Gulf Coast Bariatrics

Surgical Consultants of Southwest Florida, LLC

PATIENT INFORMATION — *Informacion del Paciente*

Patient Name: ______________________
Nombre del Paciente

Home Address: ______________________
Direccion del Hogar

City: __________ **State:** __________ **Zip Code:** __________
Ciudad Estado Codigo Postal

Occupation: __________ **Email:** __________
Ocupacion

Employer: ______________________
Empleo

Name of Spouse or Emergency Contact:______________________
Contacto de Emergencia

How did you hear about us? □ Internet □ newspaper □ doctor □ patient □ other_____
Quien refirio a nuestra oficina?

Primary Language: __________**Race:**__________
Lenguaje primario *Raza*

Home Phone: ______________________
Telefono del Hogar

Work Phone: ______________________
Telefono del Trabajo

Date of Birth: __________**Age:**__________
Fecha de Nacimiento

Social Security #: ______________________
Numero de Seguro Social

Marital Status: ______________________
Estado Civil

Phone Number: ______________________
Telefono

Referring Physician: ______________________
Nombre de su Medico

Ethnicity (circle)? Non-hispanic **or** Hispanic.
Etina? Non-hispano o Hispano

INSURANCE INFORMATION — *Informacion de Seguro*

Name of Primary Insurance: ______________________
Nombre del Seguro

Name of Subscriber:______________________
Nombre del Asegurado

Relation to Patient: ______________________
Relacion al Paciente

Subscriber's Employer: ______________________
Empleo del Asegurado

Insured ID: ______________________
Numero de indentificacion de Asegurado

Subscriber's SS#:______________________
Numero de Seguro Social del Asegurado

Subscriber's Date of Birth:______________________
Fecha de Nacimiento del Asegurado

Subscriber's Work Number: ______________________
Telefono de Trabajo del Asegurado

Name of Secondary Insurance: ______________________
Nombre del Seguro Secundario

Name of Subscriber:______________________
Nombre del Asegurado

Relation to Patient: ______________________
Relacion al Paciente

Subscriber's Employer: ______________________
Empleo del Asegurado

Insured ID: ______________________
Numero de indentificacion de Asegurado

Subscriber's SS#:______________________
Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: ______________________
Fecha de Nacimiento del Asegurado

Subscriber's Work Number: ______________________
Telefono de Trabajo del Asegurado

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, American Express and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees, interest, and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta dueda, usted es responsable de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby assign payment directly to Surgical Consultants of Southwest Florida, LLC, dba Gulf Coast Bariatrics, of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by LLC. I understand that I am financially responsible to LLC for any and all charges that the carrier declines to pay (including but not limited to: "Not a covered benefit" (e.g. gastric band adjustment - S-2083 – injection of saline); and/or "Disallowed by plan"). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits. Your signature below acknowledges that you; understand it is your responsibility to contact your insurance company for benefit information related to weight loss surgery; that you understand that you are responsible for knowing when your insurance policy renews or terminates and to alert LLC of any changes/ potential changes to your insurance policy that may affect coverage. **I understand the practice strives to increase patient's accessibility to the practice, in order to do so, is important to minimize the no-show rate. In light of the mentioned, I understand that I will be charged a $25 no-show fee if I fail to come to my appointment without a 24 hour prior cancellation notice.**

Por la presente autorizo el pago directamente a Surgical Consultants of Southwest Florida, LLC, dba Gulf Coast Bariatrics, todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico (incluyendo el S-2083).

