PATIENT PROFILE
PERSONAL INFORMATION

Date_____ Date I attended information seminar_____

Last Name _____First Name _____MI_____

Date of Birth_____SS#_____

Home Address_____Apt#_____

City_____State_____Zip Code_____

Telephone: Home (_____) _____Work(_____)_____

Cell (_____) _____

E-Mail Address_____

Current Occupation _____ Marital Status _____

Gender: Male ( ) Female ( ) **Height**: _____'ft _____ins. **Weight**_____

How many years have you been at your present weight? _____

Greatest single Weight Loss _____Lbs Weight Loss Was sustained for _____months

Ethnic Group:

American Indian ( ) Hispanic ( ) Other____

African American ( ) Caucasian ( ) Asian ( )

Preferred Language:

English ( ) Spanish ( ) Other:_____

CONTACT PERSON

This information is vital to us if we need to contact you urgently

Next of Kin (NOT LIVING WITH YOU)

Name_____Relationship_____

Telephone: Home (_____) _____Work (_____)_____

INSURANCE

Insurance Company: _____Policy#_____

HMO_____ PPO_____ POS_____ Other_____

Name of Insured _____

Relationship to Insured: _____ Date of Birth of Insured: _____

SS# of Insured _____Insured ID#_____

REFERRAL INFORMATION

How did you hear about us? Check all that apply.

Physician ( ) Other Patient ( ) Facebook ( ) Magazine ( )

Yellow Pages ( ) Television ( ) Our Web Site ( )

Internet Chat Room/ e-group_____ Other_____

REFERRING DOCTOR:

Name of Physician_____ Date of Referral_____

Address_____

City_____State_____Zip_____

CURRENT PHYSICIANS ROSTER:

Primary Care Physician:

Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Cardiologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Psychologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Psychiatrist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Pulmonologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Endocrinologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

Orthopedic Surgeon: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(___)_____

DETAILED DIET HISTORY

Please check all diet's you have tried and note the estimated dates of treatment

Acupuncture	( )_____	Duke University Programs	( )_____
American heart Association	( )_____	Inpatient Psychiatric Programs	( )_____
Weight Watchers	( )_____	Outpatient psychiatric Programs	( )_____
Nutrisystem	( )_____	Ionamin	( )_____
Pritikin	( )_____	Redux	( )_____
Scarsdale	( )_____	Phenteramine/ Fenfluramine	( )_____
Diet center	( )_____	fastin	( )_____
Jenny Craig	( )_____	Zenical	( )_____
Dexatrim	( )_____	Herbal diet	( )_____
Grapefruit diet	( )_____	Teeth wiring.	( )_____
Rice	( )_____	Tops	( )_____
Atkins	( )_____	Calorie Counting	( )_____
Slim Fast	( )_____	Richard Simmons	( )_____
O.A.	( )_____	Exercise	( )_____
Hypnosis	( )_____	Radar Institute	( )_____
Low Fat	( )_____	Meridian	( )_____
Cabbage Diet	( )_____	Optifast	( )_____
Structure House	( )_____	Carefast	( )_____

PERSONAL MEDICAL HISTORY

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.	*Are you currently being treated for it? Check if yes*	*Are you currently Taking medication for it? Check if yes*
ENDOCRINOLOGY			
Diabetes	( )	( )	( )

If you have been diagnosed with or treated for diabetes. Please complete the following section

Juvenile Onset ( ) Adult Onset ( )

Current form of Control: Check all that apply.

- Diet Control ONLY ( )
- Oral Hypoglycemics ( )
- Insulin ( )

Hypothyroid	( )	( )	( )
Hyperthyroid	( )	( )	( )
Goiter	( )	( )	( )
Graves Disease	( )	( )	( )

Cardiovascular

High Blood Pressure	( )	( )	( )
Angina	( )	( )	( )
Pulmonary Hypertension	( )	( )	( )
Chest Pain with effort	( )	( )	( )
High Cholesterol	( )	( )	( )
High Blood Fats (Lipids)	( )	( )	( )
Irregular Heart Beat	( )	( )	( )
Heart Palpitation	( )	( )	( )
Congestive Heart Failure	( )	( )	( )
Leg Ulcers	( )	( )	( )
Varicose Veins	( )	( )	( )
Ankle Swelling	( )	( )	( )

Gastrointestinal

GERD ( ) ( ) ( )

How often do you have reflux during the day?

