



Patient Information Packet

Preferred Procedure:

- Laparoscopic Sleeve Gastrectomy
- Laparoscopic Greater Curvature Plication (LGCP)
- Laparoscopic Adjustable Gastric Banding
- Laparoscopic Roux-en-Y Gastric Bypass
- Orbera Balloon

Revision-Previous Weight Loss Surgery

Original surgery: _____

Revision to

- Laparoscopic Sleeve Gastrectomy
- Apollo OverStitch-Previous Roux-en-Y Gastric Bypass
- SIPS

Surgeon: G. Derek Weiss, MD or Paige Quintero, MD

Program: Baptist Health Lexington, formerly Central Baptist Hospital / Baptist Physician Surgery Center - Lexington, Kentucky

Are you able to read, write and communicate in the English Language? YES NO

If not, what is your primary language? _____

Please list any other barriers to communication, or special accommodations that you require: _____

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender: Female Male

Marital Status: Married Single Divorced Separated Partnered Widow(er)

How many children do you have (please list ages)? _____

Ethnicity: African American Hispanic Native American or Alaska Native Choose not to specify
 Asian Caucasian Native Hawaiian / Other Pacific Islander Other: _____

Religious affiliation: _____ Patient's level of Education: _____

What is your height? _____ **ft** _____ **in** **How much do you weigh?** _____ **lbs.** **BMI:** _____

Address Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone (home): _____

Phone (work): _____ Phone (cell): _____

OK to leave message at: Home Work Cell

Patient Employment Information:

Employment status: Full Time Retired Disabled Student
 Part Time Unemployed Homemaker Leave of Absence

Patient's Current Employer: _____ Years Employed: _____

Patient's Employer's address: _____

Patient's Present or Former Occupation: _____

Disabled? Yes No If Yes, specify the year and cause: Year: _____ Cause: _____

Can you walk unassisted? Yes No How far before needing rest? _____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? Cane Walker Crutches Other: _____

Are you wheelchair bound and unable to stand at all? Yes No How long in wheelchair? _____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

YES NO If yes, who? _____ Relationship to you? _____

Spouse Information:

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employment Status: Full Time Retired Disabled Student
 Part Time Unemployed Homemaker Leave of Absence

Spouse's Occupation: _____ Spouse's SSN: _____

Spouse's Employer: _____ Years Employed: _____

Spouse's Employer's address: _____ Spouse's Cell Phone: _____

Insurance Information: – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: Insurance Self Pay

Primary Insurance:

Insurance Company: _____

Policy Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Customer Service Phone: _____ Provider Phone: _____

Secondary Insurance:

Insurance Company: _____

Policy Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Customer Service Phone: _____ Provider Phone: _____

Emergency Contact:

First Name: _____ Last Name: _____

Relation to you: _____ Phone: _____

"I hereby authorize Bluegrass Bariatrics to discuss my process, diagnostic test results
and any scheduled appointments with the following named person(s)":

Name: _____ Relation to you: _____

Name: _____ Relation to you: _____

Patient Signature: _____ Date: _____

Primary/Referring Physician:

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Have you discussed Weight Loss Surgery with your physician? Yes No is your physician supportive? Yes No

How did you hear about us? Radio TV Newspaper Family/Friend Internet Social Media

Other (Please List): _____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

Blood Consent:

*You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. *(If Jehovah's Witness please check)*

Patient Signature: _____ Date: _____

Weight Loss History:

How long have you been overweight? _____ Years How long have you been 35 pounds overweight? _____ Years

How long have you been 100 pounds or more overweight? _____ Years When did you start dieting? _____ Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? Yes No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet? _____ lbs. How did you lose the weight? _____

How long did you sustain the weight loss? _____ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: NONE

- | | | | |
|---|--|--|------------------------------------|
| <input type="radio"/> Body for Life/Bill Phillips | <input type="radio"/> High Protein | <input type="radio"/> Low Fat | <input type="radio"/> Cabbage Soup |
| <input type="radio"/> Pritikin | <input type="radio"/> Stillman Diet | <input type="radio"/> Mayo Clinic | <input type="radio"/> Fasting |
| <input type="radio"/> Gloria Marshall | <input type="radio"/> Herbal Life | <input type="radio"/> Calorie Counting | <input type="radio"/> Scarsdale |
| <input type="radio"/> Richard Simmons | <input type="radio"/> Sugar Busters | <input type="radio"/> Atkin's Diet | <input type="radio"/> Slim Fast |
| <input type="radio"/> Health Spa | <input type="radio"/> Low Carbohydrate | <input type="radio"/> South Beach | <input type="radio"/> Other: _____ |