PATIENT'S SIGNATURE *&* **NOTICE OF PRIVACY ACKNOWLEDGEMENT:** I have read and understand the Privacy Act:

Signature *Firma del Paciente* :______________________**DATE:** ______________________

Checklist for a Consultation Appointment with the Surgeon

STEP 1:

☐ **REQUESTING A CONSULTATION WITH THE SURGEON:**

- **Complete the request form found in your folder so that we can verify insurance and call you in advance to discuss benefits.**
- How to get the completed request form to us:
  - ✓ Hand the request in at the completion of the information seminar
  - ✓ Go to our website and complete the online registration: **www.gulfcoastbariatrics.com**
  - ✓ Fax it: **239-494-8752**
  - ✓ Mail it: **Gulf Coast Bariatrics, 4519 Tilton Court, Ft Myers, FL 33907**
  - ✓ Email it: **amber@lapdox.com**

STEP 2:

☐ **CALL YOUR INSURANCE COMPANY:**

- Verify that your individual policy covers weight loss surgery. Every insurance company has an exclusion section that explains what the insurance company will and will not pay. If your policy states that it excludes surgical treatment of obesity, then it may not pay for weight loss surgery without an extensive appeal process**. If you do not have coverage, a self-pay option is available to you.**
- If the weight loss surgery is a covered benefit with your insurance plan, you will also want to ask them what requirements need to be met. Most insurance companies require completion of a 3-6 month physician directed weight loss program, which includes nutrition, exercise and behavior modification.
  - ➢ ***Questions to ask your insurance:***
    - ✓ ***Does my policy cover weight loss surgery?*** ____
    - ✓ ***Does my policy cover "Gastric Bypass"(43644),"Gastric Band"(43770), "Sleeve Gastrectomy" (43775)?*** ___________
    - ✓ ***Do I have to do a physician directed weight loss program?*** ___________________________
    - ✓ ***Can you please send me a letter stating coverage and requirements?*** ___________________
- If your insurance policy requires a referral or authorization to see a specialist it is your responsibility to obtain the referral prior to your appointment. If you do not obtain the required referral or authorization the appointment will not be covered by your insurance and the appointment will be cancelled.

STEP 3:

☐ **COMPLETE THE ATTACHED BARIATRIC REGISTRATION PROFILE:**

- Fill out the attached 8 page **REGISTRATION PROFILE**.
  - ✓ You must bring the profile to your appointment with the surgeon or your appointment will be rescheduled.
  - ✓ It must be 100% completed or your appointment will be rescheduled.

STEP 4:

☐ **CALL YOUR PRIMARY DOCTOR AND REQUEST THE FOLLOWING:**

- Referral (if required by your insurance)
- **Letter of Medical Necessity** *(see sample letter in your folder)*

  ****REQUIRED for ALL Medicare, Medicaid and HMO insurances before or at the time of consultation***
- Please bring any recent labs and diagnostic testing (sleep studies, stress test, ECHO, etc.) to the appointment

STEP 5:

☐ **WHAT TO BRING TO THE CONSULTATION WITH THE SURGEON:**

- **Picture ID and insurance card**
- **Completed registration profile (attached).** ***If not completed you will be rescheduled.***
- **Referrals are your responsibility to have faxed or bring to our office if required.** ***If not received you will be rescheduled.***
- **Copays, deductibles and consultation fees are due at the time of services rendered.** We accept cash, check, VISA & MasterCard. ***If unable to pay you will be rescheduled.***

We kindly ask that you reschedule or cancel your appointment 24 hours in advance or you will be subject to a $25.00 fee.

Information Session Attended:____________________ **Consult date:_____________________**
EMMI (BIDM):____________ **Surgeon:________________________**

COMPREHENSIVE WEIGHT LOSS SURGERY PATIENT HISTORY

DEMOGRAPHICS:

Patient Name:____________________________________ Date of Birth:________________Age:__________
Address Information:____
City____________________ State___________ Zip____________ Email:____________________________
Home Phone:__________________________ Alternate Phone Number:__________________________
May we leave a message at either of these phone numbers? □ Yes □ No
How did you hear about us? □ internet □ newspaper □ doctor □ patient □ other___________________

WEIGHT-LOSS HISTORY:

