Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# Prestige Bariatric and Surgical Specialists

## Conditions of Registration

## Patient Name: _____

**CONSENT TO TREAT**

I consent to the medical procedures that may be performed at the Clinic. These procedures may include but are not limited to, laboratory procedures, X-ray examinations and medical or surgical treatment or procedures deemed necessary and performed by and under special instructions of my physician. I understand that the practice of medicine and surgery is not an exact science and that diagnoses and treatment may involve risks of failure to resolve the condition under treatment, injury or even death. I acknowledge that no warranties or guarantees have been made to me regarding the results of examination or treatment.

**FINANCIAL AGREEMENT**

I agree to promptly pay all clinic bills in accordance with the regular rates and terms of the Clinic, including charity care and discount payment policies, if applicable. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts will bear interest at the legal rate, unless prohibited by law.

Patient Initials: _____

**ASSIGNMENT OF INSURANCE BENEFITS**

I assign and authorize direct payment to the clinic of all insurance benefits payable for these outpatient services. I agree that the insurance company's payment to the Clinic pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

**HEALTH PLAN OBLIGATION**

The clinic maintains a list of Health Plans with which it is contracted with. A list of these plans is available upon the request from the Practice Manager. The Clinic has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the Clinic, if I belong to a plan that does not appear on the list provided. It is my responsibility to determine if the Clinic contracts with my Health Plan.

I confirm that I have read the preceding information and have received a copy of this form if requested. Any questions that I may have had have been answered fully and to my satisfaction. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

**CONSENT TO PHOTOGRAPH**

I consent to have my photo taken and stored in my electronic health record for identification purposes only.

## SIGNATURES

Date: _____ Time: _____AM/PM

Signature: _____

(Patient/legal representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____

(Legal Representative)

Witness Signature: _____

(Witness only required for telephone consent, physical inability to sign, or signature by mark.")

Witness Print Name: _____

**FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE**

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Date: _____ Time: _____AM / PM

Signature: _____

(Legal Representative/Interpreter)

Print Name: _____

(Legal Representative/Interpreter)

Address: _____

Phone Number: _____

Witness Signature: _____ Witness Print Name: _____

(Witness only required for telephone consent, physical inability to sign, or signature by mark.")

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# *Financial Policies*

Prestige Bariatric and Surgical Specialists Inc. appreciates your confidence in choosing us to provide for your health care needs. Our services imply a financial responsibility on your part - an obligation to ensure payment in full of our fees. We would like to share our financial policies with you since a clear understanding of our financial policies is an important component of our professional relationship.

***Methods of Payment***
We will bill your insurance as a courtesy to you with a copy of your current insurance card, which must be presented at each visit. If you do not have your insurance card, payment is due at the time of service. For your convenience, we accept cash, debit and credit cards.

***Participation with Insurance & Medicare***
PBSS participates with Medicare, as well as many HMO & PPO plans, which means that we accept assignment of benefits. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. If we do not have a contract with your insurance company, you are responsible for payment in full and considered to be Self-Pay. Payment is due at the time of service; we will supply you with a statement to submit to your insurance company for direct reimbursement.

> ***Medicare:*** As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance with a company with whom we are contracted, we will bill your secondary insurance for you. Any remaining balance will be billed to you.
> ***PPO Plans:*** As a component of our contracts, we collect co-payments for every visit. If you have not met your deductible, we collect a deposit toward your services. You will receive a statement for the remaining balance after your insurance plan processes your claim.
> ***HMO Plans:*** If you are insured through an HMO, a referral is required from your primary care physician. If we do not receive a referral, we will require payment at the time of service.

***Self-Pay***
Payment is due at the time of service.

***Dietician Fees:***
There is a minimum charge of $25 for all appointments with the dietician.

***No Show Fees***
Please note that we may find it necessary to charge a No Show fee of $25 if you do not cancel within 24 hours of your appointed time. We appreciate your calling so that your appointment time can be opened up to someone else in need.

***Our Fees***
We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates. Co-payments, co-insurance, and deductibles, or unpaid balances are due at the time of service.

***Fees for Completion of Forms***
There is a minimum charge of $25 to complete forms such as disability or FMLA forms.

I have read the Financial Policies of PBSS. I understand that it is my responsibility to provide current insurance information at each visit, as required by my insurance provider.