Supervised Diet Attempts: NONE

- | | | | |
|--------------------------------------|--|---------------------------------------|-----------------------------------|
| <input type="radio"/> Nutri-System | <input type="radio"/> Overeaters Anonymous | <input type="radio"/> Weight Watchers | <input type="radio"/> Jenny Craig |
| <input type="radio"/> TOPS | <input type="radio"/> Optifast | <input type="radio"/> HMR | <input type="radio"/> DASH |
| <input type="radio"/> LA Weight Loss | <input type="radio"/> Diet Center | <input type="radio"/> Other: _____ | |

Over-the-Counter or Prescribed Medications for Weight Loss:

NONE

- | | | | | |
|--|------------------------------------|--------------------------------------|------------------------------------|--------------------------------|
| <input type="radio"/> Acutrim | <input type="radio"/> Dexatrim | <input type="radio"/> Ionamin/Adipex | <input type="radio"/> Phendiet | <input type="radio"/> Prozac |
| <input type="radio"/> Wellbutrin | <input type="radio"/> Amphetamines | <input type="radio"/> Didrex | <input type="radio"/> Tenuate | <input type="radio"/> Phentrol |
| <input type="radio"/> Redux | <input type="radio"/> Byetta | <input type="radio"/> Plegine | <input type="radio"/> Sanorex | <input type="radio"/> Meridia |
| <input type="radio"/> Xenical | <input type="radio"/> Diuretics | <input type="radio"/> Pondimin | <input type="radio"/> Phenteramine | |
| <input type="radio"/> Fen-Phen, # of months: _____ | <input type="radio"/> Other: _____ | | | |

Behavioral Treatments for Weight Loss: NONE

- Hospitalization
- Physical Therapy
- Residential Programs
- Hypnosis
- Psychological Therapy
- Other: _____

Exercise: NONE

- Walking or Running
- Swimming
- Team Sports
- Stationary cycle or treadmill
- Weight Training
- Other: _____

Eating Habits, Do you:

- Snack between meals? Yes No
- Eat a lot of sweets? Yes No
- Drink caffeine-containing drinks? Yes No
- If yes, how many cups per day? _____

- Eat large meals? (gorge) Yes No
- Drink carbonated beverages? Yes No
- If yes, how many cans/bottles per day? _____
- Drink soda pop? Yes No Diet Regular

Have you used any of the following to control your weight? (Check all that apply)

- Binging and Purging
- Excessive Exercise
- Binging followed by food restriction
- Excessive Calorie Restriction/Fasting
- Vomiting

If so, when and how long was this period of behavior? _____

- Do you currently force yourself to vomit after eating? Yes No
- Why do you feel you eat? Physical Hunger Makes me happy Loneliness Bored Anxiousness
- What reasons do you feel contribute to your weight? Over Consumption Inactivity Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

Please tell us how your weight is interfering with your health and life? _____

Why are you seeking weight loss surgery? _____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

If you use eating as an emotional outlet, what will you substitute when your eating is restricted? _____

What is your greatest fear regarding surgery? _____

Medical History/Review of Symptoms: (Check all that apply)

General:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> NONE | <input type="checkbox"/> Tired / No Energy |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Insomnia | |
| | <input type="checkbox"/> Other: _____ | |

Head and Neck:

- | | | |
|---|--|---|
| <input type="checkbox"/> Wear contacts / glasses | <input type="checkbox"/> NONE | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Sinus Drainage | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Dentures, Partial / Full | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Regular Ear Infections | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Blurred / Double Vision | |

Cardiovascular:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> NONE | <input type="checkbox"/> Rhythm Changes |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Chest Pain w/ Activity | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Ankle / Leg Ulcers | <input type="checkbox"/> Dyspnea on Exertion | <input type="checkbox"/> Phlebitis / DVT |
| <input type="checkbox"/> Clogged Heart Arteries | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Rheumatic Fever / Valve Damage / MVP | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Cramping in legs when walking | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Elevated Cholesterol | |

Respiratory:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> NONE | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema / COPD | <input type="checkbox"/> Shortness of Breath at Rest |
| <input type="checkbox"/> Use of Cpap / Bipap | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Use of Oxygen | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Sleep Apnea | |

Gastrointestinal:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> NONE | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> History of Liver Enzymes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Umbilical Hernia |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> IBS | <input type="checkbox"/> Fissure / Polyps |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ventral Hernia |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Black, Tarry Stool | <input type="checkbox"/> Cirrhosis / Hepatitis |
| <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Enlarged Liver | <input type="checkbox"/> Pancreatic Disease |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Incisional Hernia |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> GERD | |
| | <input type="checkbox"/> Other: _____ | |

