

Thank you for your interest in the weight-loss programs offered at the SSM Weight-Loss Institute. Inside this brochure you will find information on the weight-loss options we offer. To pursue either option, surgical or non-surgical, we recommend attending free educational seminars. Dates for surgical seminars and non-surgical orientations can be obtained on-line. Additionally, for your convenience, the surgical seminar can be completed on-line at ssmweightloss.com.

If you are inquiring into weight-loss surgery options it is strongly recommended that you call your insurance company and inquire about your benefits, the criteria, and pre-authorization for surgical treatment of morbid obesity. When inquiring about your benefits your insurance company may request a procedural code, commonly referred to as a CPT code. The CPT code for gastric bypass is 43644, adjustable gastric banding is 43770 and the sleeve gastrectomy is 43775. Please note that not all health insurance policies cover surgery for obesity.

If you are interested in pursuing surgical weight-loss options through the Institute, the paperwork needed to begin the process along with a self-addressed stamped envelope to return is included, or you can fax your completed packet to 314-622-6453 Att: Pre Op.

Your timely completion of these items will expedite the process of obtaining your surgical approval.

Patient Registration Form: Please complete including primary and secondary insurance information if applicable and sign at the bottom. **A copy of your insurance card(s) front and back must be included to process your packet.**

Patient Medical Questionnaire: Mark appropriate choice of surgical tool at the top of the page along with noting our preference, if any, for surgeon. Fill out entire form as completely as you can.

Primary Care Physician Request Form: This form is to be utilized as a tool for your primary care physician on what the Weight-Loss Institute will need to support your request for weight-loss surgery. Please take it with you to your appointment so he/she knows what information is needed.

Privacy Practices: Please complete and return with appropriate person(s) noted to have permission by you to speak with. This will help assist us in best contacts.

Once the paperwork is completed and returned to our office your information will be processed, insurance verified and you will be contacted as to your next steps.

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME _____ FIRST NAME & INITIAL _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ PAGER _____
HOME PHONE _____ CELL PHONE _____ E-MAIL _____
DATE OF BIRTH _____ SEX: M F AGE: _____ MARITAL STATUS: Married Single RACE: _____
REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____
SPOUSE'S NAME _____ SPOUSE'S DOB _____ SPOUSE'S WORK PHONE _____
EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____
PATIENT SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____
PATIENT EMPLOYER _____ EMPLOYMENT STATUS: Full Time Part Time Retired
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMPLOYER PHONE _____ EXT. _____

GUARANTOR

RESPONSIBLE PARTY LAST NAME _____ FIRST NAME & INITIAL _____ RELATIONSHIP _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____ RESPONSIBLE PARTY SOCIAL SECURITY # _____ DOB _____
RESPONSIBLE PARTY EMPLOYER _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

INSURANCE INFORMATION

1. MEDICARE OR INSURANCE #1 NAME _____
MEDICARE OR INSURANCE #1 ADDRESS _____ MED. OR INS. #1 PHONE _____
POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____
CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____
2. MEDICARE OR INSURANCE #2 NAME _____
MEDICARE OR INSURANCE #2 ADDRESS _____ MED. OR INS. #2 PHONE _____
POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____
CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

I request payment of authorized Medicare, Medigap or any other insurance benefits be made on my behalf to Weight Loss Institute for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or to other insurers any information needed to determine benefits payable for services from the provider. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

FINANCIAL LIABILITY: I understand I am fully responsible for all Physician charges. If I have insurance that will cover a portion of my bill, I agree to pay the patient's portion of the bill and understand I may be required to make a deposit toward the amount and the balance. The fact I may be covered by insurance does not relieve my personal obligations to pay all charges. I agree to assure payment of all charges by Weight Loss Institute.

All of the above information I have given is to the best of my knowledge correct.

SIGNATURE _____

DATE _____

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

PAST MEDICAL HISTORY

WHAT MEDICAL PROBLEMS ARE CURRENTLY BEING TREATED?

