requested except when indicated.)

Patient Name





Scottsdale Healthcare Bariatric Center

Mail completed packet to: 10210 North 92nd Street, Suite 101 Scottsdale, Arizona 85258

480-882-7460

http://www.shc.org

Seminars are held at:

All three Scottsdale Healthcare campuses and is also available online. Please visit: www.shc.org/events to register.

Patient Name	
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Congratulations!

By considering the option to undergo weight loss surgery, you have taken the first step necessary to change your health...and your life. Please read the following information carefully.

Please do not print the packet double sided.

Steps in the Process:

- 1. You must attend one of our free public educational seminars. A list of our current seminars is located on our website http://www.shc.org or call 480-882-4636.
- 2. Confirm your insurance coverage for weight loss surgery.

Patients Paying Cash:

Patients who have decided to pay cash either because they have no insurance benefit or because they do not want or are not able to meet the requirements of their insurance company go directly to #3 below.

Note: If you are paying cash, you do not need to provide any supporting documentation of medically supervised weight loss programs, but you are required to lose 10% of your excess weight prior to surgery to participate in our program. You can easily do that during the process with the guidance of our registered dietician staff. If you have 100 pounds to lose, this would be 10 pounds prior to surgery.

If you are going to use insurance to pay for your surgery:

Contact your insurance carrier to determine whether you have a weight loss benefit as part of your insurance coverage.

A common requirement is a six month medically supervised weight loss program, but there may be other specific requirements.

Your insurance company may require a six month medically supervised weight loss program. You may opt to work within our system of care to complete your initial consult and preliminary requirements to expedite authorization for surgery. Options for completing the weight loss requirement are:

- 1. A six month program through Kelly Polak, NP for Scottsdale Healthcare Bariatric Center.
- 2. Supervised weight loss with your primary care physician.
- 3. Other Bariatricians providing this service which can be found on our website.

OUT OF NETWORK:

If we are not a contracted provider for your insurance company, you may still choose to complete our program. You will be required to either pay the surgery fee or if you have out-of-network benefits you will be responsible for part of the fee.

3. Complete and submit your new patient packet.

You must **completely fill out** your new patient packet and **sign it** in order for us to determine whether you're a candidate for surgery at Scottsdale Healthcare Bariatric Center. **Please complete this packet in ink.**

- Include a copy (front and back) of your insurance card with your completed packet.
- **4. Support documentation is now required** by all insurance companies for HMO, POS and PPO type plans. At you will need to provide:
 - A **letter** from your Primary Care Physician supporting your decision to undergo weight loss surgery. The physician will refer to this as a **letter of medical necessity**. We have attached a copy of a sample letter that you can give to your primary care doctor to complete.
 - Documentation of all weight loss attempts through diet centers and programs. This documentation includes enrollment cards and copies of office visits where weight loss programs were discussed.
 Documentation of your participation in a medically supervised weight loss program will help facilitate approval from your insurance company if required by your insurance.
 - ☐ If your insurance company requires a supervised medical weight loss period, we can help by having you work with our medical weight loss specialist. The cost of the program is \$750 for 6 months and \$26 for an EKG.
- 5. Submitting your completed packet:
 - i. You can bring the packet, insurance information and supporting documentation to the public seminar, or
 - ii. Mail your completed packet and documentation to:

Scottsdale Healthcare Bariatric Center 10210 North 92nd Street, Suite 101 Scottsdale. Arizona 85258

Please do not fax your completed new patient packet

6.	When	we	have	received	your	packet:.	
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We will verify your insurance benefit, co-pay and eligibility requirements. The new patient
liaison will then call you to answer any questions you may have and help you develop a plan
to complete the program.
For cash patients our New Patient Liaison will call you to schedule your initial consultation
and answer any remaining questions you may have.
All patient packets are evaluated for possible medical problems or special situations that might
require a different pathway of care.

7. Your initial consultation will include:

A comprehensive health history and physical evaluation by the nurse practitioner or surgeon.
A nutritional evaluation by our staff Registered Dietician. This is now required by all insurance
companies in order to obtain an authorization for surgery.
A comprehensive psychological evaluation and testing <u>by our</u> Licensed Clinical Psychologist
specializing in Bariatric surgery.
A exercise consultation by our staff Exercise Physiologist.