Many times per day ( ) Everyday ( ) Most days ( )
Most weeks ( ) occasionally ( )

Do you suffer from Heart Burn/ Indigestion during the night? If so how often?

Many times per night ( ) Everyday ( ) Most days ( )
Most weeks ( ) occasionally ( )

Does fluid or food reflux in the mouth?

Yes ( ) No ( )

Do you vomit with reflux?

Yes ( ) No ( )

Stomach Ulcers	( )	( )	( )
Duodenal Ulcers	( )	( )	( )
Constipation	( )	( )	( )

Number of Bowel Movements_____

Number per week_____

Days between Bowel Movements_____

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.	*Are you currently being treated for it? Check if yes*	*Are you currently taking medication for it? Check if yes*
Vomiting	( )	( )	( )
Everyday	( )	Most Days ( )	Most Weeks ( )
Occasionally	( )	If everyday how many times per day_____	
Diarrhea	( )	( )	( )
Everyday	( )	Most Days ( )	Most Weeks ( )
Occasionally	( )	If everyday how many times per day_____	
Gallbladder Disease	( )	( )	( )
Gall Stones	( )	( )	( )
Inflammation/ infection	( )	( )	( )
Genito-urinary	( )	( )	( )
Urinary Frequency (Over 6x per day)	( )	( )	( )
Recurrent Urinary Tract Infection	( )	( )	( )
Kidney Stones	( )	( )	( )
Kidney Disease	( )	( )	( )
Renal Failure	( )	( )	( )
Gout	( )	( )	( )
Stress Incontinence (Leaking of Urine)	( )	( )	( )
Everyday	( )	Most Days ( )	Most Weeks ( )
Occasionally	( )	If everyday how many times per day_____	

Respiratory

Sleep Apnea: ( ) ( ) ( )

Are you currently on CPAP? No ( ) Yes ( )

If yes what are the settings? _____

Are you currently on BIPAP? No ( ) Yes ( )

If yes what are the settings? _____

Clinical symptoms of Sleep Apnea:

Do you have any of the following symptoms: (please check all that apply)

- Snorting or Gasping ( )
- Loud Snoring ( )
- Struggle for a breath or Breathing stops ( )
- Breathing chokes you ( )
- Frequent awakening ( )
- Tossing, Turning or thrashing ( )
- Difficulty falling asleep ( )
- Morning headaches ( )
- Night sweats ( )
- More than three pillows used under head ( )
- Falling asleep when at work or school ( )
- Excessive sleepiness during the day ( )
- Awaken feeling paralyzed, unable to move for short periods ( )

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.	*Are you currently being treated for it? Check if yes*	*Are you currently taking medication for it? Check if yes*

How well rested do you feel after a full nights sleep?

Not at All ( ) Somewhat ( ) Well Rested ( )

Do You Feel Comfortable Sleeping in an upright position?

YES ( ) NO ( )

Shortness of Breath	( )	( )	( )
Activity	( )	( )	( )
Emphysema	( )	( )	( )
Chronic Cough	( )	( )	( )
Wheezing	( )	( )	( )
Asthma	( )	( )	( )
As a child?	( )		
As an adult?	( )		

Musculo- Sketal

Fibromyalgia	( )	( )	( )
Rheumatoid Arthritis	( )	( )	( )
Lupus	( )	( )	( )
Osteoarthritis	( )	( )	( )
Arthritis	( )	( )	( )
Ankle Pain	( )	( )	( )
Back Pain	( )	( )	( )
Knee Pain	( )	( )	( )
Plantar Fascitis	( )	( )	( )
Heel Pain	( )	( )	( )

OB/GYN

Irregular periods	( )	( )	( )
Excessively Heavy Periods	( )	( )	( )
Excessively Painful Periods	( )	( )	( )
Difficulty in Conceiving	( )	( )	( )
Infertility			
With or without treatment	( )	( )	( )
Excess Body Hair or Acne	( )	( )	( )

