Dear Prospective Patient,

Thank you for your interest in the Bariatric Surgery Program at Southern Surgical Associates, PA. We received a referral for you either from yourself or your doctor, to be considered as a candidate for Bariatric Surgery. We are committed to providing the best quality and up-to-date care for our patients in the most compassionate manner.

You are scheduled to attend a Patient Education Class to orient you to our program. . If you are unable to attend, please notify our office. If you do not attend the education class then you will not be able to move forward in our program. The orientation will be held at **Southern Surgical Conference Center. This is located at 2459 Emerald Place, Suite 100** (at the back of the building).

The purpose of this orientation is to provide you with information about our program, to meet our staff and to obtain your current medical and surgical history. You will need to complete the enclosed paperwork and bring it with you to the class. The orientation will last from **8:30 am until 12:30 pm. Due to limited space in the class and no waiting room, you will not be able to bring any family members or support persons with you**. Please bring all medications that you are currently taking with you, as well as your insurance card and driver's license.

Prior to your appointment, you should contact your insurance company to verify that the bariatric surgery you are interested in, either gastric bypass or sleeve gastrectomy is a covered benefit under your policy. Also, you will need to verify that you meet the qualifications of your policy for the procedure. Each insurance company has different requirements. Your insurance company will give you this information. It is your responsibility to be aware if our physicians, Vidant Medical Center, formerly Pitt County Memorial Hospital, Pitt County Anesthesia, and any other physicians that we may refer you to for your preoperative evaluation testing are in network for your insurance company. This will help you determine how much of your total bill will be your responsibility and how much will be the responsibility of your insurance company. Enclosed you will find a benefit verification form to help you gather this information.

If you have any questions or need additional information regarding our program, please call us at (252) 758-2224.

Sincerely,

The Staff of Southern Surgical

IMPORTANT INFORMATION about your appointment: Please Read!

You have to meet several requirements to be considered as a candidate for the Bariatric Program with Southern Surgical Associates. The list below does not include all of the requirements that can keep you from being a candidate, but they are some of the most important ones. Please review the list below and if you find that you do not meet all of the requirements, please call our office at 252-758-2224 to cancel your appointment for your Patient Education Class.

1. Have a Body Mass Index (BMI) of 35 or greater
2. Have a Body Mass Index (BMI) of 30 or greater for self pay
3. Have failed documented attempts at weight loss in the past. This is not your first attempt at weight loss that you have had. The forms enclosed will help you meet this requirement. Please fill out the best you can.
4. Have to be able to stop smoking and the use of any other nicotine products for three months prior to surgery and life long thereafter.
5. If you are not able to walk without the use of a wheelchair, cane, walker or other assistive device. If you use one of these devices occasionally, you must be able to participate in an exercise program.
6. No use of illicit drugs or alcohol on a daily basis.
7. Must not have a diagnosis of Schizophrenia, Crohn's Disease or Hepatitis C.

The forms included in your packet are very important and they ALL need to be filled out in detail and signed PRIOR to coming to your appointment. The forms will be collected upon your arrival. **If the forms are not filled out when you arrive, then you will be asked to reschedule your appointment for that day.**

Benefit Verification Form

This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Understanding your benefits for weight loss surgery is an important part of the process. Many insurance companies have specific requirements that must be met before surgery is approved. Please make every effort to complete the form below. It is your right and responsibility as a member to know and understand your benefits.

Instructions:

1. Medicare patients: You do not have to fill out a form for Medicare, but if you have any other insurance, this form will be very helpful to fill out.
2. Call the customer service number located on your insurance card and speak to a customer service representative.
3. Tell the representative that you would like to check policy benefits for weight loss surgery for morbid obesity. (codes are at the bottom of this form)
4. Ask the following questions to get the necessary information.
5. If you have more than one insurance you must contact each policy.
6. Keep this form for your records!

Disclaimer:

- Southern Surgical Associates, PA is not responsible for incorrect information that 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 also 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 a bariatric surgeon.