_____ _____

Print name and Signature of Patient or Guardian Date

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# Prestige Bariatric and Surgical Specialists
# Notice of Privacy Practices

## Acknowledgement Form

As a patient of Prestige Bariatric and Surgical Specialists Inc., you have been provided with your *Notice of Privacy Practices.* The *Notice* is provided to you in compliance with the Health Insurance Portability Accountability Act (HIPAA). Please take time to review.

To help us further comply with this new federal legislation, we ask that you sign this Acknowledgement Form. The Department of Health and Human Services requires that we ask for your signature to acknowledge that you have received your Notice of Privacy Practices. Your signature confirms that we have provided you with a copy of our *Notice.*
I hereby acknowledge receipt of the *Notice of Privacy Practices.*

_____
*Print Patient Name*

_____ _____
Signature of Patient Signature of Legal Representative, if not patient

_____
Date of Signature

**INABILITY TO OBTAIN ACKNOWLEDGMENT**

To be completed only if no signature is obtained. If it is not possible to obtain patient acknowledgement, describe the good faith efforts made to obtain the individuals acknowledgment, and the reason why acknowledgement was not obtained.

Handed to Patient: Yes / No

Patient refused to Sign: Yes / No

Other:_____
_____
_____

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

Name:_____

| Prescription: | Dose: | Notes: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |

**Patient Name:** _____ **Sex:** ☐ M ☐ F D.O.B. _____

# Medical History

| | | | |
|---|---|---|---|
| ☐ Yes | ☐ No | Head Aches | Date: _____ |
| ☐ Yes | ☐ No | Stroke | _____ |
| ☐ Yes | ☐ No | Seizures | _____ |
| ☐ Yes | ☐ No | Pneumonia | _____ |
| ☐ Yes | ☐ No | Diabetes (Type 1 or Type 2) | _____ |
| ☐ Yes | ☐ No | Thyroid Disease (Low or High) | _____ |
| ☐ Yes | ☐ No | Glaucoma | _____ |
| ☐ Yes | ☐ No | Macular Degeneration | _____ |
| ☐ Yes | ☐ No | Hearing Loss | _____ |
| ☐ Yes | ☐ No | High Blood Pressure | _____ |
| ☐ Yes | ☐ No | Blood Clots | _____ |
| ☐ Yes | ☐ No | Heart Burn, Reflux | _____ |
| ☐ Yes | ☐ No | Stomach Ulcers | _____ |
| ☐ Yes | ☐ No | Heart Disease | _____ |
| ☐ Yes | ☐ No | High Cholesterol | _____ |
| ☐ Yes | ☐ No | Gastrointestinal Bleeding | _____ |
| ☐ Yes | ☐ No | Hepatitis (A, B, C), Liver Disease | _____ |
| ☐ Yes | ☐ No | HIV / AIDS | _____ |
| ☐ Yes | ☐ No | Chronic Wounds | _____ |
| ☐ Yes | ☐ No | Cancer (type) | _____ |
| ☐ Yes | ☐ No | Urinary Tract Infections | _____ |
| ☐ Yes | ☐ No | Incontinence | _____ |
| ☐ Yes | ☐ No | Kidney Stones | _____ |
| ☐ Yes | ☐ No | COPD (Emphysema, Bronchitis) | _____ |
| ☐ Yes | ☐ No | Asthma | _____ |
| ☐ Yes | ☐ No | Depression | _____ |
| ☐ Yes | ☐ No | Bipolar Disorder | _____ |
| ☐ Yes | ☐ No | Anxiety | _____ |
| ☐ Yes | ☐ No | Fibromyalgia | _____ |
| ☐ Yes | ☐ No | Chronic Fatigue Syndrome | _____ |
| ☐ Yes | ☐ No | Arthritis | _____ |
| ☐ Yes | ☐ No | Gout | _____ |
| ☐ Yes | ☐ No | Osteoporosis | _____ |
| ☐ Yes | ☐ No | Prostate Disease | _____ |
| ☐ Yes | ☐ No | Breast Disease | _____ |
| ☐ Yes | ☐ No | Erectile Dysfunction | _____ |
| ☐ Yes | ☐ No | Sleep Apnea | _____ |