Head and Neck

Glaucoma	( )	( )	( )
Cataracts	( )	( )	( )
Hearing Loss	( )	( )	( )
Vertigo	( )	( )	( )
Tinnitis	( )	( )	( )
Migraine Headaches	( )	( )	( )

	Have you been diagnosed with, Or do you suffer from each of the following:	*Are you currently being treated for it?*	*Are you currently Taking medication for it?*
NEUROLOGICAL			
Numbess/ Tingling-hands	( )	( )	( )
Feet	( )	( )	( )
Front or side of thigh	( )	( )	( )
Seizures	( )	( )	( )
Weakness- Hand	( )	( )	( )
Weakness- Feet	( )	( )	( )
Epilepsy	( )	( )	( )
Pseudotumor Cerebri	( )	( )	( )
SKIN			
Dermatitis	( )	( )	( )
Urticaria	( )	( )	( )
Rashes	( )	( )	( )
Open Sores	( )	( )	( )
HEMATOLOGY			
Anemia	( )	( )	( )
Heparin Exposure			
When where you exposed?_____			
Why?_____			
Coumidin Use			
When did you use?_____			
Why?_____			
Iron Supplemensts			
When did you use?_____			
Why?_____			
PSYCHOLOGICAL			
Depression	( )	( )	( )
Bi-Polar Disorder	( )	( )	( )
Anxiety	( )	( )	( )
Schizophrenia	( )	( )	( )
Anorexia	( )	( )	( )
Bulimia	( )	( )	( )
Suicide Attempt	( )	( )	( )
INFECTIOUS DISEASES			
HIV Positive	( )	( )	( )
Staph Infection	( )	( )	( )
Liver Disease	( )	( )	( )
Hepatitis A	( )	( )	( )
Hepatitis B	( )	( )	( )
Hepatitis C	( )	( )	( )

PAST SURGICAL HISTORY

Please indicate with a check any type of surgeries you have had and indicate the year of the surgery

TYPE OF SURGERY		YEAR	TYPE OF SURGERY		YEAR
Adenoidectomy	( )	_____	Hemorrhoidectomy	( )	_____
Angioplasty	( )	_____	Gastric Bypass	( )	_____
Ankle Surgery	( )	_____	Hernia Repair	( )	_____
Appendectomy	( )	_____	Hysterectomy	( )	_____
Back Surgery	( )	_____	Knee Surgery	( )	_____
Breast Augmentation	( )	_____	Lap Band	( )	_____
Breast Reduction	( )	_____	Liposuction	( )	_____
Breast Biopsy	( )	_____	Lumbar Laminectomy	( )	_____
Carpal Tunnel Surgery	( )	_____	Mastectomy	( )	_____
Cesaren Section	( )	_____	Oral Surgery	( )	_____
Cholecystectomy (Gall Bladder)	( )	_____	Ovarian Cystectomy	( )	_____
Coronary Bypass	( )	_____	Panniculectomy	( )	_____
D&C	( )	_____	Pilonidal Cystectomy	( )	_____
Lasik	( )	_____	Tonsillectomy	( )	_____
Prostate Surgery	( )	_____	Tubal Ligation	( )	_____
VBG	( )	_____	Wisdom Teeth	( )	_____

Any problems with anesthesia?
Yes ( )No ( )
If yes, please
describe_____
_____

Have you ever had a Hernia?
Yes ( ) No ( )
If yes, what type?
Umbilical ( ) Hiatal ( )
Inguinal "groin" ( ) Ventral ( )

Do you currently have a Hernia?
Yes ( ) No ( )
If yes, what type?
Umbilical ( ) Hiatal ( )
Inguinal "groin" ( ) Ventral ( )

Will you accept a Blood Transfusion if needed?
Yes ( ) No ( ) If no, reason_____

Have you had a previous blood Transfusion?
Yes ( ) No ( )
If so, Date and Reason_____

Please list any current medical conditions or concerns not covered above
_____
_____
_____