Fill in this information before you call the insurance company.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	

SOUTHERN
SURGICAL ASSOCIATES

#	Question for Representative	Answer from Representative
1	Please look in my current certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	❒ Yes (Continue with this form.) ❒ No (Complete #s 2, 8, & 9, then end the call.) **See explanation at bottom of page.
2	Do I have a requirement to complete a medically supervised weight management program? If so, how long does it have to be?	
3	Please have the representative read the benefit or exclusion to you. Write it down and ask that a copy be sent to you via mail or fax. Request your medical policy for bariatric surgery.	
4	What is the effective date of my policy?	
5	What is the calendar year renewal date?	
6	Do I have a pre-existing clause?	
7	If yes, what is the end date of the pre-existing clause?	
8	Is a referral required?	
9	Name of the representative.	
10	Date you spoke to representative.	

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.**

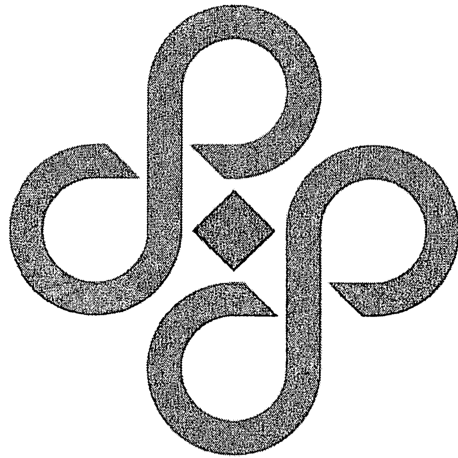
Patient Signature: ______________________________ **Date:** ____________________

**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 that it is not covered in your contract and they will not pay for it.

If asked about diagnosis codes or CPT codes, please refer to the following information:

Diagnosis code:	Morbid Obesity	E66.01
CPT codes:	43774 Band Removal	
	43775 Sleeve Gastrectomy	
	43644 Gastric Bypass	

If your insurance company requires a physician supervised medical weight management program before surgery is approved, there are options available. Your family physician can assist you with this. It is important that you have monthly appointments with your physician, and there is a documented treatment plan that includes height, weight, and discussion/recommendations for diet and exercise plan.



SOUTHERN
SURGICAL ASSOCIATES

OUTPATIENT SURGERY CENTER

GENERAL + BARIATRIC

Please be sure to sign and complete the following forms in detail and bring them ALL to your appointment

Identification

Last Name		Sex	
First Name		Date of Birth	
Middle Name		SSN	

Contact

Street Address		Home Phone	
		Mobile Phone	
Mailing Address		Consent to text	Y N
		Work Phone	
City		Email	
Zip		Contact Preference	

Demographics

Language		Pharmacy	
Race		Address	
Ethnicity	Non-Hispanic/Hispanic/Decline	Phone	
Marital Status		OK to import meds	

Emergency Contact

Name	
Relationship	
Phone	

Primary Insurance ~ Please present the receptionist with your card

Policy Holder *(if other than patient)*		Plan Name	
Name		Policy Information	
Date of Birth		ID/Policy	
SSN		Group	
Relationship		Do you have or expect to have Medicare? Y N	

Secondary Insurance ~ Please present the receptionist with your card

Policy Holder *(if other than patient)*		Plan Name	
Name		Policy Information	
Date of Birth		ID/Policy	
SSN		Group	
Relationship			

Primary Care Physician

Name		Phone	
Address		Did they refer you?	

Additional Information

How did you hear about Southern Surgical? ____________________

ASSIGNMENT AND RELEASE:

-I hereby assign my insurance benefits to be paid directly to Southern Surgical Associates, PA.

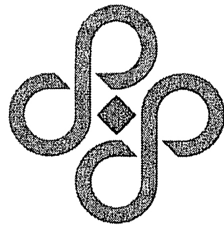
-I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I authorize and give consent for my provicer to bill me directly for recommended services performed that are not covered under the terms of my health plan.

-I authorize the physician to release any medical information required to process this claim.

-I authorize my providers office to contact me by telephone to remind me of my appointments.

-A fee for no shows may apply.