Height:________________Weight:_______________ BMI:_________________
Maximum weight:_____________ Years at Current Weight:________________Years obese?______________
Reasons / personal accountability for obesity?____
Motivation for seeking this intervention for weight control?__________________________________
Preferred Procedure: ____
Have you had previous weight loss surgery? □ Yes □ No What procedure?_____________________________
Have you verified your insurance coverage for weight loss surgery? □ Yes □ No
Additional Comments: ____

MEDICATIONS: *attach a separate sheet if necessary*

Name, dose and frequency

Pharmacy Name____________________ Phone #:___________________

		ALLERGIES:

PATIENT SOCIAL HISTORY:

Marital Status: □ Single □Married □ Separated □ Divorced □ Widowed □ Partnered
Employed: □ Yes □ No Occupation:_______________________________
Alcohol Use: □ Never □ Rarely □ Moderate □ Daily_______________________
Tobacco Use: □ Never □ Quit □ Current packs per day_______________________
Drug Use: □ Never □ Type/Frequency________________________________
Carbonated Beverages: □ Never □ Rarely □ Moderate □ Daily__________________

FAMILY MEDICAL HISTORY:

	Age(s)	Diseases (including obesity)	If deceased, cause of death
Father	____	______________________________	____________________
Mother	____	______________________________	____________________
Siblings	____	______________________________	____________________
	____	______________________________	____________________
	____	______________________________	____________________
Spouse	____	______________________________	____________________
Children#____	_______	______________________________	____________________

PREVIOUS SURGERY:

List previous hospitalizations/surgeries/serious injuries & date

PREVIOUS DIAGNOSTIC TESTING:

Check all that were performed in the past 2 years

- □ CXR
- □ ECHO
- □ EKG
- □ Heart Catheterization
- □ Mammogram
- □ Pap Smear
- □ Pulmonary Function Tests
- □ Sleep Study
- □ Stress Test- Exercise
- □ Stress Test- Nuclear
- □ Upper GI
- □ Ultrasound of Gallbladder
- □ Ultrasound of Lower extremities
- □ Other ___________________
- □ Other ___________________
- □ Other ___________________
- □ Other ___________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING: ***Please answer all questions***

Constitutional			**Date**
Good general health lately	NO	YES	
Night sweats	NO	YES	
Fevers	NO	YES	
Chronic Fatigue	NO	YES	
Hereditary Defects	NO	YES	
Eyes			
Eye disease or injury	NO	YES	
Wear glasses or contacts	NO	YES	
Blurred vision	NO	YES	
Double vision	NO	YES	
ENT	NO	YES	
Hearing loss	NO	YES	
Ringing in the ears	NO	YES	
Earaches or drainage	NO	YES	
Sinus problems	NO	YES	
Bleeding gums	NO	YES	
Bad breath or bad taste	NO	YES	
Sore throat or voice change	NO	YES	
Swollen glands in the neck	NO	YES	
Cardiovascular			
Heart trouble	NO	YES	
High Blood Pressure	NO	YES	
Chest pains/ angina	NO	YES	
Sudden heart beat changes	NO	YES	
Swelling of feet,ankles,or hands	NO	YES	
Respiratory	NO	YES	
Frequent coughing	NO	YES	
Pulmonary embolism	NO	YES	
Shortness of breath or Asthma	NO	YES	
Obstructive Sleep Apnea	NO	YES	
Snoring	NO	YES	
Gastrointestinal			
Loss of appetite	NO	YES	
Change in bowel movements	NO	YES	
Nausea or vomiting	NO	YES	
Diarrhea or constipation	NO	YES	
Blood in stool	NO	YES	
Reflux or heartburn	NO	YES	
Stomach pain	NO	YES	
Endocrine			
Glandular or hormone problem	NO	YES	
Thyroid disease	NO	YES	
Low blood sugar	NO	YES	
Excessive thirst or urination	NO	YES	
Heat or cold tolerance	NO	YES	
Diabetes mellitus	NO	YES	
Change in hat or glove size	NO	YES	
Elevated cholesterol	NO	YES	
Hematologic/Lymphatic			
Slow to heal after cuts	NO	YES	
Easily bruise or bleed	NO	YES	
Anemia	NO	YES	
Phlebitis	NO	YES	
Past blood transfusion	NO	YES	
Enlarged glands	NO	YES	
Cancer	NO	YES	
Bleeding disorder	NO	YES	
Acute Infection	NO	YES	