Details of any other hospitalizations for medical problems

_____

_____

_____

ALLERGIES

DRUG			INDICATE REACTION
No Know Drug Allergies	( )	→	_____
Aspirin	( )	→	_____
Codeine	( )	→	_____
Demerol	( )	→	_____
Erythromycin	( )	→	_____
Iodine	( )	→	_____
Keflex	( )	→	_____
Morphine	( )	→	_____
Penicillin	( )	→	_____
Sulfa	( )	→	_____
Tetracycline	( )	→	_____
Vicodin	( )	→	_____
Other	( )	→	_____

Latex allergy screening questionnaire

Do you have an allergy to any latex products?
Yes ( ) No ( )

Have you experienced local swelling, itching or dermatitis associated to contact with latex?
Yes ( ) No ( )

Do you have a history of wheel or blister formation on contact with latex products?
Yes ( ) No ( )

Have you had an allergic reaction to tape?
Yes ( ) No ( )

Does your occupation involve exposure to NRL? "Natural Rubber Latex"
Yes ( ) No ( )

Food allergy screening questionnaire

Do you have any food allergies?
Yes ( ) No ( )

Are you allergic to:

Kiwi	Yes ( ) No ( )
Banana	Yes ( ) No ( )
Avocado	Yes ( ) No ( )
Chestnuts	Yes ( ) No ( )

MEDICATIONS

Name of Medication	mg/units	# of times taken daily	Reason for Medication

Please list in detail all Medications that you have used in the last 12 months. Please include dietary supplements, crèmes, eye drops, etc.

Name of Medication	mg/units	# of times taken daily	Reason for Medication

PERSONAL MEDICAL INFORMATION

Have you ever been diagnosed with Cancer?

Yes ( ) No ( )

If yes, check all that apply

( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

Year Diagnosed _____ Cancer Free for_____Years

Treatment, check all that apply

( ) surgery ( ) Chemotherapy ( ) Radiation ( ) Medication

Do you have regular dental check ups?
Yes ( ) No ( )

Have you had previous dental surgery?
Yes ( ) No ( )

Do you wear Dentures?
Yes ( ) No ( )
If yes, ( ) Upper ( ) Lower

Do you wear glasses?
Yes ( ) No ( )

Do you wear contacts?
Yes ( ) No ( )

Do you have missing teeth?
Yes ( ) No ( )
If yes, how many? _____

Have you ever had an:

EKG
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Stress Test
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Echocardiogram
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Cardiac Catheterization
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

SOCIAL PROFILE

Marital Status:
Never Married ( ) Married ( )
Divorced ( ) Widowed ( ) Separated ( )
Spouses Name_____

Family structure:
Do you have any children?
Yes ( ) No ( ) **If yes, how many?** _____

How many children/ grandchildren in each of the following age groups do you have living with you?
Include nieces, nephews or other dependents

_____ 0-2 years old	_____8-12 years old	_____18-25 years old
_____ 2-8 years old	_____ 12-18 years old	_____over 25 years old

Do you have a person for support?
Yes ( ) No ( )
Do they live with you?
Yes ( ) No ( )

Combined Household Income:

( ) Less than $20,000	( ) $40,000-59,999	( ) $80,000-$99,999
( ) $20,000-$39,999	( ) $60,000-79,999	( ) $100,000 or more

Current employment
Are you currently employed? Yes ( ) No ( )
Occupation_____
Employer_____

Approximate Income

( ) Less than $20,000	( ) $40,000-59,999	( ) $80,000-$99,999
( ) $20,000-$39,999	( ) $60,000-79,999	( ) $100,000 or more

If employed, please state what level of activity your job involves:
( ) Little ( ) moderately active ( ) Very active
Do you enjoy your work?
Yes ( ) No ( )
If you are unemployed, for how long? _____
What is the reason? (Check one)
( ) Physically unable to work ( ) emotionally unable to work ( ) Lack of skills
( ) Lack of available jobs in the field ( ) Appearance inappropriate for position sought
Are you currently disabled or on disability?
Yes ( ) No ( )
If so, for how long? _____

Education

Please check the level of highest completion.

