Patient Registration Form

Patient Information (PRINT)

First Name:_____ MI: ____Last Name:_____

Birth Date:_____/_____/_____ Sex: ☐ M☐F Social Security Number:_____-_____-_____

Street Address: _____City_____ State_____ Zip Code: _____

Email Address:_____

Mobile: (_____)_____-_____ ☐Preferred Home: (_____)_____-_____☐Preferred

Employer:_____Occupation:_____Work: (_____)_____-_____

Race: ☐American Indian/Eskimo/Aleut ☐Asian/Pacific Islander ☐Black ☐Other ☐White

Nationality: ☐Hispanic Or Latino ☐Not Hispanic or Latino ☐Refused to Report

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner Number of Children:_____

Primary Insurance (Please provide all requested information)

Insurance Company:_____

Policy #:_____ Group #:_____

Whose insurance is this: ☐Self-Skip to secondary insurance ☐Other – Complete this section

Relationship to Insured: ☐Spouse ☐Parent ☐Other:_____ Social Security Number:_____-_____-_____

First Name:_____ MI____ Last Name:_____ Birth Date: _____/_____/_____

Street Address:_____ ___City_____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Employer:_____Work Phone(_____)_____-_____

Secondary Insurance (Please provide all requested information)

Insurance Company:_____

Policy #:_____ Group #:_____

Whose insurance is this: ☐Self-Skip ☐Other – Complete this section

Relationship to Insured: ☐Spouse ☐Parent ☐Other:_____ Social Security Number:_____-_____-_____

First Name:_____ MI____ Last Name:_____ Birth Date: _____/_____/_____

Street Address:_____ City_____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Employer:_____ Work Phone: (_____)_____-_____

Emergency Contact

Name:_____ Relationship to patient:_____ Phone(_____)_____-_____

Name of PATIENT or Guardian (print):_____

Signature of Patient or Guardian:_____Date:_____/_____/_____

Patient Name: _____ Date of Birth: ____/____/____

Health History & Review of Systems (Please check all that apply)

Endocrine	
Hyperthyroidism (High)	
Hypothyroidism (Low)	
Diabetes- Year Diagnosed _____ □Type1□Type2□Gestational	
Chronic Steroid use	
Cushing's Disease	

Respiratory	
Asthma— Year Diagnosed_____	
Shortness of breath at rest/activity	
Flights of stairs you can climb_____	
COPD /Emphysema	
Snoring	
Difficulty sleeping flat	
Awakening at night	
Morning headaches	
Daytime drowsiness	
Observed apnea episodes	
Chronic insomnia	
Sleep Apnea- Year Diagnosed_____ □CPAP □BiPAP	

Gastrointestinal	
Heartburn / Reflux	
Difficulty swallowing	
Painful swallowing	
Hoarseness	
Peptic Ulcer Disease	
Frequent vomiting	
Chronic abdominal pain	
Chronic diarrhea	
Chronic constipation	
Blood in stool	
Irritable Bowel Syndrome	
Crohn's Disease	
Cirrhosis	
Fatty Liver	
Hepatitis- ☐A ☐B ☐C ☐Not Sure	
Hernia-Year Diagnosed ☐Inguinal ☐Hiatal ☐Umbilical ☐Ventral ☐Not Sure	

Cardiovascular	
Chest pain at rest/activity	
Heart attack (MI) Yr Dx	
Heart pounding/Palpitations	
Irregular heartbeat Yr Dx	
Heart Disease-Yr Dx	
Congestive Heart Failure Year Diagnosed_____	
High blood pressure (HTN) Year Diagnosed_____	
Pacemaker/Defibrillator	
History of heart surgery	
High cholesterol/triglycerides Year Diagnosed_____	

Psychological	
Depression	
Anxiety Disorder	
Suicidal thoughts	
Suicide attempts	
Bi-Polar Disease	
Obsessive Compulsive Disorder	
Schizophrenia	
Anorexia	
Bulimia	
Binge eating	

Neurological	
Seizures	
Lightheadedness	
Tremors	
Loss of consciousness	
Narcolepsy	
Stroke	
Migraines	
Fibromyalgia	
Multiple Sclerosis	

Allergies	
Do you have any allergies? □Yes □No	
Please describe:	
Allergic to any medications: □Yes □No List: Allergic to Latex ☐Yes ☐No Reaction:	

Musculoskeletal	
Swelling of legs / feet	
Osteo-Arthritis	
Rheumatoid Arthritis	
Lupus	
Scleroderma	
Joint pain- Limits ability to walk/exercise □Ankles □Knees □Feet □Hips □Back	
Herniated Disc	