Your initial appointment at SHBC will last approximately four to five hours. We will email you the confirmation of your appointment and a map to our office. If you cancel or reschedule an appointment please give several days notice.

PLEASE REMEMBER: If you did not submit a letter of medical necessity from your Primary Care Physician supporting your application for surgery, or your medically supervised weight loss documentation, **you MUST bring it with you** to your initial consultation.

AUTHORIZATION for surgery cannot be submitted without these documents.

That's it! You're now on your way to better health. While it's understandable that you may be anxious to schedule this life-changing event, we **thank you for your patience** during this process. **At Scottsdale Healthcare**Bariatric Center, we take every precaution to ensure your health, safety and long-term success.

Patient Name				•	(The	ealthcare Bariatric Center e patient completes all information quested except when indicated.)	
Please complete in ink.					HEIGHT	WEIGHT	
New Patient Information Name	е			Date of I	Birth	Gender (circle one) Male · Female	
Address/City/State/Zip							
Home Phone	Cell Pho	one			Social Securit	y No.	
Marital Status (circle one) Single · Married · Divorced	I · Widow ·	Other	E-mail Addre	ess*	<u> </u>		
Employer			Work Phone				
Emergency Contact			Emergency C	Contact Ph	none		
Referral Source (circle one) Family/Friend · Web Site · Insur	rance Company ·	Radio/TV · Ph	nysician • New	spaper/Ma	gazine · Interne	t · Direct Mailer · Other	
	ponsibility Party atient is under 1		n patient)				
Address/City/State/Zip				Social Security No.			
Phone Date	e of Birth		Employer Na & Phone No.				
	erring Physician/ st Name, Last Na					Phone	
Address/City/State/Zip			Email			Fax	
Pharmacy:						Phone	
Insurance Information Prim	nary Insurance						
Primary Insurance Address/City/State/Zip							
Policyholder Name (if other than patient	t)				Social Securit	y no	
ID/Policy No Group No					Primary Insurance Phone		
Secondary Insurance			Phone				
Policy holder name(if other than patient	y no						
ID/Policy No			Group #				
A copy of both sides of the insurance lauthorize my insurance company to presponsibility for any unpaid balance for any will pay the balance in a timely may	pay directly any following insurar	and all claims	submitted by				

Signature** Date

My signature on this document allows Scottsdale Healthcare Bariatric Center to communicate to me via my e-mail address.

^{**} My signature on this document allows Scottsdale Healthcare Bariatric Center to request copies of any and all medical records from any source pertinent to my medical care.

Patient Name _

(The patient completes all information requested except when indicated.)

AUTHORIZATION TO RELEASE RECORDS

The fo	llowing informatio	n is required:				
Patien	t Name:		Social Security #			
Addres	SS:		Date of Birth:			
			_ Phone (Day):			
I herby	authorize release o	of my medical records:				
TO:	Scottsdale Hea	althcare Bariatric Center	Phone: <u>480-882-7460</u>			
	Address: _10210	N. 92 nd Street, Suite 101, Scot	ttsdale, AZ 85258 Fax: <u>480-391-3898</u>			
FROM	:		Phone:			
	Address:		Fax:			
At my	request, purpose for	release:				
	☐ Personal ☐ Research	☐ Continuing Care ☐ Marketing	☐ Insurance ☐ Legal ☐ Other:			
	□ All Rec □ Other (
Medic	al record reports c	overing date(s):	to			
	request for release This consent will e without prejudice. I may revoke this a this effect. I understand that a shall not constitute I understand that a Treatment will not	e of medical information. expire ninety (90) days after authorization at any time produced any releases which were not a breach of my rights to coa photocopy facsimile of this be conditioned on my provides.	ur employees from any and all liability for fulfilling the authorized signed date below. I have given my consent freely, voluntarily oviding I notify Scottsdale Healthcare Bariatric Center, in writing the made prior to my revocation in compliance with this authorized in the sauthorization is considered acceptable in lieu of the original ding this authorization unless the provision of health care is sauthorization for disclosure to a third party.	y anding to		
		This form must be	completely filled out to process			
Patien	t Signature		Date			
Parent	/Guardian/Power of	Attorney/Personal Represe	entative Date			
Record	ds prepared and trar	nsmitted/Mailed by				

