Patient Information

Gregory S. Barnes, M.D.

Our staff will strive to provide you and your family the best possible surgical care. To help us meet all your needs, please fill out these forms completely. If you have any questions or need assistance, please ask us – we will be happy to help. **Your insurance card along with your driver's license is required and a copy will be made and placed in your files that we maintain in our office.** Thank You

Patient Information (Confidential) **Today's Date:** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **SSN#** _____

What name do you prefer to be called? _____ Martial Status: _____ Gender: M___F____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Work#: _____ Ext _____ Cell: _____

If patient is a minor, name of guardian: _____ Relationship: _____

Do you have an e-mail address: ☐ Yes ☐ No If yes, please let us know what it is _____

Your Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

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

Spouse's Employer and Address: _____

Spouse's Work Phone ( ) _____ Ext. _____ Cell ( ) _____

In Case of Emergency:
Name of nearest relative not living with you: _____

Address: _____
Street City State Zip
Phone Number: _____ Relationship: _____

Insurance Information:

Primary Insurance Company: _____ ID# _____

Secondary (if applicable) _____ ID# _____

If you are <u>not</u> the sponsor, please furnish the persons name, date of birth, and SSN of who is:

_____

Name, Address and Telephone Number of your Primary Care Physician:

_____

Name of physician if you were referred: _____ Phone: _____

Barnes Bariatric Surgical Services, PA
Consent to Treatment and Financial Responsibility Agreement

1. **Consent to Treatment**: The undersign consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or any other diagnostic or therapeutic treatment or services rendered the patient by the staff of the Barnes Bariatric Surgical Services, P.A.(B.B.S.S) under the general or special instructions of the physician. The undersigned also consents to the admission of observers and/or assistants to the room when procedures, tests, or examinations are performed and to the disposal of any tissue or specimens removed in accordance with the office policies.

2. **Release of Medical Information**: The undersigned hereby authorizes BBSS to release information and/or copies of his/her medical records to physicians, any guarantor of payment on his/her account's insurance companies (and other third party payors, including workers' compensation carriers and the patient's employers for which he has assigned benefits for his treatment and care). This includes authorization to release pertaining to: (1) psychiatric and/or psychological care, alcohol and/or substance abuse, serologic test results (including but not limited to Acquired Immune Deficiency Syndrome (AIDS) or HIV test results (2) care and treatment for this period of illness and (3) disclose all or part of my medical record to past and future medical care providers. Such medical care providers may discuss with the staff of BBSS and its representatives any treatment provided, procedures performed and complications there from, if any.

3. **Medicare Patients**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct to the best of my knowledge. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand that the care and services received during my treatment are subject to professional medical review according to the Federal Law P.L.97-248, and that The information regarding my treatment including psychiatric and/or psychological care, alcohol and/or substance abuse, serologic test results (including, but not limited to, Acquired Immune Deficiency Syndrome (AIDS) or HIV test results) may be forwarded to the appropriate peer review organization, who will ensure the confidentiality of information collected and maintained for purposes of professional review.

4. **Agreement to Pay Charges**: The undersigned promises to pay BBSS the total charges, on demand, for services rendered or any co-payments or deductible for which the undersign is liable. I agree to pay the charges that are listed in the current fee schedules, which are available for inspection on request and are incorporated herein by reference. I also agree that all charges for services rendered that are not covered by any insurance program, sponsorship, or other third party coverage are due and payable at the time of service. I hereby acknowledge that if BBSS has agreed to bill my insurance carrier or other third party payor, it has agreed to do so as a courtesy only and that BBSS has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or other third party payor. The statement of charges for services performed will be provided to me by BBSS on request. Any amounts paid by insurance companies, assigned to and received by BBSS will be credited to the balance due. The assignment of insurance benefits does not alter the undersigned's obligation to pay. BBSS reserves the right to decline further services to the patient without notice and to accept periodic payments without waiving its right to demand payment in full as outlined above and the right to assign the amount due under this agreement. Any overpayment by or for the patient will be first applied to other balances due then may be refunded to the paying party, or held on account at the request of that paying party. I hereby acknowledge having been told by BBSS that I may be billed for all services rendered. I further agree that, if I am more than thirty (30) days delinquent in the payment of any bill connected with this treatment and I have paid with a credit /debit card, I authorize BBSS to charge my card for the balance due. I also understand that interest may accrue at the maximum rate allowed by law. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees of 33% of unpaid balance associated with the collection process.