Genitourinary	
Frequent urination	
Urine leakage when coughing or laughing	
Kidney Disease	
Kidney stones	
Blood in urine	

Hematologic/Lymphatic	
Anemia, Type_____	
Blood clotting problem	
Sickle Cell Disease	
Blood transfusion-Yr_____	
DVT _____	
HIV- Year Diagnosed_____	

Constitutional	
Fatigue /Tiredness	

Men's Health	
Loss of erection	
Prostate Cancer	

Women's Health	
Polycystic Ovarian Syndrome	
Infertility	
Facial hair growth	
Breast Cancer	
Last Menstrual period Date_____	

Have you or any of your family members had an adverse reaction to anesthesia?

☐Yes ☐No

Surgical History:

(Historial de operaciones)

Type of Surgery (tipo de operación)	**Date** (Fecha)	**Hospital**
_____	_____	_____
_____ _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: Immediate Family (Parents, Siblings, Children)

(Historia Familiar Médica de su familia inmediata. Padres, hermanos (as), hijos (as))

Condition/ Disease	**YES**	**NO**
High Blood Pressure (presión alta)		
High Cholesterol (colesterol alto)		
Heart Disease (Enfermedad del corazón)		
Edema/ Swelling (Hinchazón, retención de líquidos)		
Blood Clots (Coágulos de sangre)		
Diabetes		
Gout (Gota)		
Sleep Apnea (Apnea del sueño)		
Asthma (Asma)		
GERD, heartburn/reflux (ERGE, enfermedad de reflujo gastroesofagico)		
Liver Disease (Enfermedad del hígado)		
Kidney Disease (Enfermedad de los rinones)		
riñones)		
Gall Bladder Disease (Enfermedad de la vesícula biliar)		
Musculoskeletal Disease (Enfermedad Musculoesqueletica, de los musculos/huesos)		
musculoesquelética, de los músculos/huesos)		
Psychological Impairment (Deterioro psicologico)		

Medications:

(Medicamentos)

Please list all medications you are taking, including vitamins, over the counter, and herbal medicines

(Por favor enliste todos sus medicamentos, incluyendo vitaminas, sin receta, y medicinas herbales)

Name (Nombre)	**Strength/Dosage** (Dosis)	**Frequency/How often** (Cada Cuando la toma)	**Indications/what is for** (Para que la toma)

Are you allergic to any medications? Yes ☐ No ☐

(Tieme alergia a alguna medicina?)

If you are please name the medication (s):_____

(Nombre del medicamento que le causa alergia)

Names of your healthcare providers:

PCP:_____ Phone Number:_____

(su doctor general)

Other:_____ Phone Number:_____

(Otro)

_____ _____

_____ _____

ULTIMATE BARIATRICS

Symptom Checklist for Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Memory Loss	☐	☐	☐	☐
Mental confusion	☐	☐	☐	☐
Decreased sex drive/libido	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐
Mood changes/Irritability	☐	☐	☐	☐
Tension	☐	☐	☐	☐
Migraine/severe headaches	☐	☐	☐	☐
Difficult to climax sexually	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Dry and Wrinkled Skin	☐	☐	☐	☐
Hair is Falling Out	☐	☐	☐	☐
Cold all the time	☐	☐	☐	☐
Swelling all over the body	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐

Family History

	NO	YES
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Breast Cancer	☐	☐

ULTIMATE BARIATRICS

Symptom Checklist For Men

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	**Never**	**Mild**	**Moderate**	**Severe**
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	**YES**
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

NAME:

STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb/kg
Age _____
Male/Female
BMI _____
Collar size of shirt: S, M, L, XL, or _____ inches/cm
Neck circumference* _____ cm

1. *S*noring
Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes ☐ No ☐

2. *T*ired
Do you often feel *t*ired, fatigued, or sleepy during daytime?
Yes ☐ No ☐

3. *O*bserved
Has anyone *o*bserved you stop breathing during your sleep?
Yes ☐ No ☐

4. Blood *p*ressure
Do you have or are you being treated for high blood *p*ressure?
Yes ☐ No ☐

5. *B*MI
*B*MI more than 35 kg/m^2?
Yes ☐ No ☐

6. *A*ge
*A*ge over 50 yr old?
Yes ☐ No ☐

7. *N*eck circumference
*N*eck circumference greater than 40 cm?
Yes ☐ No ☐

8. *G*ender
*G*ender male?
Yes ☐ No ☐

* Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
Frances Chung, F.R.C.P.C., Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.#*
Anesthesiology 2008; 108:812–21

ULTIMATE BARIATRICS

Adam B. Smith D.O., FACOS· Jay W. Roberts D.O., FACOS · Richard Novack M.D., FACS

CASH PAY/INSURANCE CONTRACT

This contract will address patients using any form of cash pay or insurance options for General or Bariatric Surgery procedure with Ultimate Bariatrics.

