FOOTHILLS WEIGHT LOSS SPECIALISTS

INSURANCE VERIFICATION FORM *(fill out and return to the office first)*

Name: _____ SSN: ____-____-_____ DOB: ____/____/_____

Address: _____City: _____ State: ____ Zip Code: _____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Phone: ____-____-_____

Email Address: _____ Male __ Female __

Referral Source: _____Primary Care Provider: _____

Primary Insurance Information:

Company: _____ Group No.: _____ Member ID: _____

Insurance Provider Information Phone Number: (_____)-_____-_____

Subscriber Full Name: _____ Male __ Female __ DOB: ____/____/_____

Subscriber Information below – *(if differs from patient):* **Subscriber SSN: ____-____-_____**

Relationship to Patient: _____ Subscriber's Employer: _____

Employment Status: Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student *(circle one)*

Address: _____ City: _____State: ____ Zip Code: _____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Phone: ____-____-_____

Secondary Insurance Information:

Company: _____ Group No.: _____ Member ID: _____

Insurance Provider Information Phone Number: (_____)-_____-_____

Subscriber Full Name: _____ Male __ Female __ DOB: ____/____/_____

Subscriber Information below – *(if differs from patient):* **Subscriber SSN: ____-____-_____**

Relationship to Patient: _____ Subscriber's Employer: _____

Employment Status: Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student *(circle one)*

Address: _____ City: _____State: ____ Zip Code: _____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Phone: ____-____-_____

I authorize Premier Surgical Associates and Foothills Weight Loss Specialists to verify my insurance benefits on my behalf. I know that I am ultimately responsible for obtaining and understanding all of my insurance benefits.

Sign: _____Date: ____/____/_____

Foothills Weight Loss Specialists
Mark Colquitt, MD FACS & Jonathan Ray, MD FACS
Center for Advanced Medicine Building
1819 West Clinch Ave, Suite 200
Knoxville, TN 37916
865-984-3413 office 865-212-5597 fax
www.foothillsweightloss.com

Patient Demographics Information Form

Patient Information:

Name: _____ **DOB:** ____/____/_____ **SSN:** _____ ____ _____

Address: _____ **City:** _____**State:** ____ **Zip Code:** _____

Home Phone: ____-____-_____ **Work Phone:** ____-____-_____ **Cell Phone:** ____-____-_____

Email Address: _____

Male __ **Female** __ *(check one)* **Marital Status:** Single __ Married __ Divorced __ Widowed __ Legally Separated __

Race: Caucasian/White, Latino/Hispanic, Black or African American, American Indian or Alaskan Native, Asian, Hawaiian or Other Pacific Islander, Other, Not Reported/Refused *(circle one)*

Language: English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other *(circle one)*

Employment Status: Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student *(circle one)*

Employer: _____ **Occupation:** _____

Referring Physician: _____ **Phone:** ____-____-_____

Other *(Current Healthcare Provider)*: _____ **Phone:** ____-____-_____

Preferred Pharmacy: _____ **Phone:** ____-____-_____

Pharmacy Address: _____ **City:** _____**State:** ____ **Zip Code:** _____

Emergency Contact Information:

Contact Name: *(first, middle, last)* _____ **Male** __ **Female** __

Language: English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other *(circle one)*

Home Phone: ____-____-_____ **Work Phone:** ____-____-_____ **Cell Phone:** ____-____-_____

Relationship to Patient: Child, Spouse, Parent, Guardian, Grandparent, Other *(circle one)*

Contact is a Parent/Guardian: Y N *(circle one)* If patient is under the age of 18, emergency contact should be a Parent or Guardian unless patient is an emancipated minor.

Do you have any of the following? *(circle all that apply)*: Living Will, Do Not Resuscitate (DNR), Power of Attorney (POA), End of Life Decision, No Cardio-Pulmonary Resuscitation (CPR), None

Notice of Privacy Practices Acknowledged:

I have been given an opportunity to review, ask questions about and understand Premier Surgical Associates' Notice of Privacy Practices for Protected Health Information. A copy is located on premiersurgical.com, Foothills Weight Loss Specialists location, under patient forms. A copy is also be available at the office.