Illness	Date	Treatment	Outcome

PAST SURGICAL HISTORY

LIST ANY SURGERIES:

Surgery	Date	Reason	Physician

PRIMARY HEALTH CARE PROVIDER

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

OTHER HEALTH CARE PROVIDER(S), INCLUDING SPECIALISTS

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Cardiac:

Have you ever had a heart attack? Y N

If yes, when _____

Do you get chest pain with activity? Y N

Have you ever had congestive heart failure? Y N

Have you ever had any heart rhythm abnormalities? Y N

Have you ever had Rheumatic Fever? Y N

Have you ever been told you have a heart murmur? Y N

Have you ever been told you have coronary atherosclerotic disease? Y N

Pulmonary:

Do you experience shortness of breath with physical activity? Y N

When do you have to stop and rest _____ Steps/Flights (*Circle one and enter number*)

Do you have asthma? Y N

Do you have COPD or emphysema? Y N

Do you smoke? Y N

Do you have sleep apnea? Y N

Are you on CPAP/Bi-Pap? Y N

Do you use oxygen at home? Y N

Do you snore? Y N

Do you ever stop breathing while asleep? Y N

Do you doze off while talking to someone? Y N

Have you had a sleep study in the past? If so, when: _____ Y N

Hepatic:

Have you ever had hepatitis? Y N

Have you been told you have cirrhosis of the liver? Y N

Have you ever been told you have a fatty liver disease? Y N

How much alcohol do you drink? _____

Have you ever had problems with alcohol? Y N

If yes, when: _____

Renal:

Are you on Dialysis? Y N

Have you ever had any kidney problems? Y N

If yes, when: _____

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Neurological:

- Have you ever had a stroke? Y N
- Do you have Multiple Sclerosis, Parkinson's disease, or any other neurological disease? Y N
- If so, what disease? _____
- Do you have Pseudotumor Cerebri? Y N
- Do you use a wheelchair OR cane? Y N
- Have you ever had lupus? Y N

Gastrointestinal:

- Have you ever had (please check all that apply):
- Gallstones Hiatal Hernia Diarrhea Hernia Blood in stool
- Hemorrhoids Ulcer Disease Crohn's Disease
- Do you have heart burn? Y N
- Have you ever had surgery for the treatment of reflux disease? Y N
- Have you had any previous weight loss surgery? Y N

Endocrine:

- Do you have thyroid disease? Y N
- Check which type you have: Hyper (high) Hypo (Low)
- Are you diabetic or insulin resistant or do you have metabolic syndrome (check) Y N
- Do you have high cholesterol or high lipids? Y N
- Are you treating your high cholesterol? Y N

Bone or Joint Problems:

- Have you ever been told you have degenerative joint changes, or arthritic changes in your joints? Y N

Psychiatric:

- Current Psychiatric treatment? Y N
- Treated by: Psychiatrist Therapist
- Current Hospitalization (last 6 months): Y N
- Treated by: Psychologist Physician
- Have you ever been diagnosed with an eating disorder? Y N

Past Treatment:

- Were you ever hospitalized for Psychiatric treatment? Y N
- When was your treatment? _____
- Where was your treatment? _____
- What was your treatment for? _____

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Psychiatric, cont'd:

Current Treatment:

Whose care are you under? _____

Current medications and dosages: _____

Current diagnosis and reason for treatment? _____

Vascular:

Do you have hypertension? Y N

Have you ever had a blood clot? Y N

If yes, when _____

What form of treatment _____

Have you ever had a Pulmonary Embolus? Y N

Do you have a family history of Pulmonary Embolisms or DVT? Y N

If yes, where was your treatment? _____

Do you get significant swelling in your legs? Y N

Have you ever had leg ulcers? Y N

Have you ever been treated for cellulites of the lower extremities? Y N

Have you ever been told you have peripheral vascular disease? Y N

Do you have any history of abnormal bleeding? Y N

Infection:

Do you have HIV or AIDS? Y N

PSYCH EVAL BACKGROUND INFORMATION

The following information is considered confidential and will be handled as such.

Patient Name _____ DOB _____ Age _____ Male Female
Your city and state _____ Highest education level _____

Are you seeking: Banding Bypass Sleeve Revision Height _____ Weight _____
Married? _____ How long? _____
Which marriage (2nd, etc.) _____ Single Widowed Divorced Separated
Who lives in your home? (wife, kids, etc.) _____ # of children born? _____
Employed where? _____ Job/position? _____ For how long? _____

What do you attribute your excess weight to? (e.g. poor food choices, genetics, large portions, etc.)