Signed:______________________________ Date:____________________



SOUTHERN
SURGICAL ASSOCIATES

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ________________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: ____
- ☐ Other: ____

Prepared By ____________________________________

Signature ____________________________________

Date ____________________________________

Authorization for Use/Release of Health Information

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

Name:________________________________

DOB: ________________________________

Chart #:______________________________

From time to time, patient's family, friends or relatives call this office asking for appointment times, refill on medications, medical information regarding the diagnosis of the patient and to discuss or give results. Without written permission, we **cannot** talk to anyone other than the patient. If you want the staff to talk to anyone other than yourself about anything regarding your chart, please list the person(s) below.

Name: _________________________ Relationship:_________________________

Name: _________________________ Relationship:_________________________

Name: _________________________ Relationship:_________________________

Name: _________________________ Relationship:_________________________

I understand that Southern Surgical Associates, PA assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Southern Surgical Associates, PA from all legal liability that may arise from this authorization.

Patient Signature:_____________________________________

Date:_____________________________________

Witness:_____________________________________

SOUTHERN
SURGICAL ASSOCIATES

Today's Date:______________________________

FOR OFFICE USE ONLY:	☐ NEW PATIENT	☐ ESTABLISHED PATIENT

Wt:________ Ht:__________ BMI:__________ IBW:__________ B/P:__________ Pulse:__________ Resp:__________

To Be Completed by Patient (please print):

Name____ Date of Birth________________ Age_________ Gender____________

Last First

CHIEF COMPLAINT:

Why are you here today?__________________________________ How long have you had the problem?__________________

Do you have any pain? ____________________ Scale: ______/10 Type: Burning/Stabbing/Sharp/Dull/Cramping/Shooting

PAST MEDICAL HISTORY:

Y N

CARDIO/PULMONARY

☐ ☐ Asthma
☐ ☐ COPD
☐ ☐ Emphysema
☐ ☐ Heart Attack *Date*__________
☐ ☐ Heart Disease
☐ ☐ Heart Murmur
☐ ☐ High Blood Pressure
☐ ☐ High Cholesterol
☐ ☐ PE/DVT
☐ ☐ Sleep Apnea *C-Pap or Bi-Pap*

Cardiologist Name______________
Pulmonologist Name______________

GASTROINTESTINAL

☐ ☐ Barrett's Esophagus
☐ ☐ Cirrhosis
☐ ☐ Diverticulitis
☐ ☐ Hepatitis *Type*_____
☐ ☐ Hiatal Hernia
☐ ☐ IBS
☐ ☐ Liver Disease
☐ ☐ Pancreatitis
☐ ☐ Reflux
☐ ☐ Ulcer

Y N

HEMATOLOGY

☐ ☐ Anemia
☐ ☐ Bleeding Disorders

ENDOCRINE/RENAL

☐ ☐ Diabetes
☐ ☐ Hyperthyroid
☐ ☐ Hypothyroid
☐ ☐ Kidney Disease
☐ ☐ Kidney Failure

MUSCULAR/SKELETAL

☐ ☐ Arthritis
☐ ☐ Fibromyalgia
☐ ☐ Gout
☐ ☐ Rheumatoid Arthritis
☐ ☐ Use cane/walker/wheelchair

NEUROLOGICAL

☐ ☐ Anxiety
☐ ☐ Bipolar
☐ ☐ Depression
☐ ☐ Migraines
☐ ☐ Seizures *Date*____________
☐ ☐ Stroke *Date*____________

CANCER

☐ ☐ Breast

Y N

☐ ☐ Colon
☐ ☐ Gastric
☐ ☐ Leukemia
☐ ☐ Lymphoma
☐ ☐ Prostate
☐ ☐ Other________________

GE

☐ ☐ Infertility
☐ ☐ PCOS
☐ ☐ Stress Incontinence
☐ ☐ Irregular Menses

OTHER

☐ ☐ Connective Tissue Disease
☐ ☐ HIV/AIDS
☐ ☐ Lupus
☐ ☐ Sarcoidosis

Other:______________________________
____
____
____

SOUTHERN
SURGICAL ASSOCIATES

REVIEW OF SYSTEMS: (Tell us what you are currently experiencing or feeling)