Patient Name			-	Scottsdale Healthcare Bariatric Center (The patient completes all information requested except when indicated.)
Patient History Que The information requanswers. Please be	uested in this questic	onnaire is very in	nportant. To gi	HeightWeight we you the best care we must have complete
Name			Date	
Age	Gender (circle	e one) · Female	Occupation	
	Patient Measurement (Please Complete)	Consult Measurement (Office Use)		Pre-Operative Measurement (Office Use)
Height				
Initial Body Weight				
Ideal Body Weight				
Excess Body Weight				
10% Pre-op Excess Body Weight Loss Goal				
Target Weight				
Body Frame (circle one)		ВМІ	ВМІ	
Small Medium		Waist	Waist	
Large		Hips	Hips	
Weight History Please estimate as	closely as possible fo	or all that applies	S. Age	Weight
	Birth Weight			· ·
After	Undergoing Puberty			
High	School Graduation			
	Marriage			
Lowest We	eight in Past 5 Years			
Highest We	eight in Past 5 Years			

(The patient completes all information requested **except when indicated**.)

Patient Name	requested except when indicated .)
Dietary History Approximate age when you first seriously dieted.	
List any <i>physician</i> -supervised and documented weight loss attempt.	
List any supervised and documented weight loss attempt.	
List all other diets and/or weight loss attempts.	

List the diets and diet programs you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Jenny Craig	Yes · No			Yes · No	
Nutri-Systems	Yes · No			Yes · No	
Weight Watchers	Yes · No			Yes · No	
Opti/Medi Fast	Yes · No			Yes · No	
T.O.P.S.	Yes · No			Yes · No	
O.A.	Yes · No			Yes · No	
Other	Yes · No			Yes · No	

List the medications and treatments you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Fen/Phen/Redux	Yes · No			Yes · No	
Meridia	Yes · No			Yes · No	
Topamax/Topiramate	Yes · No			Yes · No	
Bontril/Phendimetrazine	Yes · No			Yes · No	
Tenuate/Diethylpropion	Yes · No			Yes · No	
Alli/Xenical	Yes · No			Yes · No	
HcG Circle One: Shots or Oral	Yes · No			Yes · No	
Acupuncture	Yes · No			Yes · No	
OtherSuch as SlimShots, Stacker, Cortislim, Xenadrine, Hydroxycut	Yes · No			Yes · No	

(The patient completes all information requested **except when indicated**.)

Pat	tient Name			_	re	equested except when indicated
	eight Related Illnesses ve you had, or do you have	e, any of the fo	llowing illne	sses or symptoms?		
1.	Heart Disease (check all that apply to you)	□ Yes	□ No	Year diagnosed		
	□ Taking medications for	or heart diseas	se [Check al	I that apply: ☐ ASA	□ Coumadin	□ Plavix]
	□ Angina □	M.I. (myocard	lial infarction) 🗆 S	tent #:	_
	☐ Abnormal EKG ☐	CABG (coron	ary artery by	pass graft)		
	□ Palpitations □	Stress test to	rule out card	diac problems		
2.	High Cholesterol (check all that apply to you)	□ Yes	□ No	Year diagnosed		
	☐ High triglycerides	□ Taking	medication	s for high cholesterol		
3.	High Blood Pressure	□ Yes	□ No	Year diagnosed		
	□ Taking medications for	or high blood բ	oressure			
	Average pressure					
	List dietary restrictions.					
4.	Pre-Diabetes ☐ Taking medications for		□ No	Year diagnosed		
5.	Diabetes	No Year	diagnosed.	How Dia	gnosed? FBG	☐ HgA1c ☐ Glucola Test
	What type?	☐ Type I	□ Type II	☐ Don't know		
	Gestational	Yes	□ No			
	Controlled with	Diet	□ Medic	ations Insulin		
	Last fasting blood sugar	··	Date			
	Last HgA1c:		Date	<u>: </u>		
	Complications of T2DM	: Deuro	pathy 🗆 k	űdney Disease □ Va	ascular Disease	☐ Amputation
6.	Asthma	□ Yes	□ No	Year diagnosed		
	☐ Taking medications for	asthma				
	ER visits in last 2 years.	·				
	Hospitalizations in last 2	years				
	Steroids used in last 2 y	ears	□ Yes	□ No		
7.	Reactive Airway Disease	∍ (RAD)	□ Yes	□ No Year diagn	osed	
	Age at diagnosis		☐ Taking	g medications for RAD		
	What exacerbates RAD	?				
	Take which inhaler for R	RAD?				
	Take which steroids for	RAD?				