Patient or Guardian's Signature: _____Date: ____/____/_____

Premier Surgical Associates, PLLC PLEASE READ

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore, you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

Financial Responsibility *(to be signed prior to your visit)***:**

I understand and commit to the following:

1. I have received a copy of Premier's financial policies and have read and understand these policies.
2. I will pay my co-pay, deductible and co-insurance at the time of service.
3. I will provide the most current insurance information and immediately notify Premier of changes.
4. If surgery is required, all or a portion of my financial responsibility must be paid prior to surgery.
5. I will follow my insurance company's requirements for referrals and pre-authorizations and I understand that if I fail to do so, my insurance benefits will be reduced and I will be responsible for all denied balances.
6. I understand that I am responsible for all balances after insurance has paid.
7. If I have no insurance, I have informed Premier and I am responsible for 100% of all balances.
8. A collection fee of 30% will be added to all my accounts that are turned over to collection agencies.

Patient or Guardian's Signature: _____Date: ____/____/_____

Insurance Authorization and Release:

I request that payment of authorized benefits – including Medicare, and any other government sponsored program, private insurance, and any other health plans – be made to Premier Surgical Associates, PLLC for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize Premier Surgical Associates, PLLC to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Premier Surgical Associates, PLLC any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient or Guardian's Signature: _____Date: ____/____/_____

As of October 16, 2013, the FCC is requiring all businesses (including healthcare companies) to retrieve consent from their customers before enrolling their cell phones in auto-dialing. This includes appointment reminders, which obviously affects us.

By including your cell phone number, you have given Premier Surgical Associates, PLLC consent to call your cell phone for appointment reminders using our automated system.

Patient or Guardian's Signature: _____Date: ____/____/_____

Missed Appointment Policy:

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit, ultrasound or other diagnostic test appointment. A minimum of 30 and up to 90 minutes is set aside for each appointment and your communication and compliance is much appreciated by your physician and supporting staff. **Please be aware that if 24 hour notice is not received a fee of $25 may be charged to your account which must be settled before another appointment is scheduled.** Please call us at **865.984.3413** if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

Patient or Guardian's Signature: _____Date: ____/____/_____

FOR MEDICARE SUPPLEMENT POLICIES ONLY ONE TIME MEDIGAP ASSIGNMENT AND RELEASE

Name: _____ Medicare Number _____

Medigap Policy Name _____ Medigap Policy Number _____

I request that payment of the authorized Medigap benefits be made on my behalf to Premier Surgical Associates, PLLC for services furnished to me by them. I authorize any holder of medical information about me to release it to:

Name of Policy: _____

Any information needed to determine these benefits to the benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient or Guardian's Signature: _____Date: ____/____/_____

Bariatric Patient History

Date ____/____/_____

Last Name: _____ Suffix: _____

First Name: _____ Middle initial: ____ Preferred Name or Nickname: _____

Date of Birth: _____/_____/_____ Age: _____

How did you find us?: (choose one)

1. Someone you know – [ ] Friend [ ] Family [ ] Patient [ ] Hospital or Premier employee
2. Physician – [ ] Primary care [ ] Specialist [ ] Other bariatric surgeon. Who? _____
3. Newspaper – Which one? _____
4. Internet – [ ] Search web site. Which one? _____
   [ ] Foothillsweightloss.com [ ] Hospital website [ ] Obesityhelp.com [ ] Premiersurgical.com
   [ ] Other. Which one? _____
5. Expo – [ ] Healthy Living Expo [ ] Womens Expo [ ] Other _____
6. TV – [ ] Commercial [ ] Live interview [ ] Other _____
7. Insurance company. Which one? _____
8. Other _____

Coordinated Care Physicians:

Primary Care/Physician Name: _____ Office Number: ____-____-_____

Endocrinologist/Physician Name: _____ Office Number: ____-____-_____

Cardiologist/Physician Name: _____ Office Number: ____-____-_____

Pulmonologist/Physician Name: _____ Office Number: ____-____-_____

Gastroenterologist/Physician Name: _____ Office Number: ____-____-_____

OB/GYN/Physician Name: _____ Office Number: ____-____-_____

Current illnesses/diseases:

(check all that apply)	How long? (years)	First diagnosed (year)	Other information
[ ] Diabetes			How long on insulin? _____ yrs.
[ ] Hypertension			
[ ] Hyperlipidemia (high cholesterol)			
[ ] Arthritis			
[ ] Sleep apnea			CPAP/BIPAP pressure? _____
[ ] Gout			
[ ] Hypothyroidism (low thyroid)			
[ ] GERD (esophageal reflux)			
[ ] COPD / Emphysema			
[ ] Asthma			
[ ] Pulmonary hypertension			
[ ] Congestive heart failure			
[ ] Coronary artery disease			
[ ] Varicose veins			
[ ] Depression			
[ ] Anxiety			
[ ] Bipolar disease			
[ ] Stroke			How long ago?
[ ] Skin fold rash			Location:
[ ] Neuropathy			
[ ] Pseudo Tumor Cerebri			
[ ] Cancer			Type?
[ ] Fibromyalgia			
[ ] Hemorrhoids			
[ ] Blood clots in leg or lungs			
[ ] Other			

Surgical History: (List all surgeries including dates. Attach additional page if necessary.)

Surgery:	Date:	Hospital:

Previous Bariatric Surgery [ ] Yes [ ] No

If yes, what procedure: _____

When:_____ Surgeon: _____

Address: _____ City: _____ Hospital: _____

Phone number: (_____)_____-_____

Original weight _____ lbs. Lowest weight achieved _____ lbs.

Where there any complications? [ ] Yes [ ] No

If yes, explain: _____

Allergies:

Medication:	Reaction:
Food Allergies:	**Reaction:**
Latex? Yes [ ] No [ ] Iodine? Yes [ ] No [ ]	

Medications: (Include over the counter or herbal medications, including vitamins. Attach additional page if necessary)

Prescription Drug name: (Copy name from bottle)	**Dose: (mg, units, etc.)**	**How often: (daily, twice a day, etc.)**	**Prescribing Physician**
Over the counter, herbal medication or vitamin name: (Copy name from bottle)	**Dose: (mg, units, etc.)**	**How often: (daily, twice a day, etc.)**	

Family History: (check all that apply)

Disease:	Relationship:	Age at onset of disease:
[ ] Obesity		
[ ] Diabetes		
[ ] Cancer		
[ ] Heart disease		
[ ] Hypertension		
[ ] Stroke		
[ ] Other		

Do you have any family or friends who have had bariatric surgery? If so, who are they and what procedure did they have?

_____

_____

Social History:

Habits:

Smoking [ ] Yes (packs per day? _____) [ ] Never [ ] Quit (when?) ____ months / ____ years ago.

Alcohol [ ] Yes [ ] No If yes, how much? _____per week/month

Illicit or recreational drug use? [ ] Yes [ ] No if yes, name of drug and last use. _____

Limitations/Disabilities:

Disabled [ ] Yes [ ] No If yes, for how long _____yrs.

Cause of disability _____

Limitations: _____

How many hours do you usually sleep out of a 24 hour day? _____

What time do you get up? _____ What time is your first meal of the day? _____

Do you follow any religious or cultural rules that influence what or how you eat? [ ] Yes [ ] No If yes, please explain:

_____

Weight History: Current height _____ feet, ____ inches Current weight: _____lbs. BMI (if known) ____

Highest adult weight: _____ lbs. At what age? _____ Lowest adult weight: _____ lbs. At what age? _____

When did you begin to gain excess weight and what would you attribute the weight gain to at that time?

_____

Weight gain in last 6 mths? _____ lbs. *or* Weight loss in last 6 mths? _____ lbs.

Have you previously seen a dietitian? [ ] Yes [ ] No If yes, reason for visit? _____

Ideal weight? _____ lbs. How much weight do you expect to lose post weight loss surgery? _____ lbs.