Y N

GENERAL
- ☐ ☐ Weight Loss
- ☐ ☐ Weight Gain
- ☐ ☐ Fever
- ☐ ☐ Night Sweats
- ☐ ☐ Fatigue

EYES
- ☐ ☐ Blurred Vision
- ☐ ☐ Double Vision
- ☐ ☐ Corrective Lenses
- ☐ ☐ Glaucoma
- ☐ ☐ Cataracts

EARS/NOSE/MOUTH/THROAT
- ☐ ☐ Ringing in Ears
- ☐ ☐ Sinus Trouble
- ☐ ☐ Swollen Glands in Neck
- ☐ ☐ Hearing Loss
- ☐ ☐ Bleeding Gums
- ☐ ☐ Nose Bleeds

CARDIOVASCULAR
- ☐ ☐ Chest Pain
- ☐ ☐ Heart fluttering/racing
- ☐ ☐ Heart Murmur
- ☐ ☐ Leg Swelling
- ☐ ☐ Venous Insufficiency

Y N

RESPIRATORY
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing
- ☐ ☐ Persistent Cough
- ☐ ☐ Spitting up Blood
- ☐ ☐ Pneumonia

GASTROINTESTINAL
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Rectal Bleeding
- ☐ ☐ Black Stools
- ☐ ☐ Trouble Swallowing
- ☐ ☐ Heartburn
- ☐ ☐ Loss of Appetite

HEMATOLOGIC/LYMPHATIC
- ☐ ☐ Easy Bruising
- ☐ ☐ Enlarged Glands

ENDOCRINE/RENAL
- ☐ ☐ Thyroid Problems
- ☐ ☐ Excessive Thirst or Urination
- ☐ ☐ Hormone Problem
- ☐ ☐ Heat/Cold Intolerance

MUSCULAR/SKELETAL
- ☐ ☐ Back Pain

Y N

- ☐ ☐ Muscle Cramping
- ☐ ☐ Cold Extremities
- ☐ ☐ Joint Pain
- ☐ ☐ Pain in Legs with Walking

NEUROLOGICAL
- ☐ ☐ Seizures
- ☐ ☐ Stroke
- ☐ ☐ Numbness/tingling
- ☐ ☐ Headache

INTEGUMENTARY
- ☐ ☐ Rash
- ☐ ☐ Lesions
- ☐ ☐ Itching

GENITOURINARY
- ☐ ☐ Pain with Urination
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Difficult Catheterization
- ☐ ☐ Urinary Tract Infection

ALLERGY/IMMUNOLOGIC
- ☐ ☐ Seasonal Allergies
- ☐ ☐ Frequent or Unusual Infections

FAMILY HISTORY:

	Living	Deceased	Age	Health Problems/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

SOUTHERN
SURGICAL ASSOCIATES

SURGICAL/PROCEDURE HISTORY:

	When		When
Appendectomy		Gastric Bypass	
Back Surgery		Gastric Sleeve	
C-Section		Hemorrhoidectomy	
CABG		Hip Replacement	
Cardiac Bypass		Hysterectomy	
Cardiac Cath		Knee Replacement	
Carpal Tunnel		Lap or Open Gallbladder	
Cataract		Mastectomy	
Colonoscopy		Nissen (reflux surgery)	
Colon Resection		Pace Maker	
Defibrillator		Tonsillectomy	
Endoscopy		Tubal Ligation	
Gastric Band		Other	
Gastric Band Removal		Other	

SOCIAL HISTORY:

Tobacco Use: ☐ Never ☐ Previously but quit ☐ Daily *Amount:*_________ Type: ☐ Cigarettes ☐ Chew ☐ Snuff
Alcohol Use: ☐ Never ☐ Rare ☐ Moderate ☐ Frequent
Street Drug Use: ☐ No ☐ Yes *Type/Frequency*:__________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Occupation:________________________________ ☐ Full Time ☐ Part Time

ALLERGIES:

☐ None

Name of Medication	Type of Reaction

MEDICATIONS:

Medication	Dose/Strength	How Often?

I declare that the above information is accurate to the best of my knowledge.