Scottsdale Healthcare Bariatric Center (The patient completes all information

requested except when indicated.)

8.	Sleep Apnea Syndi (check all that apply to you		been diagnose	d with sleep apnea o	or not)		
	Morning headaches	Yes	□ No				
	Daytime drowsiness	☐ Yes	□ No				
	Restless sleep	Yes	□ No				
	Snoring	Yes	□ No				
	Awakenings at night (including choke or o		□ No				
	Observed apnic epis	sodes Yes	□ No				
	Last sleep study (mo	onth/year)					
	Have you been diag	nosed with sleep	apnea?	□ Yes	□ No	Year diagnosed.	
	CPAP used	Yes	□ No	Setting			
10.	Barrett's esophagitis Endoscopy		□ No □ No	Year diagnos	sed		
11.	Hiatus hernia Upper GI series Endoscopy		□ No □ No	Year diagnos	sed		
12.	Gastroesphageal ref ☐ Taking medications	•	Yes [∃ No Year	diagnosed		
13.	Gallbladder disease	□ Yes	□ No				
	How was it diagnose	ed?□ Ultras	ound 🗆 Phy	sical exam	Year diagnos	sed:	
	Did you have your g	allbladder remove	ed? 🗆 Yes	s □ No			
	If yes, was it remove	ed: Laparoscop	ically Ope	en procedure			
14.	Stress Incontinence Wear pads frequent	•	e with laugl □ No	ning/coughing/s	sneezing)	□ Yes □ No	
15.	Diagnosis of Chronic	Joint Disease	□ Yes	□ No			
	How was it diagnose	ed?	<u> </u>	_	Year:		
	What treatments have	ve been prescribe	ed to you by a	a medical doctor	(check all tha	t apply):	
	□ Physical therapy	☐ Lifestyle mod	ification				
	Medication	Type of medicat	ion:		<u> </u>		
	□ Surgery	Type of surgery					

(The patient completes all information requested **except when indicated**.)

16.	•	□ Yes	□ No			
	How was it diagnosed?			ear:		
	What treatments have been preso		medical doctor (ch	eck all that apply):		
	☐ Physical therapy ☐ Splints/Ins	serts				
	☐ Medication Type of med	ication:				
	☐ Surgery Type of surg	ery:				
15.	Can you walk unassisted?	□ Yes	□ No			
	If no , do you use a: cane		□ No			
		□ Yes	□ No			
	wheelchair	□ Yes	□ No			
16.	Weight related injuries and traum	a				
17.	Swelling in legs	□ Yes	□ No			
18.	Thyroid disease ☐ Taking medications for thyroid dis	□ Yes sease	□ No			
19.	Do you have a personal history o	f blood clots in y	our arms, legs or	lungs? Yes	□ No	
20.	Have you ever been on a blood the lf yes, which medication:	inner to prevent	or treat the forma	ation of blood clots?	□ Yes	□ No
	□ Warfarin □ Coumadin	□ Lovenox	☐ Heparin	□ Other		
21.	Do you have any personal histor	y of problems w	ith your blood bei	ng too thin or too thic	k? □ Yes	□ No
22.	Deep Venous Thrombosis	□ Yes	□ No			
23.	Pulmonary Embolism	□ Yes	□ No			
24.	Hepatitis Which type (circle one):	□ Yes B C Unknown	□ No			
25.	Cancer Type: Treatment:	□ Yes	□ No			
26.						