1. If you the patient start as "Insurance" we will collect your specialist co-pay for every office visit. Fees for the Dietitian will be collected at the time of your appointment.
2. If you receive a denial from your insurance company, you will then meet with our financial coordinator regarding your options for converting to "Cash Pay"
3. The CASH PAY price will be determined by the financial coordinator depending on which facility your procedure will be scheduled.
4. *You may receive a bill from Pathology that may range from $300-$500 that you will be responsible for. * **Initials_____**
5. Payment will be made to the facility unless otherwise determined by the financial coordinator.
6. Cash Pay adjustments will pay a $150 fee in full at the time of each visit. Cash pay consults are $120.
7. Insurance adjustments will be filed with your insurance and you will be responsible for all co-pays, coinsurance, and or deductibles.
8. Health Exchange Plan patients will strictly be cash pay only. We are not contracted with these insurances. All tests and or clearances needed, will have to be provided by the patient or simply pay cash.
9. **<u>NOT COVERED BY CASH PAY PRICE</u>**
   a. EKG, Chest X-Ray, possible EGD, possible stress test, possible sleep study, lab work, History and physical (needs to be done within 30 days of surgery), or any other clearance deemed necessary by surgeon.
   b. Emergency room evaluations and any future diagnostic testing including but not limited to CT Scan, Venous Doppler, Gall Bladder Sonogram and Hida Scan.
   c. The six-month follow-up and all other visits after are NOT COVERD under the "CASH PAY PRICE".

ULTIMATE BARIATRICS

If you are required to have an EGD prior to surgery this procedure will be filed with your insurance and you will be responsible for any co-pay, coinsurance, or deductible as required by your policy. ***Initials**_____

If no EGD is performed prior to surgery and during the Bariatric procedure and the surgeon finds a hernia or gall bladder problem the surgeon will repair the hernia or remove the gall bladder and this will be filed with your insurance and you will be responsible for any co-pay, coinsurance or deductible as required by your insurance. ***Initials**_____

*If you change your mind and decide to NOT to have the surgery you will be responsible for any and all charges on your account**.* Initials**_____

For patients using insurance for all surgeries and procedures you will be responsible for any co-pay, coinsurance, deductible, and out of pocket expense as required by your insurance. ***Initials**_____

This agreement has been fully explained to me, and I have had the opportunity to ask, and have any questions answered.

I agree to the conditions of this agreement and will fulfill my responsibilities.

Patient Signature_____**Date**_____

ULTIMATE BARIATRICS

HOW DID YOU HEAR ABOUT US?

Patient Name: _____ Date: _____

Phone Number: _____ DOB:_____

Please check **all** that apply:

- ☐ Doctor Referral (Name of Dr. _____)
- ☐ Friend/ Family (Name, if possible: _____)
- ☐ Radio Station (Station if possible: _____)
- ☐ True Results/ AIGB
- ☐ Website/ Internet Search
- ☐ From my Insurance Provider
- ☐ Television commercial (pick one): Ultimate Bariatrics True Results
- ☐ Billboard
- ☐ Facebook / Social Media
- ☐ Texas Pain Group
- ☐ Other:_____

ULTIMATE BARIATRICS

Adam B. Smith D.O., FACOS · Jay W. Roberts D.O., FACOS · Richard Novack M.D., FACS

To our Current and New Patients:

Please read the following policies for Ultimate Bariatrics and sign:

Our office will verify benefits and submit any pre-determinations as required by your insurance policy. Benefit verification may take 5-10 business days. Pre-determinations will be done after we have received the benefit verification. Please be assured that our office will do our part in obtaining this information in a timely manner.

You will be responsible for any co-pay, co-insurance, deductibles and or office fees as required by your insurance policy. At your Pre-op appointment, we will collect $500 to offset any of these fees. In the event that your insurance determines that a procedure is not covered under your policy, or is deemed not medically necessary, you will be responsible for payment in full.

In an effort to provide a healthy environment for patients, staff and visitors, Ultimate Bariatrics expects visitors, patients, and individuals that accompany them to refrain from unacceptable behaviors. This would include any behaviors that are disruptive, disrespectful, or pose a threat to the rights or safety of other patients and staff. If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to termination of professional relationship with this practice.