Other: _____

**Patient Name:** _____

# Surgical History (Indicate date if known)

☐ None

☐ Yes ☐ No Cataracts_____

☐ Yes ☐ No LASIK_____

☐ Yes ☐ No Tonsillectomy/Tonsils_____

☐ Yes ☐ No Thyroidectomy/Thyroid_____

☐ Yes ☐ No Open Heart Surgery_____

☐ Yes ☐ No Cardiac Stents_____

☐ Yes ☐ No Pacemaker _____

☐ Yes ☐ No Heart Valve _____

☐ Yes ☐ No Gall Bladder _____

☐ Yes ☐ No Appendix _____

☐ Yes ☐ No Bowel/Stomach _____

☐ Yes ☐ No Hemorrhoidectomy _____

☐ Yes ☐ No Bariatric Surgery _____

☐ Yes ☐ No Hysterectomy _____

☐ Yes ☐ No Upper Endoscopy _____

☐ Yes ☐ No Colonoscopy _____

☐ Yes ☐ No Hernia Repair _____

☐ Yes ☐ No Tubal Ligation _____

☐ Yes ☐ No Bladder Surgery_____

☐ Yes ☐ No Prostate Surgery/Resection _____

☐ Yes ☐ No C-Section _____

☐ Yes ☐ No Orthopedic/Joints _____

_____

☐ Yes ☐ No Other_____

_____

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate box)

| | Mother | Father | Sister | Brother | Maternal Grand-mother | Maternal Grandfather | Paternal Grand-mother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | | |
| Bleeding Disorder | | | | | | | | | |
| Cancer (Type) | | | | | | | | | |
| Stroke | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| Diabetes | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| Blood Clots | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | |
| Obesity | | | | | | | | | |
| Psychiatric Disorder | | | | | | | | | |
| Sudden Death (Age) | | | | | | | | | |

**Patient Name:** _____

**Please check any of the following problems that apply to you:** ☐ **None of these problems**

**General**
- ☐ Fever
- ☐ Sweats

**Eyes**
- ☐ Blurred vision
- ☐ Changing vision

**Nutrition**
- ☐ On a special diet
- ☐ Weight gain or loss greater than 10 lbs.

**Musculoskeletal**
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Muscle pains

**Respiratory**
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Shortness of breath with exertion

**Ear/Nose/Throat**
- ☐ Ear Pain
- ☐ Runny Nose
- ☐ Sneezing
- ☐ Post nasal drip swelling

**Skin**
- ☐ Rash
- ☐ Changing mole
- ☐ Itching
- ☐ Slow healing wounds

**Hematologic System**
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Hard to stop bleeding

**GI System**
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Blood in stool

**Mental Health**
- ☐ Insomnia
- ☐ Guilt
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

**Endocrine System**
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

**Neurologic System**
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Weakness

**Genitourinary**
- ☐ Urinary frequency
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Problems urinating
- ☐ Awaking at night to urinate
- ☐ Problems with sex
- ☐ Exposure to sexually transmitted disease

**Daily Living**
- ☐ Violence in your home
- ☐ Changes in functional ability
- ☐ Changes in eating habits
- ☐ Changes in sleeping habits

**Allergy**
- ☐ Seasonal symptoms
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Post nasal drip

**Alcohol & Tobacco Use**
- ☐ Do you drink alcohol?

  How much /week?

  _____
- ☐ Do you smoke?
  - ☐ Pipe ☐ Cigars
  - ☐ Cigarettes

  How many packs?

  _____

  How many years?

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# AUTHORIZATION FOR RECORDS RELEASE

I hereby authorize: _____

_____

To disclose to: Prestige Bariatric and Surgical Specialists
7551 Timberlake way Suite 230
Sacramento, CA 95823

RECORDS AND INFORMATION PARTAINING TO:

_____ _____
Patients Name DOB

FOR THE REASON OF:

_____

_____

_____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless Date is specified here. _____

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective from upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further us or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____ _____
Signature: Date:

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# Alcohol and Bariatric Surgery

## Fact Sheet

Weight loss surgery patients have a greater lifetime risk of alcohol and substance use disorders, and the physiological changes with surgery lead to a greater sensitivity to alcohol. Alcohol is not advised after bariatric surgery.

- Alcohol is a type of sugar and it slows down a patient's weight loss.
- Alcohol may cause dumping syndrome.
- Alcohol contains lots of calories and is not nutritional.
- Alcohol can obstruct eating behaviors which may lead to malnutrition.