Review of Systems

	Yes	No		Yes	No
Constitutional			**GU**		
Recent weight gain_____lbs			Blood in urine		
Recent weight loss_____lbs			Urinary frequency		
Fever			Pain during urination		
Eyes			**Musculoskeletal Symptoms**		
Pain in or around the eyes			Leg pain with exercise		
Vision problems			Lower leg swelling		
ENMT			**Psychiatric**		
Hearing loss			Depression		
Bleeding gums			Anxiety		
Cardiovascular			Memory lapses or loss		
Chest pain or discomfort			**Skin/Breast**		
Fast heart rate			Breast lump		
Chest pain when climbing			Breast pain		
flight of stairs			Skin lesions		
Respiratory			Skin rash		
Cough			**Neurologic**		
Shortness of breath			Dizziness		
Stomach or Intestine			Confusion		
Black or bloody stool			**Hematologic**		
Jaundice			Easy bleeding		
Nausea			Easy bruising		
Vomiting			Swollen glands in neck		
Constipation			Groin lymph node swelling		
Diarrhea			**Other**		
Abdominal pain			Possible pregnancy		
Heartburn/reflux			Planning to become pregnant		
			Currently breast feeding		

Bariatric Eating Self Perception:

In the space below, write a paragraph or more about your relationship to food. Describe eating behaviors that worry you now as well as those that have worried you in the past. (attach additional page if necessary)

On a scale from 1 – 5, circle the number that best describes you or your situation:	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I have family and friends that will be a strong support system for me after surgery.	1	2	3	4	5
I have researched bariatric surgery and talked with people who have had weight loss surgery.	1	2	3	4	5
I will be involved with my follow up care and attendance at bariatric support groups after surgery.	1	2	3	4	5
I am highly motivated.	1	2	3	4	5
I am quick to learn and can easily follow directions.	1	2	3	4	5

Exercise History: (be honest)

Type: (walking, weights, etc.)	How often: (daily, weekly, etc.)	Date of last exercise:

Do you own exercise equipment? [ ] Yes [ ] No Do you have a gym membership? [ ] Yes [ ] No

What sports have you played? :_____

What keeps you from being able to exercise? _____

_____

Bariatric Behavior Questionnaire © Actual (BBQA)

Answer All Questions. Read each item carefully and rate the Actual behaviors being expressed by you to achieve weight loss and good health. Rate whether the behaviors are expressed **Rarely** (R), **Sometimes** (S), **Often** (O) or **N/A** (not applicable because of stage of progress toward surgery). Please be very thoughtful and take time with this survey. The information is very important to long term success of weight loss with bariatric surgery. **Make a circle around your choices.**

NOTE: we will ask you from time to time to repeat this survey and also might ask people who support you and know you well to complete the survey about you from their viewpoint. We do this to help get accurate information about your compliance behaviors. We want you to be very happy with your outcome in the long term.

1. Eats foods that offer good nutrition.	Rarely	Sometimes	Often	
2. Eats and chews slowly; savors food to enjoy it.	Rarely	Sometimes	Often	
3. Eats in secret, not letting others see.	Rarely	Sometimes	Often	
4. Eats small meals, 4-6 per day.	Rarely	Sometimes	Often	N/A
5. Eats sufficient protein 60-80 grams per day.	Rarely	Sometimes	Often	
6. Eats correct quantity of food, not too much and not too little.	Rarely	Sometimes	Often	
7. Drinks mostly water and gets about 4 pints of water a day.	Rarely	Sometimes	Often	
8. Eats sweets, starchy carbohydrates or both.	Rarely	Sometimes	Often	
9. Takes proper vitamins and supplements to insure proper nutrition.	Rarely	Sometimes	Often	

10. Eats quickly, chewing and swallowing quickly.	Rarely	Sometimes	Often	
11. Exercises or moves with vigor at least 60 minutes per day.	Rarely	Sometimes	Often	
12. Makes excuses for not moving or exercising.	Rarely	Sometimes	Often	
13. Shows long term commitment to exercise.	Rarely	Sometimes	Often	
14. Has positive vision for personal future.	Rarely	Sometimes	Often	
15. Mindful and makes deliberate choices to have better health.	Rarely	Sometimes	Often	
16. When faced with negative thoughts, chooses positive thoughts instead.	Rarely	Sometimes	Often	
17. Memories of past failures disrupt current good health practices.	Rarely	Sometimes	Often	
18. Works to eliminate controllable stress and strain.	Rarely	Sometimes	Often	
19. When faced with adversity, gives in or gives up.	Rarely	Sometimes	Often	
20. Complains about pains and problems.	Rarely	Sometimes	Often	
21. Optimistic about life's possibilities and the future.	Rarely	Sometimes	Often	
22. Provides encouragement to others; shares knowledge and wisdom.	Rarely	Sometimes	Often	N/A
23. Sees self as deprived of food enjoyment.	Rarely	Sometimes	Often	
24. Grateful for blessings of life.	Rarely	Sometimes	Often	
25. Sees self as victim of circumstance and bad luck.	Rarely	Sometimes	Often	
26. Engages in activities that add meaning and richness to life.	Rarely	Sometimes	Often	
27. Changes mental picture of body to match actual weight loss.	Rarely	Sometimes	Often	
28. Accepts positive comments about changing body.	Rarely	Sometimes	Often	N/A
29. Shows understanding that PERFECT weight or shape is unattainable.	Rarely	Sometimes	Often	
30. Gets restorative sleep (7-10 hours of sleep each 24 hour period)	Rarely	Sometimes	Often	