Patient Name

Patient Name (The patient completes all information requested except when indicated.				
Past Medical History Please identify which of the fo	ollowing <i>childhood</i> illnes	sses and opera	ations you have expe	erienced. Year
Rheun	natic fever	Age		rear
	endectomy			
	sillectomy			
Please list below all serious il No Major Illness		□ No Major S		
Major Illno	ess	Date		Treatment
Major Surg	gerv	Date	Ope	en or Laparoscopic
	<i>y</i>		J _r	
FOR FEMALE PATIEN	TS ONLY:			
Age at first period:	Date of last period:			
Total # of Pregnancies:	# of live births:	# of m	iscarriages/abortions	s:
	Year		Weight at Start	Weight at Delivery
Pregnancy #1				
Pregnancy #2				
Pregnancy #3				
Pregnancy #4				
What were the birth weights of	of vour children: Child #1	·	Child #2:	Child #3:
Obstetric complications. :				
· —				
Preeclampsia:	Hypertension du	ring Pregnanc	/:	HELP syndrome:
Do you have Polycystic Ovari	ian Syndrome? Y N	Age at dia	gnosis:	
Do you consider yourself infe	rtile? Y N H	ave you unde	gone any treatment	for infertility? Y N
Do you presently use: Birth	control pills□ Yes	□ No	List type.	
Estro	ogens Yes	□ No	List type	

Patient Name			_	(The patient completes all information requested except when indicated .)
Allergic to surgical tape. If yes , please list reaction.	□ Yes	□ No		
Allergic to latex. If yes , please list reaction.		□ No		
Allergic to any medications.	□ Yes	□ No		
If yes , please list medication	n and reaction	on		
Please be accurate and use you	luding supp	lements, you n bottles to a	assist you with the	
Medication		Dose	and Frequency	Reason
Do you use tobacco?	□ Yes	□ No	Frequency.	
Are you willing to quit?	□ Yes	□ No		
Do you use alcohol?	□ Yes	□ No	Frequency	
Do you use illegal substances?	□ Yes	□ No	1	

□ kidney disease

(The patient completes all information requested except when indicated.)

	Living (circle one)	Current Age (if living)	Deceased at Age	Illness/ Cause of Death	Overweight/Obese
Mother	Yes · No				Yes · No
Father	Yes · No				Yes · No
Maternal Grandmother	Yes · No				Yes · No
Maternal Grandfather	Yes · No				Yes · No
Paternal Grandmother	Yes · No				Yes · No
Paternal Grandfather	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No

Please check if there is a family history of:		
high blood pressure	□ obesity	□ colon cancer

□ high blood cholesterol □ diabetes □ breast cancer □ bleeding tendency or blood disorder

☐ lung disease, asthma or emphysema ☐ deep vein thrombosis □ pulmonary embolism

☐ heart disease

☐ Hepatitis A B C Unknown (circle one)

Please list all the physicians whose care you are under. Please complete this section in full.

	First Name, Last Name	Address/City/State/Zip	Telephone	Email
Primary Care Physician				
Internist				
Gynecologist				
Orthopedist				
Psychiatrist				
Psychologist				
Therapist				
Other				

(The patient completes all information requested **except when indicated**.)

Patient Name								requested except wher	in in c
System Revie	w								
Please check a	all sympt	oms that you l	nave or ha	ave h	ad. Write in any add	itional pro	blems.		
Head, Eye, Ea	r, Nose,	and Throat	□ No Com	nplain	ts				
□ vertigo		□ headache			sinus problems	□ balan	ce disturba	ances	
□ pain in/arou	nd ears	□ nasal con	gestion		double vision	□ decrea	sed night	vision	
☐ dizziness		□ nasal drai	nage		ump in throat	☐ dyspha	asia		
☐ Rhinitis		□ hoarsenes	SS		ringing in ears	□ ear dra	ainage		
□ sore throat		□ blurred vis	sion	□h	earing loss	□ visual	aura		
□ Uvulectomy		□ buzzing in	ears	□ p	ain with swallowing				
Respiratory	□ No	Complaints							
_ cough		nchitis	□ blood	d in s	outum	□ wake	up at nigh	t short of breath	
□ asthma	□ em	ohysema			ath with exertion		_	t coughing or chokin	g
□ wheezing		two pillows			of breath at night			3 3	_
J		·			Ç				_
Cardiovascula	ar 🗆 No	o Complaints							
□ cold feet		□ heart attac	k		heart murmur		squeezi	ing of chest	
□ blue toes		□ pains in ne	eck		loss of pulses		□ skipping	g of heartbeat	
□ blue finger		□ pains in ar	ms		pounding of heart		□ high blo	ood pressure	
□ palpitations		□ pains in ch	est		irregular heartbea	t	abnorm	al electrocardiogram	í
□ pain in legs									_
Gastrointestir	nal □ N	·							
□ colitis		□ vomiting			irritable colon		•	in stomach	
□ cramps		□ heartburn			acid stomach			cking in chest	
□ nausea		□ gassiness			blood in stools			g fluid in throat	
☐ fissures		□ constipatio	n		burning in throat		□ pain with	h bowel movement	

□ pains in stomach

□ hemorrhoids

□ diarrhea

(The patient completes all information requested **except when indicated**.)

