatrim……	_____	_____	_____	_____	_____
Metabolife…….	_____	_____	_____	_____	_____
Other_____	_____	_____	_____	_____	_____
OTHER TYPES OF WEIGHT LOSS					
Psychotherapy….	_____	_____	_____	_____	_____
Acupuncture……	_____	_____	_____	_____	_____
Hypnosis…….	_____	_____	_____	_____	_____
Subliminal Tapes	_____	_____	_____	_____	_____
Other_____...	_____	_____	_____	_____	_____

EXERCISE

Health Club……	_____	_____	_____	_____	_____
VCR Tapes…….	_____	_____	_____	_____	_____
Other_____...	_____	_____	_____	_____	_____

How long have you been overweight? _____ Age of first Diet? _____

Greatest single weight loss? _____ lbs How was weight loss obtained?_____

How many times have you lost 25 pounds? _____

Are you a snacker? ☐ Yes ☐ No Favorite Foods / snacks_____

Do you eat a lot of sweets? ☐ Yes ☐ No How often do you eat sweets? _____

Are you currently under a physicians care for weight loss? ☐ Yes ☐ No

Type of program_____

Physician Name_____

Address _____

Today's Date: _____ Signed _____

Case Management

- ◯ **Weight Loss Surgery Benefits**
- ◯ **Call insurance company & employer benefits department to see if you have the weight loss surgery benefits.**

Insurance	Pre- Requisites
Aetna	6 months MD supervised diet w/in the last 2 yrs/ mnthy wgh-in
Alliance	Psych Eval, Endocrine Clrnce, Medical Clrnce, Sprvsd Diet
BC BS	Diet History failed for over 1 year
Cigna	6 months diet doc w/in last yr. psych Eval.Mtly wgh-in
Mamsi	Psych Eval, Supervised diet documentation
(Mail Handlers /First Health)	Supervised diet documentation
UHC	Supervised diet, Psych Eval
GEHA	Psych Eval, Diet History by MD
PHCS	6 Months supervised diet w/in the last year/ mthly wgh-in, psych Eval, sprvsd diet doc, Endo Clrnce, Med Clrnce

Due to the changing requirements from the insurance companies the above information is subject to change frequently.

AUTHORIZATION TO SHARE HEALTH INFORMATION

I, _____, allow my doctor(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my use or need for the Adjustable Gastric Band or other Bariatric Procedures. This information can include spoken or written facts about my health or payment benefits I may have.

It can include copies of records from my healthcare providers or health plans about my health or care.
The information will use and give out this information to check to see if I Have coverage for Adjustable Gastric Band or other procedures.

Healthcare Consultants will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it. This Authorization will last for 3 years after the date I sign this form. If I change my mind before that time, I can tell my doctor, healthcare provider, and/or my insurer in writing that I do not want them to share any more information.

I will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers.

Patient Sign Here/ Date: _____

(If the patient cannot sign, patient's representative must sign below)

Patient Name: _____

By: _____
(Signature of person signing for patient)
Describe relationship to patient and right to act for patient:

Patient contract

The purpose of this Agreement is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.

Instructions: Please read each paragraph, and once you agree to the contents of that paragraph, please write your initials on the line underneath the paragraph. If you have any questions as to the meaning of any paragraph, please ask your physician to explain it to you.

____ I understand that this Agreement is essential to the trust and confidence necessary in a physician-patient relationship.

____ I understand that if I do not follow through with all of the terms of this Agreement, my physician may refuse to perform bariatric surgical procedure or may discharge me as a patient from the practice at anytime.

____ I understand that my care and treatment may include use of prescription drugs such as narcotics for pain control. I agree that if I misuse the drugs prescribed for me, my physician may terminate my care and treatment. Misuse includes altering prescriptions, taking other than the prescribed dosage, or using fraudulent or illegal means to obtain drugs.

____ I will fully communicate to my physician or other applicable healthcare provider any concerns or any suspected complications after the surgery.

____ I agree to comply with the pre- and post-surgery protocols, which includes following the diet(s) provided to me, and behavior modification.

____ I agree to keep my follow-up appointments as recommended by my surgeon and/or primary care physician.

____ I agree to take my vitamins, and calcium and other supplements for life as directed by my surgeon and/or primary care physician.

____ I agree to have blood work done for life on an at least annual basis.

____ I agree to see my surgeon and family physician as directed. It is my responsibility to provide both of them with records from these visits.

____ Any medical condition that exists or may develop, not in direct relationship to the weight reduction surgery, must be treated by my primary care physician (and/or appropriate specialty physician) and I agree to coordinate my care with my surgeon. I understand that my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

____ I understand that successful long-term weight loss is depends on following the principles and guidelines of my surgeon's bariatric surgery program.

____ I verify that I have completed a medical history questionnaire and that to the best of my knowledge it is true and correct.

I have read all medical forms and discussed any questions that I may have with my surgeon.

Patient Name (printed) _____ signature _____

WITNESS:

☐ the patient/Authorized Representative has read the form or had it read to him/her
☐ the patient/Authorized Representative expresses understanding of the form
☐ the patient/Authorized Representative has no questions

Witness Name: _____ signature _____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ other specify _____

Interpretation provided by_____

(Fill in name of Interpreter and Title or Relationship to Patient)

_____ _____ _____

Signature (Individual providing assistance)