Gulf Coast Bariatrics
Surgical Consultants of Southwest Florida, LLC

PATIENT INFORMATION (Informacion del Paciente)

Patient Name: _____ **Home Phone:** _____
Nombre del Paciente Telefono del Hogar

Home Address: _____ **Mobile Phone:** _____
Direccion del Hogar Telefono del Trabajo

City: _____ **State:** _____ **Zip Code:** _____ **Date of Birth:** _____ **Age:**_____
Ciudad Estado Codigo Postal Fecha de Nacimiento

Occupation: _____ **Email:** _____ **Social Security #:** _____
Ocupacion Numero de Seguro Social

Employer: _____ **Marital Status:** _____
Empleo Estado Civil

Name of Spouse or Emergency Contact:_____ **Phone Number:** _____
Contacto de Emergencia Telefono

How did you hear about us? □ Internet □ newspaper □ doctor □ patient □ other_____ **Referring Physician:** _____
Quien refirio a nuestra oficina? Nombre de su Medico

Primary Language: _____ **Race:**_____ **Ethnicity (circle)?** Non-hispanic **or** Hispanic.
Lenguaje primario *Raza* *Etina? Non-hispano o Hispano*

INSURANCE INFORMATION (Informacion de Seguro)

Name of Primary Insurance: _____ **Insured ID:** _____
Nombre del Seguro Numero de indentificacion de Asegurado

Name of Subscriber:_____ **Subscriber's SS#:**_____
Nombre del Asegurado Numero de Seguro Social del Asegurado

Relation to Patient: _____ **Subscriber's Date of Birth:**_____
Relacion al Paciente Fecha de Nacimiento del Asegurado

Subscriber's Employer: _____ **Subscriber's Work Number:** _____
Empleo del Asegurado Telefono de Trabajo del Asegurado

Name of Secondary Insurance: _____ **Insured ID:** _____
Nombre del Seguro Secundario Numero de indentificacion de Asegurado

Name of Subscriber:_____ **Subscriber's SS#:**_____
Nombre del Asegurado Numero de Seguro Social del Asegurado

Relation to Patient: _____ **Subscriber's Date of Birth:** _____
Relacion al Paciente Fecha de Nacimiento del Asegurado

Subscriber's Employer: _____ **Subscriber's Work Number:** _____
Empleo del Asegurado Telefono de Trabajo del Asegurado

Do you have any other form of medical insurance that is not indicated above as a Primary or Secondary insurance? YES NO

If YES, complete above or provide the information below:

I understand I am responsible for disclosing ALL health insurance policies that are active in my name as well as when my insurance policy renews or terminates. Failure to disclose a policy could result in responsibility for all charges related to the services. This includes primary, secondary insurance, tertiary insurance, Medicaid and Medicare plans, commercial plans, government plans, etc. **INITIALS: _____**

Entiendo que soy responsable de divulgar TODAS las pólizas de seguro de salud que estén activas en mi nombre, así como también cuando mi póliza de seguro se renueve o termine. No revelar una política podría resultar en responsabilidad por todos los cargos relacionados con los servicios. Esto incluye seguro primario, secundario, seguro terciario, planes de Medicaid y Medicare, planes comerciales, planes gubernamentales, etc. INICIALES:

PATIENT SIGNATURE:_____**DATE:**_____
Firma del Paciente

Gulf Coast Bariatrics

Checklist for a Consultation Appointment with the Surgeon

STEP 1: 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**. *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 / surgical preparatory 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? _____*
    - ✓ *Do I need to have my surgery at a Center of Excellence? _____*
    - ✓ *What is the reference number to the call today?_____*

STEP 2: CONSULTATION WITH THE SURGEON:

- **Return the attached consultation paperwork:**
  - ✓ Bring it completed to your scheduled consult appointment to avoid delay or rescheduling of appointment
    - ✓ Fax it: 239-221-0277
- **Bring the following to your appointment**:
  - ✓ Picture ID and insurance card are required for your appointment
  - ✓ 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 and certified check and credit card. *If unable to pay you will be rescheduled. Personal checks are not accepted.*

STEP 3: OTHER MEDICAL PROVIDERS

- Referral from your primary doctor (if required by your insurance)
- Letter of Medical Necessity from your referring doctor *(a sample letter can be provided and is REQUIRED for most insurances*
- Request recent labs (TSH, Lipid Panel, Hemoglobin A1C, B12, B1) and diagnostic testing results (sleep studies, stress test, ECHO, EKG, CXR, etc.) to be faxed to 239-221-0277

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

COMPREHENSIVE WEIGHT LOSS SURGERY PATIENT HISTORY

DEMOGRAPHICS:

Patient Name:_____ Date of Birth:_____

Pharmacy (local) Name: _____Pharmacy Phone Number: _____

ALLERGIES: ***List names of ALL allergens and the reaction to the allergen*** **(**attach a separate sheet if necessary)

□ **NO DRUG ALLERGIES** □ **NO NON-DRUG ALLERGIES** (ex. latex, adhesive, dyes or food)