31. Takes prescribed medications on time and in proper dosage.	Rarely	Sometimes	Often	
32. Keeps appointments with weight loss surgeon and other weight loss professionals.	Rarely	Sometimes	Often	N/A
33. When seriously off track, seeks professional help.	Rarely	Sometimes	Often	N/A
34. Attends bariatric support groups regularly.	Rarely	Sometimes	Often	N/A
35. Takes personal responsibility for own health.	Rarely	Sometimes	Often	

Psychiatric History: Please list any psychological or psychiatric treatments received in the past.

A. List any psychological medications taken by prescription (dates and dosages).

_____

_____

B. List any talk therapy or counseling you have had. (duration + dates)

_____

_____

C. List any benefits that you perceive yourself as receiving and any adversity that you perceive resulted from the above treatments.

_____

_____

Personal Statement: (attach additional pages if necessary)
Please write about personal downside of being overweight or obese, and why you want to have bariatric surgery. This can be related to health, pain, embarrassment, harassment, or other events. The writing provides insight into personal barriers and gateways that influence lifestyle change.

Form completed by (print): _____ Relationship to patient: _____ [ ] Self

Signed _____ Date ____/____/_____

Nutrition Screening Evaluation Form – List of Popular Diets

Circle from the list below any programs, medications, diets or remedies you have tried in the past.

Commercial Programs

Diet Center
Jenny Craig
LA Weight Loss
NutriSystems
Overeaters Anonymous (OA)
Physician's Weight Loss Center
Take Off Pounds Sensibly (TOPS)
Weight Watchers

Prescription Diet Medications

Amphetamines
Meridia (sibutramine)
Phentermine (Fastin/Adipex/Ionamin)
Xenical (orlistat)

Liquid Diets

Carefast
Formula 3
HMR
Medifast
New Direction
Optifast
Slimfast

Herbal and Non-Prescription Remedies

Alli
Dexatrim
Ephedra (ma huang)
Hydroxcut
Laxatives
Metabolife

Popular Diets or Fad Diets

Blood Type Diet
Body for Life
Cabbage Soup Diet
Calorie Counting
Carbohydrates Addicts Diet
Dr. Phil's Ultimate Weight Loss
Eat More, Weigh Less (Dr. Ornish)
eDiets.com
Glycemic Index
Grapefruit
Hollywood
Low Carb (i.e. Atkins)
Low Fat
Mayo Clinic Diet
Protein Power
Richard Simmons
South Beach
Sugar Buster's
The Zone
Volumetrics

Therapy and Other Programs/Diets

Acupuncture
Behavior Therapy
Diabetic Diet
Exercise Programs
Fasting
Hypnosis
Inpatient psychiatric program
Previous gastric stapling
Psychotherapy
Registered Dietitian

Other (not listed above) _____

_____

Premier Surgical Associates, PLLC

Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____/_____/_____

Entity Requested to Release Information:

_____

_____

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____Phone: (_____) _____-_____

Address: _____

Description of information to be disclosed: - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ office notes

☐ lab results, pathology reports

☐ x-rays

☐ financial history report (previous 3 years only)

☐ nursing home, home health, hospice, and other physician records

☐ record of HIV and communicable disease testing

☐ record of mental health or substance abuse treatment

☐ only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____/_____/_____
patient or representative signature date

_____ _____/_____/_____
patient or representative signature date

_____ _____/_____/_____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.