Flowers Hospital
Center for Metabolic and Weight Loss Surgery

Congratulations on taking the first step towards a healthier lifestyle!

You have chosen to make a life style change towards a new and healthier you. At Flowers Hospital we understand that this is not an easy decision to make and we are prepared to guide you through this journey one step at the time. Flowers Hospital is the only Accredited Bariatric Surgery Center in our area. Our staff is trained to treat patients with dignity and respect while providing equipment for safety and comfort to meet the needs of our bariatric patients.

Did you know losing weight can put diabetes in remission, help alleviate joint pain, improve or eliminate sleep apnea, lower blood pressure and overall improve quality of life? Patients are often able to decrease or stop medications with weight loss surgery. During your weight loss journey you will be meeting with our comprehensive bariatric team and together we will work to make your journey from your first visit to day of surgery be as smooth as possible. At your first appointment we will go over all of the requirements for surgery and make sure you do qualify. That appointment is just an informational session with the staff at the bariatric clinic. At your second appointment, you will meet with a surgeon to confirm your candidacy for weight loss surgery.

As noted above there are many reasons to have weight loss surgery most of them related to your health; however, there are also skinny jeans, new clothes and having a social life once again! Dr. Marker, Dr. Fendley, Dr. Cannon and the rest of our bariatric team look forward to working with you and helping our community improve its overall health, *one surgery at a time!*

Your first appointment is scheduled for: _____
*PLEASE NOTE THIS APPOINTMENT LAST BETWEEN **2-2 ½ HOURS**. PLEASE MAKE ARRANGEMENTS TO BE HERE THE ENTIRE TIME. IF YOU HAVE TO LEAVE EARLY OR IF YOU ARE LATE THEN YOU MAY HAVE TO RESCHEDULE OR REATTEND THE CLASS.*

Location: Flowers Hospital's Doctors' Center – North Tower– Suite 45
Enter through main entrance Doctor's Center then take elevators to your right up to the 4th floor and exit right off of the elevator.

Address: 4300 W Main St. Suite 45
Dothan, AL 36305

Phone: 334-944-7095

Visit our website: www.FlowersBariatricCenter.com

****Please complete paperwork and bring to your first appointment, along with a photo ID and insurance card(s).**

Patient History Form

Please complete and bring to your first appointment. If this is not complete to its entirety, it may delay future appointments.

First Name:_____ Middle Initial:_____ Last Name:_____ DOB:_____

Family Care Provider: _____ How Did You Hear About Us? _____
(↑List specific Doctor, if applicable)

Preferred Pharmacy: _____
(specify location, please)

Allergies: _____
_____

Current Medications: _____
(Include vitamins) _____
_____
_____

Surgery History: _____
_____
_____
_____

**You are not a candidate if you had prior bariatric surgery or a Nissen Fundoplication (sometimes called acid reflux surgery)*

Have you ever had an EGD (Scope) before? _____
If yes, when was the last one, where was it done, and who was the doctor? _____

***If you are over 50 years old:* Have you ever had a colonoscopy before**? _____
If yes, when was the last one, where was it done, and who was the doctor? _____

If you are a woman over 40 years old: when was your last mammogram*?*_____

Weight Loss Attempts: ☐ Low Fat ☐ Low Carb ☐OTC Diet Pills ☐Jenny Craig ☐Weight Watchers☐ Exercise ☐Prescription Diet Pills ☐Other (please specify):_____

How many years have you had a weight problem? _____ What is your desired weight goal? _____
What was your lowest weight over the last 5 years? _____ highest during same period? _____

Smoking History: ☐ Never ☐Former – Quit: _____/_____/_____ ☐Current Smoker

Do you use any product with nicotine in it? ☐ No ☐Yes, please specify: _____

Medical Conditions:

☐Morbid Obesity	☐ Lupus	☐ Osteoarthritis	☐ High Cholesterol	☐ Acid Reflux
☐ High Blood Pressure	☐ COPD	☐ ASTHMA	☐ Hypothyroidism	☐ Lower Back Pain
☐Heart Disease	☐ Diabetes	☐ Joint Pain	☐ Fibromyalgia	☐ Snoring
☐Sleep Apnea	☐ Crohns	☐ Ulcer History,	☐ Kidney Disease	☐ Fatigue
↑If checked:		specify _____		☐ Muscle Weakness
What year was study? _____		Where was it done?_____		

Please explain ***any other health information or conditions*** you think we should be aware of: _____

Office Only to Complete: Date of Intake Class: _____ 3 or 6 month track? _____
Intake Height: _____ Weight: _____ BMI: _____ Weight Loss Goal: _____
Is patient BMI>35 with a qualifying comorbidity? _____ If no, is patients BMI>40? _____
If OSA is only comorbidity is it *very important* to request the sleep study to make sure OSA is severe enough to qualify. If Medicare, patient only qualifies if they have a comorbidity, regardless of BMI. Be sure BMI qualifies them for at least 3 years!