5. **Assignment of Insurance Benefits**: The undersigned hereby assigns to BBSS reimbursement benefits on all insurance policies otherwise payable to him/her for this visit. The undersigned authorizes BBSS to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to the BBSS bill and to make refunds to insurance companies if refunds are due under provision of such insurance policies. The undersigned hereby assigns all rights, as the insured, to bring an action against his insurance company for benefits due under the insurance policies. I hereby authorize and direct payment to BBSS and any consulting physicians for services provided during my care. I understand that I am financially responsible to these physicians for charges not covered by my insurance company. The undersigned does hereby authorize BBSS to endorse any checks or other payment instruments to the undersigned and to apply the same to any account of the undersigned or any account for which the undersigned could be liable. The undersigned authorizes BBSS or its representatives to prepare and submit to his/her insurance carrier or plan administrator all the insurance claims, forms, questionnaires and all other statements or documents required by the insurance carrier or plan administrator.

6. **Fraudulent Information**: The undersigned certifies that he/her has read, understands and accepts the foregoing, received a copy thereof, and is personally empowered, or is duly authorized by the patient as the patient's general agent, to execute the above.

Patient (or Parent/Guardian/Representative) Signature	Date Signed
Relationship to Patient (If Not Patient Signature Above)	Print Patient Name
Witness	Print Witness Name

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal healthcare information may be disclosed or used by this office. Please read this notice carefully. If you have any questions please contact our Privacy Officer. After reviewing this document, you will be asked to consent to the use and/or disclosure of your personal health information as described below. Your consent may be revoked in writing at any time. This office is required to abide by the terms of this Notice of Privacy Practices. The terms may change at any time and the revised notice will apply to all protected health information maintained at that time. You may request a revised copy of this notice by calling our office. This office has taken reasonable steps to safeguard the privacy and confidentiality of your Protected Health Information (PHI). The staff of this office will only use your health information for the intended patient care purpose. Conversations among staff members that reference your information will be conducted in a confidential and professional manner.

1. Uses and Disclosures of Protected Health information for TPO

This office will need to access you protected health information for purposes of treatment, payment and operations (TPO) in accordance with State and federal Law.

- **USING & DISCLOSING INFORMATION FOR TREATMENT PURPOSES**
  To maintain high quality healthcare, it will be necessary to share protected health information with all members of your treatment team. This can include employees in this office as well as other providers.
- **USING & DISCLOSING INFORMATION FOR PAYMENT PURPOSES**
  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for our internal billing personnel to have access to protected health information to carry out their job functions.
- **USING & DISCLOSING INFORMATION FOR OPERATIONS PURPOSES**
  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, and compliance with all federal and state laws.

2. Specific Authorization required for other uses and disclosures

Other uses and disclosures of your protected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form. Some examples include but are not limited to: some marketing activities, the use or disclosure of psychotherapy records in our possession and in some instances for research purposes.

3. Other uses and disclosures without your consent or authorization

The following are situations where this office may use or disclose your protected health information without your consent or authorization:

- Uses and disclosures of protected health information (PHI) as required by law, court orders, a legal process, or government agencies.
- Uses and disclosures of PHI for matters of public health for the purpose of controlling disease as dictated by law.
- Uses and disclosures to government oversight agencies for the purpose of health and privacy audits or investigations.
- Uses and disclosures may be made to public health authorities in situations of suspected abuse or neglect.
- Uses and disclosures to Institutional Review Boards for the purpose of medical research.