____ ____________________
Signature Date

SleepMed

SLEEPMED ARES Questionnaire ©

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name | First Name | Middle Initial | Gender: Male / Female

Date of Birth: Month Day Year | Weight: Pounds | Height: Feet Inches | Neck Size: Inches

I.D. Number (optional)

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female ≥15

Score

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Condition	Yes	No	Condition	Yes	No
High blood pressure	Yes	No	Stroke	Yes	No
Heart disease	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Sleep Apnea	Yes	No
Lung disease	Yes	No	Nasal oxygen use	Yes	No
Insomnia	Yes	No	Restless legs syndrome	Yes	No
Narcolepsy	Yes	No	Morning Headaches	Yes	No
Sleep Medication	Yes	No	Pain Medication e.g. vicodin, oxycontin	Yes	No

Co-morbidities
+1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale tomark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze   1 = slight chance of dozing
2 = moderate chance of dozing   3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (theater, meeting, etc)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Epworth Score
Total the values from all 8 questions.
If 11 or less Score = 0
If 12 or more Score = 2

Score

Frequency (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Do you wake up choking or gasping?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never | Rarely | Sometimes | Frequently | Almost always

Assign points for each of the first three responses

Point Total

I have personally completed this questionnaire.
Signature | Date | Phone Number

Epworth Sleepiness Scale:
If points total =3 or lower (no risk)
4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)

© SLEEPMED 2014

Directions: For each **YES** Response, score "**1**" point. For each **NO** response, score "**0**" points.

Add the points to get a **TOTAL SCORE**. (Note: Answering **YES** to all questions = Score **8**)

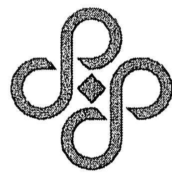
Place this form into the patient's medical record.

Questions	Response	Score
Snoring: Do you snore loudly? Louder than talking, or loud enough to be heard through closed doors?	☐ YES ☐ NO	
Tiredness: Do you often feel tired, fatigued or sleepy during the daytime, even after a "good" night's sleep?	☐ YES ☐ NO	
Observed Apnea: Has anyone ever observed you stop breathing during your sleep?	☐ YES ☐ NO	
Pressure: Do you have or are you being treated for high blood pressure at home?	☐ YES ☐ NO	
Body Mass Index: Is Body Mass Index (BMI) over 35?	☐ YES ☐ NO	
Age: Are you older than 50 years?	☐ YES ☐ NO	
Neck Size: Does your neck measure more than 16" (female) or 17" (male)?	☐ YES ☐ NO	
Gender: Are you male?	☐ YES ☐ NO	
	TOTAL SCORE	

PRINT NAME: ____________________ DOB: __________ Today's Date: __________

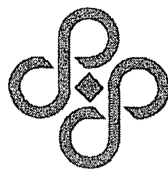
SIGNATURE: ____________________

STOP-BANG SCREENING ASSESSMENT



Weight Loss Attempts
Diet/Weight loss Medication Name:______________________________DOB:_________

Program	# of Attempts	Year	Length of Time	Amount Lost	Amount Regained
Weight Watchers					
Nutrisystem					
Jenny Craig					
TOPS					
Overeaters Anonymous					
Slimfast					
Medi-Fast					
Opti-Fast					
Alli					
Fen/Phen					
Redux					
Meridia					
Hypnosis					
Behavior Modification					
Psychotherapy					
Acupuncture					
Inpatient Weight Program					
Dietician					
Physician Supervised					
South Beach Diet					
Atkins Diet					
Low Calorie Diet					
Low Fat Diet					
Portion Control					
Fasting					
Richard Simmons					
Metabolife					
Herbal Life					
Other:					
Other:					



Weight Loss Attempts
Exercise

Name________________________________DOB__________

Program	# of Attempts	Year	Length of Time	Amount Lost	Amount Regained
Aerobics					
Bicycling					
Gym Membership					
Jogging					
Swimming					
Personal Trainer					
Walking					
eight Lifting					
Weight Training					
Home Equipment					
Workout videos					
Other:					
Other:					
Other:					