Genitourinary □ N	o Complaints		
□ nephritis	☐ kidney stones	□ pain with urination	☐ trouble stopping urine
□ blood in urine	□ bladder stones	□ small urine stream	☐ urinary tract infections
☐ kidney failure	☐ frequent urination	□ trouble starting urine	☐ getting up at night to urinate
☐ leakage of urine w	ith cough or sneeze		
Men □ No Complai	nts		
□ loss of erection	□ painful erection	☐ discharge from penis	0
Women □ No Com	plaints		
□ irregular periods	vaginal bleeding	vaginal discharge	□ pain with intercourse
Endocrine (Glandul	ar) □ No Complaints		
□ goiter	□ hyperthyroid	☐ grave's disease	□ adrenal gland tumor
□ diabetes	☐ x-ray to thyroid	☐ frequent flushing	☐ frequent heavy sweating
☐ low thyroid	☐ thyroid nodules		
Musculoskeletal 🗆	No Complaints		
□ flatfeet	□ foot pain	□ slipped disk	□ broken bones
□ sprains	□ knee pain	☐ fluid in joints	☐ herniated disk
□ arthritis	□ ankle pain	□ pain in joints	□ swelling of joints
□ sciatica	□ warm joints	□ low back pain	□ redness of skin over joints
□ hip pain			
Neurological □ No) Complaints		
□ fits	□ fainting	□ convulsions	☐ twitching of muscles
□ tremor	□ dizziness	☐ falling at night	□ loss of consciousness
□ vertigo	□ shakiness	☐ falling to the side	☐ pins & needles feelings
□ tingling	□ numbness	□ weakness of grip	□ weakness of any muscles
П			

Patient Name

(The patient completes all information requested except when indicated.)

Patient Name	requested except when indicated .
Psychological □ No Complaints	
□ major depression (once)	□ drug abuse/dependency
when?	psychotic disorder
□ major depression (twice or more)	□ anorexia
last episode?	bulimia
□ posttraumatic stress disorder	☐ generalized anxiety disorder
□ borderline personality disorder	□ panic disorder
□ schizophrenia	□ panic attacks
□ schizoaffective disorder	□ obsessive compulsive disorder
□ bipolar disorder	☐ in-patient hospitalization
□ manic depression	when?
☐ dissociative disorder	condition?
☐ dissociative identity disorder	□ psychotherapy
□ multiple personality disorder	when?
□ alcohol abuse/dependency	condition?
How did you hear about Scottsdale Healthcare ☐ Electronic Newsletter	Bariatric Center (please check one).
□ Family	□ Radio
□ Friend	□ Search Engine
□ Magazine	□ T.V.
□ Newspaper	□ Website
☐ Other (please explain)	
Have you attended a Scottsdale Healthcare Ba	riatric Center Informational Seminar?
□ No	
□ Yes	
□ When and Where?	

(The patient completes all information

Patient Name		requested except when indicated.
Race: (Please select one or more options)		
☐ White	☐ Asian (Please specify)	□ Native Hawaiian and Other Pacific Islander (Please specify)
	☐ Asian Indian	☐ Native Hawaiian
☐ Black or African American	☐ Chinese	☐ Guamanian or Chamorro

□ Samoan

☐ Other Pacific Islander

☐ Other race Ethnicity: (Please select one or more options) ☐ Hispanic or Latino (of any race): □ Not Hispanic or Latino Mexican □ Puerto Rican

Filipino

☐ Korean Vietnamese

Japanese

Other Asian

Clinical Study Participation:

Cuban

☐ Other Hispanic or Latino: _

☐ American Indian and Alaska Native

Tribal Affiliation

Scottsdale Healthcare Bariatric Center strives to provide our patients with various methods of achieving weight loss and is currently participating in clinical trials of new devices being tested for use in overweight/obese patients. If you are interested in participating in one of these clinical trials or want to at least discuss participation, check this box.