Bladder/Kidney:

- | | | |
|---|--|--|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> NONE | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Kidney Failure / Renal Insufficiency | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Men: PSA test in last year? |
| <input type="checkbox"/> Trouble starting urine | <input type="checkbox"/> Leaking urine w/ cough/laugh/sneezing | <input type="checkbox"/> Urinary Urgency/Frequency |
| <input type="checkbox"/> Overall Loss of Bladder Control | <input type="checkbox"/> Burning / Pain on urination | |
| | <input type="checkbox"/> Other: _____ | |

Gynecologic: (for women only) **NONE**

- Problems Conceiving / Infertility
- PCOS
- Excessively Heavy Periods

- Currently Pregnant
- Menstrual Irregularity
- Plan to have more children

- Uterine / Ovarian Cancer
- Menstrual Pain
- Post Menopausal

How many pregnancies have you had: _____

Date of Last Pap Smear? _____

How many miscarriages or abortions have you had: _____

Date of last menstrual period? _____

Breast: **NONE**

- Nipple Discharge
- Pain

- Lumps / Fibrocystic Disease
- Cancer

- Other: _____
 - Date of last Mammogram: _____
-

Musculoskeletal: **NONE**

- Shoulder Pain
- Hip Pain
- Foot Pain
- Plantar Fasciitis
- Broken Bones
- Muscle Pain / Spasm
- Fibromyalgia

- Neck Pain
- Wrist Pain
- Knee Pain
- Heel Pain
- Carpal Tunnel Syndrome
- Sciatica
- Other: _____

- Elbow Pain
 - Back Pain
 - Ankle Pain
 - Ball of Foot Pain
 - Lupus
 - Rheumatoid Arthritis
-

Neurologic: **NONE**

- Balance Disturbance
- Stroke
- Knocked Unconscious
- Pseudotumor Cerebri (loss of vision from high pressure in brain)

- Dizziness
- Seizures or convulsions
- Numbness / Tingling

- Restless Leg Syndrome
 - Weakness
 - Multiple Sclerosis
 - Other: _____
-

Psychiatric: **NONE****Are you currently under the care of a mental health provider? Yes No**

- Depression
- Bipolar Disorder ("manic-depression")
- Alcoholism / Substance Abuse
- Been in a chemical dependency program
- Currently taking medications for psychiatric problems or for depression
- Attention Deficit Disorder

- Anxiety
 - Seen a Psychiatrist or Counselor
 - Been hospitalized for psychiatric problems
 - Attempted suicide
 - Victim of Mental/Emotional/Sexual/Physical Abuse
 - Other: _____
-

Endocrine: **NONE**

- Parathyroid
- Low Blood Sugar
- "Pre-Diabetes"
- Abnormal Facial Hair
- Other: _____

- Hypothyroid
- Excessive Thirst
- Diabetes (Diet or Pills)
- Excessive Urination

- Goiter
 - Endocrine Gland Tumor
 - Diabetes (Insulin Shots)
 - Gout
-

Blood/Lymphatic:

- Low Platelets (thrombocytopenia)
- Bruise Easily
- Bleeding/Clotting Disorder
- Prior blood Transfusion

 NONE

- Anemia
- Lymphoma
- Blood thinning medicine use
- Other: _____

- HIV / AIDS
- Swollen Lymph Nodes
- History of DVT / PE

Skin:

- Frequent Skin Infections
- Psoriasis
- Hair or Nail Changes

 NONE

- Keloids (Excessively Raised Scars)
- Rashes under Breasts / Skin Folds
- Other: _____

- Poor Wound Healing
- Rosacea

List Prescribed Medications:**Taken for what condition:****Dosage/How Often:** **NONE**

List Prescribed Medications:	Taken for what condition:	Dosage/How Often:
<input type="checkbox"/> NONE		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:**Taken for what purpose:****Dosage/How Often:**

Product:	Taken for what purpose:	Dosage/How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: **NONE**

- Latex, Reaction: _____ Tape (adhesives), Reaction: _____
- Iodine, Reaction: _____ IV Contrast Dye, Reaction: _____

Medications (List any medications that you are allergic to and your reaction): _____