Genitourinary			**Date**
Frequent urination	NO	YES	
Burning or painful urination	NO	YES	
Blood in urine	NO	YES	
Change of force or strain	NO	YES	
Kidney Stones	NO	YES	
Venereal Disease	NO	YES	
Male: testicle pain	NO	YES	
Female: pain with periods	NO	YES	
Female: irregular periods	NO	YES	
Female: vaginal discharge	NO	YES	
Female: #pregnancies_____			
# miscarriages_____			
Female: date of last pap smear ___			
Female: findings of last pap smear □ normal □ abnormal			
Musculoskeletal			
Joint pain	NO	YES	
Arthritis	NO	YES	
Joint stiffness or swelling	NO	YES	
Weakness of muscles/joints	NO	YES	
Muscle pain or cramps	NO	YES	
Gout	NO	YES	
Back pain	NO	YES	
Cold extremities	NO	YES	
Difficulty in walking	NO	YES	
Skin			
Rash, itching or dry skin	NO	YES	
Change in skin color	NO	YES	
Change in hair or nails	NO	YES	
Varicose veins	NO	YES	
Raised scars	NO	YES	
Breast pain	NO	YES	
Breast lump	NO	YES	
Breast discharge	NO	YES	
Neurological	NO	YES	
Frequent/ recurring headaches	NO	YES	
Lightheaded or dizzy	NO	YES	
Convulsions or seizures	NO	YES	
Numbness/ tingling sensations	NO	YES	
Tremors	NO	YES	
Paralysis	NO	YES	
Stroke	NO	YES	
Pseudotumor	NO	YES	
Psychiatric			
Memory loss or confusion	NO	YES	
Nervousness	NO	YES	
Depression	NO	YES	
Sleep problems	NO	YES	
Psychiatric problems	NO	YES	

DIET HISTORY

Fill in the dates you participated in the following diet programs, the pounds lost, pounds regained, and the time spent in each program. **<u>Please be complete and specific as this information is required for insurance</u>**.

Name of diet program	Dates From	To	Number of months	Pounds lost	Pounds regained
American Heart Association					
Atkins					
Cabbage Diet					
Calorie Counting					
Carefast					
Dexatrim					
Diet Center					
Duke University Programs					
Exercising					
Grapefruit Diet					
Herbal Diets					
Jenny Craig					
Low Fat					
Nutrisystem					
Pritikin					
Oleic Acid					
Radar Institute					
Results					
Richard Simmons					
Scarsdale					
Slim Fast					
South Beach Diet					
Structure House					
Tops					
Weight Watchers					
Acupuncture					
Dexatrim					
Fastin					
Inpatient Psychiatric Programs					
Ionamin					
Hypnosis					
Medifast					
Meridia					
Optifast					
Outpatient Psychiatric Programs					
Phenteramine/Fenfluramine					
Teeth Wiring					
Xenical					
Physician Directed					
Other					
Other					

PATIENT NAME:______________________________

CONFIDENTIAL INFORMATION

Do you authorize Surgical Consultants of SW Florida to discuss your confidential information with others such as your spouse, partner, family member, etc.? (PLEASE INITIAL)

___________ I **DO NOT AUTHORIZE** Surgical Consultants of SW Florida, LLC to discuss my confidential information with others.

If there is someone specific, please let the person below:

Name: ____

Relationship: _______________________________

___________ I **DO AUTHORIZE** Surgical Consultants of SW Florida, LLC to discuss my confidential information with following people. I have also designated my primary emergency contact person below.