4. Patient Privacy Rights effective April 14, 2003

- In general you will have the right to review and copy your protected health information as well as amend your record. Some exceptions include, but are not limited to: psychotherapy notes, information compiled fore use in a civil, criminal, or administrative proceeding.
- You have the right to request a restriction of the disclosure of your protected health information for treatment, payment, or operations. This office is not required to agree to the request, but will do so at our discretion.
- You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests.
- You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment, or operations.

5. Privacy Officer & Complaints

Should you have any concerns you may contact our Privacy Officer who is responsible for the privacy and confidentiality of your information in accordance with state and federal law. Any complaints or issues you have regarding the privacy or confidentiality of your information should be directed to the privacy officer.

_____ _____

Signature of Patient Date

BARNES BARIATRIC SURGICAL SERVICES
GREGORY S. BARNES M.D.

Please read the following, initial and sign at the bottom.

_____ Please give our office at least **24 hours'** notice in the event that you need to reschedule your appointment.

_____ If you need FMLA paperwork please give our office 48 hours' notice to prepare the paperwork. There will be a **$50.00** fee to complete and submit the paperwork; the fee will need to be paid in advance.

_____ If you cancel or have to reschedule an EGD or surgery, there will be a **$100.00** cancellation fee.

_____ If you miss or cancel (with less than 24 hours' notice) more than **three** consecutive appointments we will collect a **$75.00** dollar deposit in order to hold your next appointment spot.

This document must be read and signed by the patient.

Name: _____

Signature: _____

Date: _____

3608 Preston Rd. Suite 105
Plano, Texas 75093
P: 214-506-2660 F: 972-865-6996

BARNES BARIATRIC SURGICAL SERVICES
GREGORY S. BARNES M.D.

Patient Authorization to Release Medical Records

Patient Name:_____ DOB:_____

If you would like our office to be able to send and receive your medical records, please check both boxes.

☐ I authorize the office of Dr. Gregory S. Barnes M.D. to release my medical records **to the following Doctor's office:**

Doctor: _____

Address: _____
_____
_____

Phone: _____
Fax: _____

☐ I authorize the following clinic and/or Doctor's office to release my medical records **to the office of Dr. Gregory S. Barnes M.D.**

Doctor: _____

Address: _____
_____
_____

Phone: _____
Fax: _____

Please read above carefully and sign below.

Patient Signature: _____ Date: _____

3608 Preston Rd. Suite 105
Plano, TX 75093

Bariatric Patient Health History

Patient name: _____

Review of Systems/Health Assessment

Please check any of the following which you experience or have experienced in the past

General
- O Fatigue
- O Fever
- O Recent weight gain/loss *(please circle)*

Neurological
- O Fainting
- O Memory Problems
- O Paralysis
- O Seizures/Convulsions
- O Unexplained falls

Psychological
- O Depression
- O Nervousness/Anxiety
- O Anorexia/Bulimia/Binge eating *(please circle)*
- O Psychiatric or psychological counseling
- O Suicidal thoughts/attempts
- O Other psychiatric problems

HEENT
- O Blurred vision
- O Difficulty swallowing
- O Dizziness
- O Headaches
- O Mouth lesions
- O Nose bleeds
- O Sinus problems
- O Sore throat/Hoarseness
- O Loss of smell/vision/hearing *(please circle)*
- O Lymph node enlargement

Cardiovascular
- O Chest/Arm/Neck pain
- O Circulation problems
- O Heart attack
- O Heart murmur
- O High cholesterol
- O Stroke
- O High/Low blood pressure *(please circle)*
- O Abnormal heart beats (palpitations, tachycardia, etc.)
- O Congestive Heart Failure

Respiratory
- O Asthma/Wheezing
- O Emphysema/COPD
- O Pneumonia/Bronchitis
- O Shortness of breath
- O Cough – recent/chronic *(please circle)*
- O Nighttime breathing problems
- O Tuberculosis

Breast
- O Lumps
- O Nipple discharge
- O Swollen breast
- O Tenderness
- O Skin changes/dimpling/redness