Foods (List foods and the reaction): _____

Surgical Procedure(s):	<input type="checkbox"/> NONE	Year		Year
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery: _____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery: _____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	<input type="radio"/> Ovaries Removed	_____	Pacemaker	_____
Hernia:	<input type="radio"/> Hiatal <input type="radio"/> Umbilical	_____	Back: _____	_____
Tubal Ligation		_____	Knee: <input type="radio"/> Right <input type="radio"/> Left	_____
Cesarean Section		_____	Breast Biopsy: <input type="radio"/> Right <input type="radio"/> Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Colostomy		_____	Kidney Surgery	_____
Colon Resection		_____	Other: _____	_____
Endoscopy		_____	Other: _____	_____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery: _____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ Estimated Actual – Lowest Weight Achieved: _____ Estimated Actual

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: **NONE**

Nausea Heart Stopped Woke up during procedure

Vomiting Stopped Breathing Other: _____

Difficulty Waking Up Difficulty Urinating

Social History:

Do you smoke now? Yes No If yes, how many packs per day? _____

Have you smoked in the past? Yes No If you have quit, how many years since? _____

For how many years did you use tobacco? _____ Years

Do you use snuff or chew? Yes No If yes, how frequently do you use? _____

Do you consume alcohol now? Yes No

If yes, how many times per week? _____ If yes, how many drinks each time? _____

For how many years do/did you drink alcohol? _____ Years

Is anyone concerned about the amount you drink? Yes No If you have quit, how many years since? _____

Do you use street drugs now? Yes No If yes, what drugs? _____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since? _____

How many hours a day do you watch TV? Never Rarely 3-5 hours 5+ hours

What hobbies do you have that are important to you? _____

Could someone help care for you if you were seriously ill? Yes No Who? _____

Are there people for whom you are the primary care giver? Yes No Who? _____

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life.

Married Life? 1 2 3 4 5

Present job/activities? 1 2 3 4 5

Overall satisfaction with yourself? 1 2 3 4 5

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before sending in your packet:

- Filled out this form completely
- Made a copy of the front and back of your insurance card
- Signed the Blood Consent
- Called your insurance and completely fill out the Insurance Review Form

Date Completed: _____

Mail completed packet and Insurance Card to:

BHMG-Bariatric Surgery
2716 Old Rosebud Road, St. 350
Lexington, Kentucky 40509

Fax: 859-543-1637

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. **Do not leave any fields blank.**
5. **Sign the form on the back. Failure to do so will result in the form being returned.**
6. Once complete, return this form, along with a copy of your insurance card(s), to our office.
7. Please also make sure that you submit your patient profile packet via mail or internet.
8. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
 - a. Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. **You must complete this form if you have a Medicare supplement plan, Medicare Replacement plan, or a Medicare HMO.**

Fill in this information before you call the insurance company. Please write clearly.

Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	<input type="checkbox"/> Yes (Continue with this form.) <input type="checkbox"/> No (Complete #s 2, 23, 25 & 27-29 then end the call.) **See explanation below
<p>**An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.</p>		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3	Do I have a Bariatric Lifetime Max?	
4	Am I required to have Weight Loss Surgery at a Center of Excellence facility or Blue Distinction Center?	Center of Excellence: <input type="checkbox"/> Yes <input type="checkbox"/> No Blue Distinction: <input type="checkbox"/> Yes <input type="checkbox"/> No
5	Is BHMG-Bariatric Surgery in my network?	
6	Is Baptist Physician Surgery Center in my network? Tax ID #: 043665929	
7	Is Baptist Health Lexington in my network? Tax ID #: 610444707	

8	What is the effective date of my policy?	
9	What is the calendar year renewal date?	
10	Do I have a pre-existing clause?	
11	If yes, what is the end date of the pre-existing clause?	
12	Is a referral required?	
13	What is the deductible per calendar year?	
14	How much have I met towards my deductible?	
15	What is the maximum out of pocket per calendar year?	
16	How much have I met towards my maximum out of pocket?	
17	Is the deductible applied to the maximum out of pocket?	
18	What is the co-insurance percent for my policy?	
19	What are my financial obligations to the doctor for inpatient surgery?	
20	What are my financial obligations to the doctor for outpatient surgery?	
21	What are my financial obligations to the hospital for inpatient surgery?	
22	What are my financial obligations to the hospital for outpatient surgery?	
23	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
24	What is my copay for a primary care office visit?	
25	What is my copay for a specialist office visit?	
26	What is the fax number for pre-determination?	
27	Name of the representative	
28	Date you spoke to representative	
29	If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Disclaimer:

- **BHMG-Bariatric Surgery** is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by **BHMG-Bariatric Surgery**.

By signing below, I certify the following:

- I have read and understand the instructions that were provided to me.
- I have read and understand the disclaimer which includes that I am not approved for surgery.
- I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.

Patient Signature: _____

Date: _____