Yes, I am interested in learning more about the clinical studies being performed at Scottsdale Healthcare
Bariatric Center
No, I am not interested at this time.

Patient Name	(The patient completes all information requested except when indicated .)
Exercise	

Type of Exerc	cise	Duration (how	long each time)	Frequency (times per week
od Preferences cate which foods you	u prefer (which foo	ods would most like	ly make you go off a di	et).
cate which foods you		ich to 4-don't care		et). steaks/chops
cate which foods you lk each selection fron	m 1-like very mu	ich to 4-don't care eam).	
cate which foods you k each selection from candy	m 1–like very mu ice cre	uch to 4-don't care eam es	cakes/pies	steaks/chops
cate which foods you ik each selection from candy pizza	ice cre	eam es late	cakes/pies fried foods	steaks/chopssalad dressings

Food Diary

Please write down everything you ate or drank over the last 7 days.

	Date (Month/Day)	Breakfast	Lunch	Dinner	Other
1					
2					
3					
4					
5					
6					
7					

Scottsdale Healthcare Bariatric Center Diagnostic Questionnaire

The following questions are to help us determine a well suited program for your success. Please answer questions accurately to the best of your ability.

1.	Are you a large v YES	volume eater at NO	mealtimes	with min	imal snac	king bet	ween?	>
2.	Do you react to s	stress by eating	or snacking	g?	YES	NO		
3.	Do you consider	yourself typical	ly well disci	plined a	nd focuse	ed? YE	S	NO
4.	Name your top t	hree favorite foc	ods?					
a_		b			C			-
5.	Do you like to ea	at after 7pm?	YES	NO				
6.	Do you have eith	ner diabetes or i	nsulin resis	tance?	YE	S	NO	
7.	_	uccessful weight ur maximum we g did it take you	ight loss?			NO		
8.	Can you refrain	from drinking ald	cohol?	YES	NC)		
9.	Are you dependa	ant on anti-inflar	mmatory ag	ents?	YE	S	NO	
10.	Name stressor	s or triggers whi	·		•			
11.	Which bariatric							
	Medical We	ight Loss Progra	am, Ac	ljustable	Gastric E	Band, _	Sle	eve
	Lap Gastric	Bypass, E	3PD/Duode	nal Swite	ch, F	Revision		
	Other:							

Scottsdale Healthcare Bariatric Center (The patient completes all information requested except when indicated.) Patient Name Sample letter of medical necessity (INSERT LETTERHEAD HERE) (Date) Scottsdale Healthcare Bariatric Center 10210 N. 92nd St #101 Scottsdale, AZ 85258 Re: (insert patient name) Letter of Medical Necessity To whom it may concern: (patient name) is a (age) year-old male/female with a current weight of (weight) and a BMI of (BMI). He/She has (insert co-morbidities and any treatments being used). He/She has tried many diets in the past including (insert diets used and the outcomes). I believe (insert patient name) would benefit from weight loss surgery and have I have referred him/her to Scottsdale

Healthcare Bariatric Center, which is an American Society of Bariatric Surgeons, National Center of Excellence.

Sincerely,

(Signature)

(The patient completes all information

requested except when indicated.)

Patient Name

Scottsdale Healthcare Bariatric Center, PLC Surgical Fee Disclosure Laparoscopic Gastric Bypass Self-pay Discount Prices

