Gulf Coast Bariatrics
Surgical Consultants of Southwest Florida, LLC

PATIENT INFORMATION (Informacion del Paciente)

Patient Name: ____________________
Nombre del Paciente

Home Phone: ____________________
Telefono del Hogar

Home Address: ____________________
Direccion del Hogar

Mobile Phone: ____________________
Telefono del Trabajo

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

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

Occupation: __________ **Email:** __________
Ocupacion

Social Security #: ____________________
Numero de Seguro Social

Employer: ____________________
Empleo

Marital Status: ____________________
Estado Civil

Name of Spouse or Emergency Contact: ____________________
Contacto de Emergencia

Phone Number: ____________________
Telefono

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

Referring Physician: ____________________
Nombre de su Medico

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

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

INSURANCE INFORMATION (Informacion de Seguro)

Name of Primary Insurance: ____________________
Nombre del Seguro

Insured ID: ____________________
Numero de indentificacion de Asegurado

Name of Subscriber: ____________________
Nombre del Asegurado

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

Relation to Patient: ____________________
Relacion al Paciente

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

Subscriber's Employer: ____________________
Empleo del Asegurado

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

Name of Secondary Insurance: ____________________
Nombre del Seguro Secundario

Insured ID: ____________________
Numero de indentificacion de Asegurado

Name of Subscriber: ____________________
Nombre del Asegurado

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

Relation to Patient: ____________________
Relacion al Paciente

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

Subscriber's Employer: ____________________
Empleo 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 insurances before or at the time of consultation***
- Please bring any recent labs (TSH, Lipid Panel, Hemoglobin A1C) and anydiagnostic 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*

Pharmacy Name____________________ Phone #:___________________

Name, dose and frequency

		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 with dates when diagnosed)*

			Date
CONSTITUTIONAL			
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			
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			
Frequent coughing	NO	YES	
Pulmonary embolism	NO	YES	**Oxygen Use**
Shortness of breath or Asthma	NO	YES	Yes No
Obstructive Sleep Apnea	NO	YES	**CPAP?**
Snoring	NO	YES	Yes No
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	Date:
*Type?			
Bleeding disorder	NO	YES	
Acute Infection	NO	YES	

			Date
GENITOURINARY			
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	

Other medical history or problems?

____

____

____

____

DIET HISTORY

Please complete and be specific as this information is required for insurance and will be included in your authorization packet sent to the insurance company.

Unsupervised Diet Attempts in the last 5 years:
(Examples: Atkins, Herbal Diet, South Beach Diet, Reduced calorie diet with exercise, Nutrisystem)

NAME of DIET	YEAR	HOW MANY MONTHS?	POUNDS LOST	POUNDS REGAINED

Supervised Diet Attempts in the last 5 years:
(Examples: Jenny Craig, Weight Watchers, TOPS, Results)

NAME of DIET	YEAR	HOW MANY MONTHS?	POUNDS LOST	POUNDS REGAINED

Medically Supervised Diet Attempts in the last 5 years:
(Examples: Frequent visits to your doctor, a dietitian, or mental health provider with or without medication prescribed)

NAME of PROVIDER who directed the diet	YEAR	HOW MANY MONTHS?	POUNDS LOST	POUNDS REGAINED	NAME of MEDICATION prescribed

Do you have records from any of your supervised or medically supervised diet attempts? YES NO

If you do not have the records, can you obtain the records? YES NO

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

Please complete the below information in entirety.
This information is important for communication with your other doctors' offices as well as authorized records release.

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 releases 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# 239-288-7139
Phone# 239-494-8777

_______________________________________ ____________________

Patient's Signature Date

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