( ) 8th grade	( ) High school graduate	( ) College graduate
( ) Some high school	( ) some college	( ) any post graduate work

SOCIAL DATA

Do you drink coffee?
Yes ( ) No ( ) How many cups per day_____

Do you smoke cigarettes?
Yes ( ) No ( ) If yes, how long_____

Do you smoke cigars?
Yes ( ) No ( ) how many per day? _____

How long ago did you stop smoking?
_____years _____months

Do you drink alcohol?
Yes ( ) No ( )
If yes, how often?
( ) Everyday ( ) Most Days ( ) Most Weeks ( ) Most Months ( ) Rarely
If yes, when drinking do you tend to binge to excess?
Yes ( ) No ( )

Do you have a history of drug or alcohol addiction?
Yes ( ) No ( )
If yes, how long have you been alcohol or drug free?
_____Months

What treatment did you receive? Check all that apply
( ) Residential treatment ( ) Counseling ( ) Support groups such as AA

SPIRITUAL CARE

Please share with us your religious preference._____
Are there any specific religious or spiritual needs we should be aware of that would directly affect your care?_____
_____

Do you have someone who will directly provide you with spiritual support through this process?
Yes ( ) No ( )
May we contact them if necessary?
Name:_____ Number: (___)_____
Our interdisciplinary team includes the service of a professional Chaplain, who is available at no charge to you and your family, and is part of the office staff.
( ) Yes, I would like to see the Chaplain
( ) Before Surgery
( ) In the Hospital
( ) After the surgery for support
( ) As a pastoral counselor to assist with necessary life-style changes

( ) No, I will not be requiring the services of the Chaplain, but understand that he is available, should I change my mind.

In the event that you are unable to make healthcare or end of life decisions for yourself, an Advance Directive for Healthcare Decisions affords you the opportunity to legally state in advance your wishes. An Advance Directive also allows you to name a Healthcare Surrogate to voice your decisions or concerns.
Have you completed an Advance Directive for Healthcare Decisions? ( ) Yes ( ) No

If yes, would you please bring a copy with you for our file. You will also be asked this question at the hospital and it would benefit you to insure they have a copy.

FAMILY MEDICAL HISTORY

FATHER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your father have a history of...
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

MOTHER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your mother have a history of...
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

SISTER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your sister have a history of...
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

BROTHER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your brother have a history of…
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

I consent to receive calls from Western Bariatric, AMC, for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief.

Patient Name: _____ DOB: _____

_____ Date: _____
Patient's Signature

Western Bariatric, AMC

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

NAME: _____ Date of Birth: _____
Last First Middle

Authorization for Use/ Disclosure of Information: I voluntary authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____
Address of Provider: _____
_____

Fax Number: ( ) _____-_____

Recipient and Address for delivery of Records:

Western Bariatric A.M.C
Douglas M. Krahn, M.D., F.A.C.S. President
401 E. Highland Ave #351
San Bernardino CA 92404
Phone: (909) 475-8611
Fax (909) 475-2566 or (909) 475-9497

Purpose: I understand that the specific purpose of this Authorization is

---

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical record:

□ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider my hold.

□ All of my health information described above except for the following:

_____

□ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that recipient will not redisclose my health information to a third party. The third party may not require abiding by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason, however such refusal or revocation may affect the commencement/continuation of care with this provider.

Revocation: I understand that the authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my regular health care provider's office.

Question: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective as valid as the original.

Signature

Date

Name (Please Print)

If Individual is unable to sign this authorization, please complete the information below.

Signature of Personal Representative

Name / Legal Relationship to Patient (Please Print)

Date

Witness Signature

Douglas M. Krahn, M.D., F.A.C.S. President
401 E. Highland Ave #351
San Bernardino CA 92404
(909) 475-8611 Fax (909) 475-2566

Late Cancellation/Missed Appointment Policy

Effective October 1, 2009

As our patient it is your responsibility to keep scheduled appointments. Active participation in the treatment process is vital to the success of your treatment. We have a strict late cancellation or missed appointment policy. If for any reason you will not be able to keep your appointment, you are required to notify the office no later than 24 hours before the scheduled time of your appointment.