MEDICATION & SUPPLEMENTS: ***Include name, dose and frequency*** (attach a separate sheet if necessary)

□ I do not take any daily medication, as needed medications or supplements (ex. vitamins)
Do you have a prescription for medical marijuana use? □ Yes □ No

PATIENT SOCIAL HISTORY:

Marital Status: □ Single □Married □ Separated □ Divorced □ Widowed □ Partnered

Employed: □ Yes □ No Occupation:_____

Alcohol Use: □ Never □ Rarely □ Moderate, drinks per week? _____ □ Daily, drinks per day? _____

Tobacco Use: □ Never □ Quit, date _____ □ Current, packs per day_____

Drug Use: □ Never □ Type/Frequency_____

Do you accept blood products? □ Yes □ No

FAMILY MEDICAL HISTORY:

	Current Age(s)	Diseases (including obesity)	If deceased, cause of death and age
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children #____	_____	_____	_____

PREVIOUS SURGERY:

List previous surgeries & approximate date

□ I have never had surgery

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
□ Ultrasound of Gallbladder
□ Ultrasound of Lower extremities
□ Upper Endoscopy
□ Upper GI
□ Colonoscopy
□ Other _____
□ Other _____

WEIGHT LOSS & DIET HISTORY

Please complete and be specific as this information is required for insurance.

Height:________________Weight:_______________ BMI:_________________

Maximum weight:_____________ Years at Current Weight:________________Years obese?______________

Reasons / personal accountability for obesity? ____

Motivation for seeking surgery for weight control? ____

Have you tried and failed multiple diets? □ Yes □ No

Preferred Procedure: □ GASTRIC SLEEVE □ GASTRIC BYPASS □ GASTRIC BAND □ UNSURE

Have you had previous weight loss surgery? □ Yes □ No If yes, what procedure?_________________________

- Preop weight? ______________________Lowest weight attained? ________________

INSURANCE REQUIRED 5 YEAR DIET HISTORY: (Do Not Leave Blank)

__CIRCLE__ 5 diets that you have attempted in the past 5 years, __CIRCLE__ the year, __CIRCLE__ how many months and write how many pounds lost and regained.

DIET ATTEMPTS (**Circle** one diet name in each box below)	**WHAT YEAR?** (**Circle** one: 2022, 2021, 2020, 2019, 2018, etc)	**HOW MANY MONTHS?** (**Circle** One: 1, 2, 3, 4, 5, 6, 18, 24)	**POUNDS LOST?**	**POUNDS REGAINED?**
Atkins, South Beach, Calorie Counting, Dietitian, Exercise, Fasting, Herbal Life, Jenny Craig, Low Carb, Low Fat, Keto, Medication, MediFast, Noom, Physician directed, Protein supplements, Results, Weight Watchers, Other:___________________________	2022, 2021, 2020, 2019, 2018, 2017	1 2 3 4 6 12 18 24		
Atkins, South Beach, Calorie Counting, Dietitian, Exercise, Fasting, Herbal Life, Jenny Craig, Low Carb, Low Fat, Keto, Medication, MediFast, Noom, Physician directed, Protein supplements, Results, Weight Watchers, Other:___________________________	2022, 2021, 2020, 2019, 2018, 2017	1 2 3 4 6 12 18 24		
Atkins, South Beach, Calorie Counting, Dietitian, Exercise, Fasting, Herbal Life, Jenny Craig, Low Carb, Low Fat, Keto, Medication, MediFast, Noom, Physician directed, Protein supplements, Results, Weight Watchers, Other:___________________________	2022, 2021, 2020, 2019, 2018, 2017	1 2 3 4 6 12 18 24		
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Atkins, South Beach, Calorie Counting, Dietitian, Exercise, Fasting, Herbal Life, Jenny Craig, Low Carb, Low Fat, Keto, Medication, MediFast, Noom, Physician directed, Protein supplements, Results, Weight Watchers, Other:___________________________	2022, 2021, 2020, 2019, 2018, 2017	1 2 3 4 6 12 18 24		

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? *(Circle YES to all that apply)*

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

GENITOURINARY	
Frequent urination	YES
Burning or painful urination	YES
Blood in urine	YES
Change of force or strain	YES
Kidney Stones	YES
Venereal Disease	YES
Male: testicle pain	YES
Female: pain with periods	YES
Female: irregular periods	YES
Female: vaginal discharge	YES
Female: #pregnancies_____	
# miscarriages_____	
Female: date of last pap smear	
Female: findings of last pap	
smear □ normal □ abnormal	
MUSCULOSKELETAL	
Joint pain	YES
Arthritis	YES
Joint stiffness or swelling	YES
Weakness of muscles/joints	YES
Muscle pain or cramps	YES
Gout	YES
Back pain	YES
Cold extremities	YES
Difficulty in walking	YES
SKIN	
Rash, itching or dry skin	YES
Change in skin color	YES
Change in hair or nails	YES
Varicose veins	YES
Raised scars	YES
Breast pain	YES
Breast lump	YES
Breast discharge	YES
NEUROLOGICAL	YES
Frequent/ recurring headaches	YES
Lightheaded or dizzy	YES
Convulsions or seizures	YES
Numbness/ tingling sensations	YES
Tremors	YES
Paralysis	YES
Stroke	YES
Pseudotumor	YES
PSYCHIATRIC	
Memory loss or confusion	YES
Nervousness	YES
Depression	YES
Sleep problems	YES
Psychiatric problems	YES

OTHER HEALTH PROBLEMS OR INJURIES:

All information provided above and on the preceding forms of the Comprehensive Patient History is accurate and honest to the best of my knowledge.