Name: ____

Relationship: _______________________________

Phone number: ________________________________

☐ This is my primary emergency contact

Name: ____

Relationship: _______________________________

Phone number: ________________________________

☐ This is my primary emergency contact

Name: ____

Relationship: _______________________________

Phone number: ________________________________

☐ This is my primary emergency contact

____ ______________________________

Patient's Signature Date

PATIENT NAME:____________________________

INSURANCE RELEASE OF INFORMATION

I am interested in having surgery with Surgical Consultants of SW Florida, PA. Therefore, I would like you to release any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Surgical Consultants of SWFL, LLC and Surgical Consultants of Hollywood, PA of the reasonable and customary reimbursements for my surgical procedure.

____ ____________________

Patient's Signature Date

____

Print Name

INSURANCE STATEMENT OF UNDERSTANDING

__________I understand it is my responsibility to contact my insurance company for benefit information related to weight loss surgery.

__________I understand I am responsible for knowing when my insurance policy renews or terminates and to alert Surgical Consultants of SWFL, LLC of any changes/ potential changes to my insurance policy that may affect coverage or I will be responsible for all charges.

__________I understand I am responsible for any co-payments, coinsurance, deductibles, and out of pocket expenses at the time services are rendered including any surgical services.

__________I understand I am responsible for any laboratory and diagnostic fees associated with my preoperative and postoperative care as per my current insurance policy.

____ ____________________

Patient's Signature Date

____

Print Name

Physician Contact information
&
Authorization for release of information

Patient Name: ____
Date of Birth: __________________________ **Patient Initials** ___________

**Please "x" the box and initial to ensure proper authorization for release of information. If you do not wish to authorize records release do not check or initial. **

Primary Doctor: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

Cardiologist: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

Pulmonologist: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

Other Specialty Type: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

Facility: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

Other: ____________________________________
☐__________ **I authorize release of my medical information**
Address: ____
Phone: _____________________________ Fax:_______________________________

I hereby authorize the hospital/facility/physician(s) named above to release my complete medical records to:
Surgical Consultants of SW Florida, L.L.C
Gulf Coast Bariatrics
4519 Tilton Court
Ft. Myers, FL 33907
Fax# 239-494-8752
Phone# 239-494-8777

_____________________________________ ____________________
Patient's Signature Date

Phone: 239-494-8777 **4519 Tilton Court, Fort Myers, FL 33907** **Fax: 239-494-8752**

Surgical Consultants of Southwest Florida, LLC

Notice of Privacy Practices-Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the privacy rule affect you?
When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable Health Information (IIHI)?
It is any health information that you provide our practice, including your mailing address. It is also information that is created and retained by our practice or by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice Posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

TREATMENT
PAYMENT
APPOINTMENT REMINDERS
TREATMENT OPTIONS
HEALTH CARE OPERATIONS
DISCLOSURE REQUIRED BY LAW
RELEASE OF INFO TO FAMILY AND FRIENDS
HEALTH RELATED BENEFIT & SERVICES

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Public health risks
Deceased patients
Military
Law Enforcement
Health Oversight Activities
Organ and tissue donation
National Security Inmates
Research
Lawsuits and similar proceedings
Serious threats to health or safety
Workers Compensation

What are your rights concerning your individually Identifying Health Information (IIHI)?
You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this Notice
7. Right to file a complaint
8. Right to provide an authorization for other uses and disclosure

If you have any questions regarding this notice or our health information privacy policies, please contact:

Surgical Consultants of Southwest Florida, LLC
4519 Tilton Court
Fort Myers, FL 33907
Phone 239-494-8777

I have read the short notice provided by Surgical Consultants of Southwest Florida, LLC practice and have been informed of how to obtain more information regarding our Notice of Privacy.

______________________________ ______________________________

Patient's Signature Date