At what age or grade were you initially overweight? _____ Highest weight ever? _____
Age or grade you made first dieting attempt _____
If you recall, what did you weigh when you graduated high school? _____
Date of most recent dieting attempt (last year, currently dieting, etc.) _____
Do you binge eat or consider yourself to be a compulsive eater? _____
Are you a grazer (consistent snacker or picker)? _____
Do you eat to compensate for stress _____ boredom _____ emotional comfort _____?
If yes to any of these, how do you plan on controlling these behaviors following weight loss surgery?

Have you ever had a suicide plan or attempt? Yes No If so, when? _____
List any current mental health diagnoses, such as depression, anxiety, etc. and any related medications:

Who prescribes the Rx and what is their phone number? _____
How many cigarettes do you smoke per day? _____
How much alcohol do you drink and what type (beer, etc.) _____
List any prior addictions _____
Ever been hospitalized for a psychiatric disorder? _____
Briefly describe your childhood when growing up (chaotic, stable, problematic, etc.) _____
Do you *regularly* feel anxious nervous sad flat down helpless worthless guilty
Ever have a visual or auditory hallucination? _____ Trouble sleeping? _____
Does the desire to eat remain about the same over time? _____
Currently under extreme stress? _____ Ever treated for a eating disorder? _____

Medical reasons for seeking bariatric surgery _____

How long have you been thinking about having a weight loss procedure? _____
Ways you have researched the surgery _____
Any other family members who had bariatric surgery? Yes No
Who referred you for surgery (self/doctor) _____
Briefly list the surgical risks of the procedure you are seeking _____

What is the most you could weigh and feel like your surgery has still been successful? _____

To be completed by your primary care physician
PRIMARY CARE PHYSICIAN REQUEST FORM

Dear SSM Weight Loss Institute,

I am referring my patient _____, date of birth _____,
to you for your opinion regarding the possibility of weight loss options, including surgery. The patient's
current weight is: _____, height is: _____, BMI is: _____. The patient has been morbidly obese
for _____ years.

The patient's five (5) year weight history:

(1) Yr: _____ Wt: _____ (2) Yr: _____ Wt: _____ (3) Yr: _____ Wt: _____
(4) Yr: _____ Wt: _____ (5) Yr: _____ Wt: _____

The patient suffers from the following co-morbid conditions associated with morbid obesity which include
(Please check all that apply)

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Type 2 diabetes – controlled by oral medications | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Type 2 diabetes – controlled by injectable medications | <input type="checkbox"/> Stress incontinence | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> GERD | |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Heart burn | |
| <input type="checkbox"/> Valvular heart disease | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> History of medical non-compliance | |

The patient also has the following conditions that are associated with morbid obesity:

The patient's previous weight loss attempts:

TSH Required. Other tests listed optional, please provide results if applicable.

- | | |
|--|--|
| <input type="checkbox"/> Laboratory testing such as lipid panel, HGB A1C, TSH (Required) | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Sleep Study | <input type="checkbox"/> Venous duplex |
| <input type="checkbox"/> Exercise stress test | <input type="checkbox"/> Other: _____ |

This patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining
adequate weight loss. I recommend this patient for weight loss surgery.

Sincerely,

Physician Signature (Required)

Date

(_____) _____
Phone

Printed Name

Address (Required)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I have received the notice of Privacy Practices on this visit or a previous one. I understand I can request another copy at any time.

First Name	MI	Last Name	Date of Birth
------------	----	-----------	---------------

Signature of Patient/Parent or Legal Guardian	Date
---	------

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request restriction on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means such as: sending correspondence to the individual's office or cell phone, instead of the individual's home phone.

PLEASE CHECK ALL THAT APPLY

HOME TELEPHONE:

- Leave message with detailed information
- Leave message with call back number only

WRITTEN COMMUNICATION:

- OK to mail to:

- OK to fax to:

WORK TELEPHONE:

- Leave message with detailed information
- Leave message with call back number only

CELL PHONE:

- Leave message with detailed information
- Leave message with call back number only

I GIVE CONSENT TO THIS OFFICE TO RELEASE ANY AND ALL RESULTS TO THE PERSONS LISTED BELOW:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

For Office Use:

Entered into system by	Date
------------------------	------