- After surgery, the intoxicating effects of alcohol occur sooner than before surgery and after smaller amounts are ingested.
- After consuming alcohol, some patients might take almost twice as long to return to sobriety. Although the patient generally FELT sober more quickly than before surgery, their blood alcohol level took longer to normalize.
- A single glass of wine potentially puts some gastric bypass patients' alcohol levels over the legal driving limit of.08 - at risk for DUI at the very least, death due to impairment at the worst.

- Alcohol can increase your risk of alcoholic liver disease.
- Alcohol is an addictive substance.
- It is best to avoid drinking alcohol for at least six months after surgery, since it can be irritating to the stomach pouch and cause ulcers.
- If you choose to drink alcohol after six months post-op, use extreme caution, only do so on special, rare occasions, and NEVER drive within 24 hours of having an alcoholic beverage.

**I have read and understand the above Alcohol and Bariatric Surgery fact sheet.**

**SIGNATURE: _____** **Date: _____**

*Alcohol Assessment and Management/Surgery for Obesity and Related Diseases 8 (2012) 357-363*

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# Smoking Cessation Policy

Since you have decided to have weight loss surgery to improve your health and prolong your life, quitting tobacco will give you even greater health benefits than weight loss alone. Tobacco is a highly addictive substance that may require multiple treatments. Therefore PBSS requires that all patients quit the use of all tobacco and nicotine containing products prior to surgery.

**Nicotine and other byproducts of tobacco can cause serious problems during and after your surgery.**

- Smoking increases the risk of a heart attack or stroke during surgery
- Smoking can cause respiratory difficulties, such as pneumonia and bronchitis
- Smoking slows healing and can lead to wound infections, due to reduced oxygen levels in your blood
- Smoking causes heartburn
- Smoking causes stomach ulcers
- Smoking decreases your body's ability to absorb vitamins and minerals.

**Program Expectations:**

- Each patient will be screened for tobacco use at the initial history and physical exam
- Patients will be offered smoking cessation intervention
- Patients will be advised to be tobacco free for 3 months prior to surgery
- Prior to surgery, nicotine levels may be ordered as proof of tobacco cessation
- Proceeding to surgery is at the discretion of the surgeon

Please make sure you have successfully quit using tobacco and nicotine prior to your appointment with the surgeon to avoid any delay in scheduling your surgery date.

**I have read and understand the above Smoking Cessation Policy. I understand the risks of smoking with Bariatric Surgery and I agree to abstain from smoking before and after surgery.**

SIGNATURE: _____ Date: _____

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# Vitamin Policy & Contract

As part of your treatment pre/post bariatric surgery, you are required to take appropriate vitamins for the rest of your life based upon what you and the Bariatric Dietitian discussed. Depending on which Bariatric surgery that you are planning to have completed, vitamin deficiencies can occur if you are not taking your vitamins regularly due to a decrease in nutrient intake.

Most common vitamin deficiencies seen with the two different procedures:

**Sleeve Gastrectomy:**

Vitamin B-12, Calcium, Iron, Multi Vitamin

**Gastric Bypass:**

Vitamin B-12, Calcium, Iron, Multi Vitamin

- You are required to purchase the recommended vitamins and nutritional supplements at your pre-op appointment or your surgery may be rescheduled. (Please Note: PBSS Office only accepts, checks, cash, debit, or credit cards for this purchase of approximately $300.00)
- You are required to take the vitamins according to the directions given to you by the Dietitian.
- You are required to make and keep regular office appointments to assess your progress. The frequency of these visits will be decided upon with you and your surgeon.

**If you are unable to abide by the above policy, we have found that the risks & burdens of not taking vitamins will outweigh the benefits of surgery. In some instances, we may be unable to continue to provide for your healthcare needs & it will be necessary for you to seek treatment elsewhere.**

_____ _____

Patient Signature Date

Prestige Bariatric
and Surgical Specialists, Inc.

7551 Timberlake Way
Suite 230
Sacramento, CA 95823
Office: (916)347-3630 ~ (209)333-7600
Fax: (916)347-3632 ~ (209)333-7608

# REGISTRATION FORM

NAME: _____ DOB:_____

HOME ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

DO YOU ACCEPT TEXT MESSAGES FOR APPOINTMENTS AND UPDATES: Y OR N

EMERGENCY CONTACTS NAME AND PHONE: _____

PRIMARY CARE DR: _____

TYPE OF INSURANCE: _____

INSURANCE ID#:_____

SPECIALTY DR'S: _____