Patient Initials: _____

CONFIDENTIAL INFORMATION

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

Primary Contact	**Additional Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone number: _____	Phone number: _____

☐ **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: _____

PHONE MESSAGES, EMAIL & TEXT CORRESPONDENCE

May we leave a phone message? □ **Yes** □ **No** Phone number to leave a voice message? _____

May we text you regarding appointments? □ **Yes** □ **No** Phone number to text a message? _____

May we contact you via email? □ **Yes** □ **No** Email address: _____

I understand that emails from this office will be titled as Gulf Coast Bariatrics, Dr. Bass's office or some variation of the practice name unless otherwise identified by the sender and/or in the case of the office staff returning an email with a title of origin from sender. I also understand that email correspondence does not take the place of a phone call to the office should I feel I am having a medical emergency. **INITIALS: _____**

FEES AND INSURANCE RELEASE OF INFORMATION & STATEMENT OF UNDERSTANDING (*initial below)*

I understand all fees are payable at the time of services rendered. Cash, certified check, and Credit card are accepted. Personal checks are not accepted as a form of payment.

INITIALS: _____

I would like my insurance company to release any information to Surgical Consultants of SW Florida, PA 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 of the reasonable and customary reimbursements for a surgical procedure. **INITIALS: _____**

I understand my medical insurance is a contract between me and my insurance carrier and therefore, my responsibility to contact my insurance company and or employer for benefit/ exclusion information as it relates to office visits or surgery. This information includes out of pocket expenses (deductibles, copays, coinsurance preoperative testing, anesthesia, etc.) and possible limits of coverage on my policy as related to office visits and surgical procedures.

INITIALS: _____

NO SHOW POLICY

I understand the practice strives to increase patient accessibility to the practice and in order to do so, it is important to minimize the no-show rate. A no-show fee will be charged to my account if I fail to show to a scheduled appointment without 24 – hour prior cancellation notice:

- **Office visits: $25.00**
- **Hospital outpatient procedures (ex. EGD): $100.00**
- **Hospital outpatient or inpatient surgery: $500.00**

INITIALS: _____

_____ _____ _____

Patient Signature Initials Date

Gulf Coast Bariatrics

Surgical Consultants of Southwest Florida, LLC

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
Phone# 239-494-8777 Fax# 239-221-0277

_____ _____
Patient 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 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. Effective 9/23/2013, the U.S. Department of Health & Human Services adopted new rules called the "HPIAA Omnibus Rule", which make changes to the existing privacy, security and breach notification requirements. The new rules are as a result of changes made under the Health Information Technology for Economic and Clinical Health (HITECH) which is part of the law that created the Electronic Health Records (EHRS) Incentive Program under Medicare and Medicaid.
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 Protected Health Information (PHI)?
It is any individually identifiable 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. The medical record is the property of this medical practice, but the information in the medical record belongs to you.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in the waiting room informing patients about their rights surrounding the protection of your PHI and our obligations concerning the use and disclosure of your Personal Health Information. This notice applies to all records created or retained by our practice. Except as described in the Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization.

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

- TREATMENT
- PAYMENT
- HEALTH CARE OPERATIONS
- APPOINTMENT REMINDERS
- SIGN IN SHEET
- NOTIFICATION & COMMUNICATION WITH FAMILY
- MARKETING
- SALE of HEALTH INFORMATION
- REQUIRED by LAW
- PUBLIC HEALTH
- HEALTH OVERSIGHT ACTIVITIES
- JUDICIAL & ADMINSITRATIVE PROCEEDINGS
- LAW ENFORCEMENT
- CORONERS
- ORGAN or TISSUE DONATION
- PUBLIC SAFETY
- PROOF of IMMUNIZATION
- SPEACIALIZED GOVT FUNCTIONS
- WORKERS' COMPENSATION
- CHANGE OF OWNERSHIP
- BREACH NOTIFICATION
- PSYCHOTHERAPY NOTES
- RESEARCH
- FUNDRAISING

What are your Health Information Rights?

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect & Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper or Electronic Copy of this Notice

Changes to this Notice of Privacy Practices:
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints:
Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer as per below. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov. The complaint form may be found at: www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

Surgical Consultants of Southwest Florida, LLC
C/O Privacy Officer: Tiffany Bass RN, BSN, CBN
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 Signature_____ Date _____