Gastrointestinal
- O Abdominal pain
- O Bloody stools
- O Gallstones
- O Heartburn/Reflux
- O Hemorrhoids
- O Hernia(s)
- O Jaundice/Hepatitis
- O Liver disease/Cirrhosis
- O Polyps
- O Stomach ulcers
- O Constipation/Pain with bowel movements
- O Irritable bowel/Colitis/Chrohn's
- O Nausea/Vomiting/Diarrhea *(please circle)*

Genitourinary
- O Bladder/Kidney infection *(please circle)*
- O Frequent/Urgent urination
- O Blood with urination
- O Pain with urination
- O Kidney stones
- O Leakage of urine

Men
- O Discharge from penis
- O Erectile dysfunction
- O Prostate problems

Women
- O Abnormal vaginal bleeding
- O Irregular periods
- O Pelvic exam/PAP smear in last year
- O Vaginal discharge

Musculoskeletal
- O Arthritis
- O Back problems
- O Herniated disk
- O Muscular aches/weakness
- O Pain/Numbness in feet or legs *(please circle)*
- O Pain/Swelling in joints *(Location:_____)*

Endocrine
- O Diabetes
- O Hormone imbalance
- O Intolerance to heat or cold
- O Thyroid problem (high/low/goiter) *(please circle)*

Bleeding/Circulation
- O Anemia
- O Easy bleeding/bruising
- O Autoimmune disease *(Specify: _____)*
- O Blood clots/Pulmonary embolism
- O History of blood transfusions
- O HIV/AIDS *(please circle)*

Skin
- O Abnormal moles
- O Rash/Itching *(please circle)*

Cancer
- O *Please specify:*_____

Other medical conditions not previously mentioned:

_____

_____

_____

Review of Systems/Health Assessment Continued

Non-surgical hospitalizations: Please list those you have experienced as an adult

Diagnosis	*Date*	*Diagnosis*	*Date*	*Date*
1. _____		3. _____		
2. _____		4. _____		

Past Surgical History: Please list all surgical procedures or operations

Procedure	*Date*	*Procedure*	*Date*	*Date*
1. _____		3. _____		
2. _____		4. _____		

Complications: Do you have any history of complications with anesthesia? O Yes O No

(If yes, please describe)

_____

Medications: Please list all medications you currently use

Name	*Dosage/Frequency*	*Indication*
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		

Please list any allergies to medications (and your reactions): *Please include food allergies!*

_____

_____

Family History: *Please indicate which family members have had any of the following conditions (I.E. mother, uncle, etc.)*

Diabetes_____

Heart Disease_____

High Blood Pressure_____

High Cholesterol_____

Kidney Disease_____

Lung Disease/Emphysema _____

Obesity _____

Stroke _____

BARIATRIC PATIENT HEALTH HISTORY

Obesity Related Health History

Name: _____ Sex: M / F Age: _____ DOB: _____

Height: _____ Weight: _____ Ideal Weight: _____

Occupation: _____

Below, please provide details about the conditions identified on the Review of Systems. Please provide accurate and complete information, as this will be used to determine eligibility for weight loss surgery and to write your letter of medical necessity for procedure approval.

Indicate whether you experience or have experienced any of the following, and include relevant details for each condition:

Cardiovascular

O Heart disease
O Angina *Date:* _____
O Heart attack/MI *Date:* _____
O Stroke *Date:* _____
O Congestive heart failure *Dates:* _____
O Palpitations (skipped beats)
O Bypass surgery *Date:* _____
O Angioplasty *Date:* _____
O Stent *Date:* _____

O Elevated cholesterol *(If yes)* Date of diagnosis: _____
Most recent lab values: _____

O Elevated Triglycerides *(If yes)* Date of diagnosis: _____
Most recent lab values: _____

O High blood pressure *(If yes)* Date of diagnosis: _____
Most recent lab values: _____
Highest recorded value: _____

Venous Stasis: O Varicose veins O Leg or ankle swelling/edema O Leg skin color changes or thickening