By signing, you certify that you have read and understand the above policy.

_____

Printed Patient Name

_____

Patient Signature DATE

ULTIMATE BARIATRICS

Consent to Use and Disclose Protected Health Information

How We May Use and Disclose Your Health Information

Your protected health information will be used by Ultimate Bariatrics, or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

The Notice of Privacy Practices

Ultimate Bariatrics is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you.

You May Place Restrictions on the Use or Disclosure of Your Health Information

You may request a restriction on the use or disclosure of your protected health information.
However, Ultimate Bariatrics may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.
It is a violation of the federal privacy standards if Ultimate Bariatrics agrees and fails to comply with your request.
The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative at the location and contact information listed on the back of the brochure.

You May Revoke This Consent at Any Time

You may revoke this consent at any time; however, Ultimate Bariatrics requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

Changes to Privacy Practices

Ultimate Bariatrics reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. Ultimate Bariatrics will notify you of any changes of privacy practices either by mail, at your next appointment or another pre-approved method that you request.

Pharmacy History

I give Ultimate Bariatrics permission to view my prescription history from external sources.

Signature

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices", and give my permission to Ultimate Bariatrics to use and disclose my health information in accordance with this consent and the notice provided.

_____	_____
Name of Patient (Print or Type)	Signature of Patient/ Date
_____	_____
Patient Representative (Print or Type)	Signature of Representative/
_____	_____
Relationship of Patient Representative to Patient	Date

ULTIMATE BARIATRICS AUTHORIZATION TO RELEASE PROTECTION HEALTH OR FINANCIAL INFORMATION

Patient Information:

Name:_____

Address:_____

Phone:_____ **Date of Birth**_____

SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Ultimate Bariatrics to share my personal health or financial information.

AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Ultimate Bariatrics as set forth below, to share my protected health/financial information for reasons in addition to those already permitted by law.

Family member authorized to receive my medical information:

Name:_____

Address:_____

Phone:_____ **Date of Birth**_____

Check each box below on information you want to be shared with your family member.

☐ History & Physical	☐Progress Notes	☐Laboratory Reports
☐Radiology Films/Reports	☐EKG Reports	☐Pathology Reports
☐Billing/Account Balance info	☐Insurance Information	☐Surgical Clearances

EXPIRATION & REVOCATION

I have read and understand the authorization to release PHI to the above mentioned person. I also understand that I may revoke this consent at any time except to the extent that action has previously been taken in reliance by Ultimate Bariatrics. To revoke this authorization, I must submit the revocation in writing to:

Ultimate Bariatrics
2501 Parkview Dr. #560
Fort Worth, TX 76102

Signature of Patient or Authorized Agent **Date**

Authorization Form to Appeal an Insurance Determination

To: _____

_____

_____

Member Name: _____Date:_____

Member ID#: _____Date of Birth: _____

I hereby authorize **Ultimate Bariatrics/Laparoscopy Bariatrics & Surgery/ JR Cardona CFA/ Matt Sapit CFA** to appeal my insurance carrier's determination concerning all denials of claims or incorrect payment of claims, on my behalf, as my designated representative. I understand that communication may contain:

All medical and financial information containing my insurance file, including but not limited to treatment for my surgical procedure, treatment and hospital confinement in connection with the determination which is being appealed.

By signing below, I understand this information is privileged and confidential and will only be released as specified in this authorization or as permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian / Representative

_____
Signature of witness or Designated Representative

_____
Name and Title of Witness IDesignated Representative

PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Dr. Adam Smith, Dr. Jay Roberts, and/or Dr. Richard Novack, Dr. Adam Smith, Dr. Jay Roberts, and/or Dr. Richard Novack may refer you to Baylor Medical Center at Trophy Club. The address of the Hospital is 2850 E. Hwy 114, Trophy Club, TX 76262.

In connection with any referral to the Hospital, you are hereby advised that Dr. Adam Smith, Dr. Jay Roberts, and/or Dr. Richard Novack have an investment interest in the Hospital.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Baylor Medical Center at Trophy Club. You will not be treated differently by your physician or Baylor Medical Center at Trophy Club if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact Mealnie Chick, CEO- Baylor Medical Center at Trophy Club.

By signing below you acknowledge that should you be referred to the Hospital, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility. Lastly, you further acknowledge by signing below that you signed Physician Ownership Disclosure Form prior to Dr. Adam Smith, Dr. Jay Roberts, and/or Dr. Richard Novack's referral of you to the Hospital.

Date: _____, 20___

Signature of Patient: _____

Printed Name of Patient: _____