You are required to sign the agreement below to acknowledge that the above policy has been explained to you and that you have read and understood the policy. By signing below, you are also agreeing to be responsible for any bills for missed appointments or late cancellations.

I hereby acknowledge that I have read the above policy and that it has been fully explained to me. I therefore agree to the following:

1. It is my responsibility to notify the office manager or any other office staff by telephone at least 24 hour prior to the scheduled appointment if I am unable to keep the scheduled appointment.
2. I agree that I will be billed at the rate of $60.00 for a consultation / $35.00 for an office visit in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

Patient Name: _____ Date: _____

Patient Signature: _____

Witness: _____

Douglas M. Krahn, M.D. F.A.C.S., President
401 E. Highland Avenue, Suite 351
San Bernardino, CA 92404
Phone: (909) 475-8611 Fax: (909) 475-2566

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, (including Medicare, Medi-Cal, private insurance and any other health plan) to Western Bariatric, A.M.C. for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is to be considered as valid as an original.

I, further, authorize Western Bariatric, A.M.C. to furnish my insurance company all medical information which the insurance company may request for the evaluation of claims.

This assignment will remain in effect until revoked by me in writing.

Patient Name: _____

Signature: _____ Date: _____

Billing Policy Statement

It is the policy of our office to collect any deductible, copayment and/or co-insurance amount prior to any elective surgery. When you make the final decision to schedule the surgery, the billing department will call you and notify you of the amount you will need to prepay.

Since insurance quotes are sometimes inaccurate, you may owe additional money or be due a refund from our office after the insurance company processes and pays your bill. In any case, we will send you a bill or refund promptly. Please clarify any information regarding this policy prior to your surgery so as to avoid confusion later.

Patient Name: _____

Signature: _____ Date: _____

Douglas M. Krahn, M.D. F.A.C.S., President
401 E. Highland Avenue, Suite 351
San Bernardino, CA 92404
Phone: (909) 475-8611 Fax: (909) 475-2566

Our Financial Policy

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to contact our office.

We ask that all patients complete our patient information forms prior to seeing the doctor, as well as reading and signing our financial policy.

Payments for services done in our office are due at the time they are rendered. We bill your insurance company for you. If you do not have any insurance we will bill you directly.

You must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. This office is ***NOT*** a party to that contract. Our relationship is with you and not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. If the insurance company does not pay in full within sixty days, we require you to pay the balance due with cash or check.
4. Returned checks will be assessed a $35.00 fee.
5. Balances older than 90 days may be subject to additional collection fees and interest charges of 2.5 percent per month.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Western Bariatric, AMC
Douglas M. Krahn, M.D. F.A.C.S President

401 E. Highland Avenue, Suite 351
San Bernardino, CA 92404
Phone: (909) 475-8611 Fax: (909) 475-2566

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that a copy of the amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:
_____

Patient Name: _____ Date: _____

Patient Address: _____

Signature: _____ Telephone: _____

If not signed by patient, please indicate relationship:
_____Patient or guardian of a minor patient
_____Guardian or conservator of an incompetent patient

Por la presente reconozco que he recibido una copia del Aviso de esta practica medica de practicas de privacidad. Ademas, reconozco que una copia del aviso actual sera fijada en la zona de recepcion, y que una copia de la Notification de Practicas de Privacidad modificado estara disponible en cada cita.

Me gustaria recibir una copia del Aviso De Practicas de Privacidad Modificado por e-mail a:
_____

Imprimir Nombre: _____ Fecha: _____

Direccion del paciente: _____

Firmado: _____ Telefono: _____

Si no esta firmada por el paciente, porfavor indique la relation:
_____El padre or tutor del pacient menor de edad
_____Tutor o curador de un pacient incompetente

Western Bariatric, AMC
Douglas M. Krahn, M.D. F.A.C.S President

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by completing an Authorization to Release Protected Health Information form, and specifying the restriction(s) on the form.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Terri at (909) 475-8611 or Terri@westernbariatric.com for further information about the complaint process.

This notice was published and becomes effective on December 23, 2014