Respiratory

O Asthma *(If yes* Date of diagnosis: _____
O Shortness of breath *(If yes)* When? O At rest O During normal daily activity O With physical exertion
O Sleep Difficulties *(If yes)* O Choking/Snoring O Awakening at night
O Morning headaches O Daytime drowsiness
O Sleep apnea *(If yes)* Do you use a CPAP or BiPAP machine? O Yes O No
Have you had a sleep study? O Yes O No
Date: _____ *Physician:* _____

Gastrointestinal

O Reflux/Heartburn/GERD *(If yes)* Date of diagnosis: _____
O Endoscopy/UGI *Date:* _____
O Nissen procedure *Date:* _____
O Abdominal wall hernia *(If yes)* Date of diagnosis: _____
Treatment: _____
O Hemorrhoids *(If yes)* Date of diagnosis: _____
Treatment: _____
O Peptic ulcer disease *(If yes)* Date of diagnosis: _____
Treatment: _____

Obesity Related Health History Continued

Genitourinary

O Urinary incontinence *(If yes)* How often? _____

For women: Date of last menstrual period: _____ O Menstrual irregularities

Age menstrual period started: _____ O Infertility

Age of menopause *(If applicable)*: _____

O Use birth control *(If yes)* Method: _____

O Have children *(If yes)* List dates of birth and type (vaginal/caesarean/adoption):

_____

_____

Musculoskeletal

O Pain or Swelling in joints *(If yes)* O Knees O Ankles O Hips

O Back pain

O Sciatica

O Muscle weakness/pain *(If yes)* Location: _____

O Arthritis/Degenerative Joint Disease *(If yes)* Date of diagnosis: _____

Type: _____ Location: _____

O Related orthopedic surgery

Date: _____ *Procedure:* _____

O Numbness *(If yes)* Location: _____

Date of onset: _____

Description: _____

Endocrine

O Diabetes *(If yes)* Date of diagnosis: _____

Most recent HgA1C: _____ *and/or* Fasting blood sugar: _____

Type: O Juvenile onset O Adult onset O Gestational (pregnancy)

Treatment: O Diet controlled O Insulin O Oral medications

Complications: O Vision problems O Wound healing problems

O Thyroid disorder *(If yes)* Date of onset: _____ Type: _____

Treatment: _____

O Hormone imbalance *(If yes)* Date of onset: _____ Type: _____

Treatment: _____

Bleeding/Circulation

O Anemia *(If yes)* Date of onset: _____ Type: _____

Treatment: _____

O Blood clots *(If yes)* Date of onset: _____ Type: _____

Treatment: _____

O HIV/AIDS *(If yes)* Date of diagnosis: _____

Treatment: _____

O History of transfusions *(If yes)* Date: _____ Reason: _____

O DVT *(If yes)* Date of diagnosis: _____

O Pulmonary embolism *(If yes)* Date: _____

Obesity Related Health History Continued

Daily Dietary Habits

How many meals per week do you eat out? _____

How many of these meals per week are fast food? _____

Do you drink coffee or tea? O Yes *(If yes)* How much/how often (ex: 4 cups/day)? _____

Do you drink soft drinks? O Yes *(If yes)* How much/how often? _____

Do you drink alcohol? O Yes *(If yes)* How much/how often? _____

Do you smoke? O Yes *(If yes)* How many packs per day? _____

Do you, or have you ever, used recreational drugs? O Yes *(If yes)* O Currently O In the past
Please list: _____

Do you use a sugar substitute? O Yes *(If yes)* Which one? _____

Do you use butter? O Yes Do you use Margarine? O Yes

What are your worst food habits? _____

_____

Snacking: How often do you snack, what do you eat, and how much do you eat?