CENTER FOR METABOLIC & WEIGHT LOSS SURGERY

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider (family doctor):

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race:	Birth date: / /	Age:	Gender: ❑ M ❑ F

Mailing address:	Social Security no.:	Home phone no.: ( )

Cell phone no.:	City:	State:	ZIP Code:

Email Address:	Employer:	Employer phone no:

How did you learn about us? (please check one box): ❑ Doctor (Please specify doctor here) ❑ Google Search ❑ Facebook ❑ Family ❑ Friend ❑ Billboard ❑ TV Commercial ❑ Radio ❑Other (please specify):

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist to make copies)

Please indicate **primary** insurance: ❑ BCBS of Alabama ❑ BCBS Anthem ❑ Medicare ❑ Cigna ❑ United Health Care ❑ Florida Blue ❑ Aetna ❑ Tricare ❑ Humana ❑ Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-pay: $

Subscriber Occupation:	Subscriber Employer:	Subscriber's Employer phone no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate **secondary** insurance: ❑ BCBS of Alabama ❑ BCBS Anthem ❑ Medicare ❑ Cigna ❑ United Health Care ❑ Florida Blue ❑ Aetna ❑ Tricare ❑ Humana ❑ Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Subscriber Occupation:	Subscriber Employer:	Subscriber's Employer phone no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I will call my insurance provider to confirm I have coverage for weight loss surgery and the related postoperative care. I understand that I am financially responsible for any balance, and will be asked to either pay old balances or set up a payment plan prior to making an appointment. I also authorize Flowers Hospital's Center for Metabolic & Weight Loss Surgery, Wiregrass Clinic, or my insurance company to release any information required to process my claims.

Patient Signature *Date*

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that that it is the policy of The Center for Metabolic & Weight Loss Surgery and Wiregrass Surgical Associates to restrict access to my Protected Health Information. I have been offered a copy of the privacy notice for this facility. I understand my medical records will be accessed by the caregiver(s) providing health services, and my insurance company for payment of my claim. **I understand that the following person/people listed will have access to my Private Health Care Information for medical and billing information concerning my treatment with this facility.**

Patient name: _____

Last Name *First Name* *MI*

Patient DOB: _____

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		
5.		

May we leave confidential clinical information on your answering machine? ❑ Yes ❑ No
Would you like to receive appointment reminders via text messaging? ❑ Yes ❑ No
May we contact you via email? (Please remember our education is offered via email) ❑ Yes ❑ No

_____ _____

Patient Signature *Date*

Patient Authorization

Patient Name: _____

Last Name *First Name* *MI*

I am signing this agreement to obtain services.

Please initial all applicable boxes. If a category does not apply to you, please write "N/A."

Definitions: "I", "me" and "my" mean the patient named above. The "Physician" means my physician, their affiliated entities, and their employees.

INITIALS

MEDICARE ASSIGNMENT OF BENEFITS

☐ I certify that the information I gave in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable for physician services to the physician, and I understand that I am responsible for any health insurance deductibles and co-insurance.

FINANCIAL RESPONSIBILITY

☐ I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for services rendered at this physician's office. I will honor the physician's office payment policy. If I cannot pay in full at the time of service, the physician's office can ask others about my credit worthiness. I agree to pay all expenses related to collection, whether by collection agency or by attorney.

INSURANCE ASSIGNMENT

☐ I irrevocably assign and transfer to the physician's office all insurance benefits covering the physicians' services (including hospitalization, health, liability, worker's compensation and any other insurance coverage) for the payment of services rendered. I understand that is it my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments and deductibles.

AUTHORIZATION FOR CARE

☐ I grant permission for the physician to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize the physician to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or third party payer for the purpose of processing a claim or otherwise as allowed by law. I release the physician from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, NIBG, and other diseases. This authorization is irrevocable and is not limited in time.

HIPAA NOTICE OF PRIVACY PRACTICES

☐ The physician is required by applicable federal and state law to maintain the privacy of your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and applicable law permits the terms of this notice at any time, provided such change are needed. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

Flowers Hospital
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Email Consent

I, _____, give my email address to the Center for Metabolic and Weight Loss Surgery. I am aware that my email may be used as a form of communication between myself and the staff/providers associated with the Center for Metabolic and Weight Loss Surgery.

I understand that the bariatric surgery education is provided to patients in many different formats to ensure complete understanding. One way to educate patients on bariatric surgery and postoperative care is through our interactive educational website. You will be **required to provide an email to us in order to receive this education**. If you do not have an email address we can assist you in creating one with one of the free-to-use computers in our lobby or you can visit your local library for assistance.

I understand that emails are sent out about support group meetings, events, and newsletters. The group emails will not allow others to view or see my email address.

I was informed that at any time I can request in writing to have my email removed from the data base or to change the status of my email.

Please initial by all the forms of communication status you approve:

_____I allow the Center for Metabolic and Weight Loss Surgery to use my email for communication between myself and their office via patient portals (Clinical portal: AthenaHealth through Wiregrass Clinic or our educational portal which is through the website www.FlowersBariatricCenter.com). This includes utilizing my email address in order to receive the online education.

_____I allow the Center for Metabolic and Weight Loss Surgery staff and providers to use my email for general communication using their secure Flowers Hospital email address. I understand these emails will be from emails ending '@flowershospital.com'.

Please initial below if you want to retract the use of your email:

_____ I wish to have my email address removed from the patient portals and request no contact through email be used.

_____ _____

Authorized Signature Date

_____

Email Address