_____

_____

Describe your usual stress level: _____

When you are in a stressful situation, either work or family related, so you tend to eat more? O Yes

Describe your usual energy level: _____

Describe your relationship with food: _____

_____

Daily Activity Habits

Please choose which level applies to your average activity over the last 6 months:

O Inactive: no regular physical activity; sit during workday

O Light activity: do house and yard work regularly, usually standing or walking during day, no organized sports/exercise during leisure activity

O Moderate activity: occasionally (a few times a month) involved in activities such as weekend golf, tennis, jogging, swimming, or cycling

O Heavy activity: consistent exercise program (jogging, swimming, cycling, active sports) at least 2-3 times per week or daily physical activity (heavy lifting, stair climbing, heavy construction work)

O Vigorous activity: intense physical exercise at a minimum of 4 times per week for at least 60 minutes a session

Weight Loss History

Highest recorded weight: _____

Lowest recorded weight since reaching adulthood: _____

Age at onset of obesity: O Childhood O Adolescence O Young adult (20s) O 30-50 yrs O Age 50+

Have you had weight loss surgery in the past? O Yes *(If yes)* Date: _____ Physician: _____

Procedure: _____

Results: _____

Please take time filling out the attached chart with a history of your diet attempts.

_____

Patient Signature *Date*

Patient Name: _____ DOB: _____

Hiatal Hernia Questionnaire

1. Have you noticed any acid reflux symptoms?
   ◯ Yes ◯ No How long have you had these symptoms?
   _____
   _____

2. Please list all the symptoms you've experienced.
   _____
   _____
   _____

3. Have you used OTC medication to treat your acid reflux?
   ◯ Yes ◯ No Which medications?
   _____
   _____

4. Do you take any prescription medication for your acid reflux? (Prilosec, Aciphex, etc.)
   ◯ Yes ◯ No Please list:
   _____
   _____

5. Have you changed your diet due to your acid reflux?
   ◯ Yes ◯ No How have you changed it?
   _____
   _____
   _____

6. Does anything you ingest worsen your symptoms? (spicy food, caffeine, alcohol, etc.)
   ◯ Yes ◯ No Comments:
   _____
   _____

7. Does Italian (tomato-based foods) or Mexican food aggravate your symptoms?
   ◯ Yes ◯ No Comments:
   _____
   _____

8. Do you have difficulty swallowing or the sensation that food gets stuck?
   ◯ Yes ◯ No Comments:

   _____

   _____

9. Do you experience any regurgitation?
   ◯ Yes ◯ No Comments:

   _____

   _____

10. What other methods have you tried to reduce your acid reflux? (changing bed positions, bought new bed, etc.)

    _____

    _____

    _____

11. Do you experience any heart burn?
    ◯ Yes ◯ No Comments:

    _____

    _____

12. Do you experience night-time acid reflux?
    ◯ Yes ◯ No Comments:

    _____

    _____

13. Does lying down or bending over worsen your symptoms?
    ◯ Yes ◯ No Comments:

    _____

    _____

14. Do you ever experience any pain/tenderness in the upper central abdominal area?
    ◯ Yes ◯ No Comments:

    _____

    _____

Today's Date:_____

BARIATRIC PATIENT HEALTH HISTORY

Diet History

Please fill out the chart below with your dieting history. The information should be as complete and accurate as possible.

Program/Method/Medication	Doctor Guided	Duration (Start-End Dates)	Lbs Lost	Results

DVT Prophylaxis Acknowledgement and Consent

My surgeon has explained to me that he/she has prescribed the use of a mechanical DVT prophylaxis (preventative) unit with intermittent limb compression, also known as a sequential compression device, as part of my post-operative recovery. I understand that my health history contains certain risk factors that have been associated with Deep Vein Thrombosis (DVT), which is a harmful potential post-operative complication, and that this device has been ordered to try to prevent the development of this condition following my surgery.

I have received instruction on the use of this device from my surgeon and/or his or her staff. **I understand that failure to comply with the physician post-operative instructions on the use of this device may increase my risk for developing DVT.** I also understand that use of this device does not guarantee that I will not experience any complications as a result of my surgical procedure(s), nor does it guarantee that I will not develop DVT.

I understand that I should call my physician's office in each of the following circumstances: (a) if I have any questions related to this use of this device, (b) if I experience any pain, discomfort or other symptoms while using this device, and (c) when it is time to discontinue use of this device.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)