	iscount Prices		
New Patient Consultation includes: Physicians consult Nutrition consults Psychological testing/evaluation		\$ \$ \$	350.00 0.00 325.00
Surgical Fee-gastric bypass (Surgery fee includes 1 year of follow-up appointment)	ents in office)	\$	7,700.00
Office visits -beyond one year		\$	75.00
Hospital Fee (no personal checks) (This payment is due the hospital 1 month prior to s	surgery)	\$ 1	14,500.00
Anesthesiologist (no personal checks) (Valley anesthesia will contact you within two week	ss of surgery)	\$	1,500.00
Miscellaneous - (estimate) (This is an estimate of lab work, chest x-ray and Elinsurance for some of these fees. Once you are so you can take to your primary care doctor)			
Additional Procedures, should you need them: Removal of Gallbladder (The hospital may have additional fees also) Hernia Repair		\$	750.00 750.00
Liver Biopsy The medical pand for a consendary curgical precedure conse	at always he prodicted prior to augree	\$	350.00
The medical need for a secondary surgical procedure cannot A deposit of \$3,850.00 is required to schedule a surgery doperative visit with the surgeon.		-	e at your pre-
Payment for the <i>Hospital only</i> will be made at the time of y usually two to three weeks prior to surgery. Contacts for the Scottsdale Healthcare			
Valley Anesthesia	480-748-2812		
Total payments for the surgical fees are due 30 days prior to surg Should any additional procedures be necessary, the remaining an Fees quoted are representative of Scottsdale Healthcare Bariatric hospital. When a laparoscopic procedure is converted to an open incision,	nount will be billed to you post-operatively c Center only. You may incur additional pro	and ofess	l is due upon receipt. sional fees while in the
I acknowledge the above and agree to the stated fees and	wish to move ahead with consultation		
Signature	Date		

(The patient completes all information

Patient Name

requested **except when indicated**.)

Scottsdale Healthcare Bariatric Center Surgical Fee Disclosure/<u>Laparoscopic Gastric Band</u> Self pay Discount Prices

New Patient Consultation includes: Physician consult		\$	350.00
Nutrition Psychological testing /evaluation		\$ \$	0.00 325.00
Surgical Fee Laparoscopic Gastric Band (Surgery fee includes 1 year of follow-up appoi	ntments in office)	\$	4,650.00
Office visits -beyond one year Fills -beyond one year		\$ \$	75.00 150.00
Facility Fee Scottsdale Healthcare Shea (No personal checks)		\$	10,350.00
Anesthesiologist (no personal checks) (Valley anesthesia will contact you within two weeks of sur	gery)	\$	900.00
Miscellaneous - (estimate) (This is an estimate of lab-work, chest x-ray and your insurance for some of these fees. Once you these tests so you can take to your primary car	ou are scheduled for surgery, we will give		
Additional Procedures, should you need them: Removal of Gallbladder		\$	750.00
(The hospital may have additional fees also) (This may Hernia Repair	be billable to your insurance)	\$	750.00
Liver Biopsy		\$	350.00
Payment for the Hospital only will be made at the time of usually two to three weeks prior to surgery. Contacts for the			
Scottsdale Healthcare	480-323-3168		
Valley Anesthesia	480-748-2812		
A deposit of \$2,325.00 is required to reserve a surgery dat visit with the surgeon. Total payment for the surgical fees is necessary, the remaining amount will be billed to you post-representative of Scottsdale Healthcare Bariatric Center or hospital. Initial	s due prior to surgery. Should any additional operatively and is due upon receipt. Fees qu	proce uoted	edures be are
When a laparoscopic procedure is converted to an open in The medical need for a secondary surgical procedure cannoccur and an additional surgery is required, that surgery is Initial	not always be predicted prior to surgery. If a	comp	lication may
I acknowledge the above and agree to the stated fees a	and wish to move ahead with Consultation	n.	
Signature	Date		

(The patient completes all information

requested except when indicated.)

Scottsdale Healthcare Bariatric Center, PLC Surgical Fee Disclosure Laparoscopic Gastric Sleeve Self-pay Discount Prices

Seil	-pay Discount Prices			
New Patient Consultation includes: Physician consults Nutrition consults Psychological testing /evaluation		\$ \$ \$	350.00 0.00 325.00	
Surgical Fee-Gastric Sleeve (Surgery fee includes 1 year of follow-up	appointments in office)	\$	5220.00	
Office visits (will take effect one year after surge	ery)	\$	75.00	
Facility Fee Scottsdale Healthcare Shea (No pers	sonal checks)	\$	12,780.00	
Anesthesiologist (no personal checks) (Valley anesthesia will contact you within two weeks	s of surgery)	\$	1,400.00	
Miscellaneous - (estimate) (This is an estimate of lab work, chest x-ray and insurance for some of these fees. Once you are you can take to your primary care doctor)				
Additional Procedures, should you need them: Removal of Gallbladder (The hospital may have additional fees a	lso)	\$	750.00	
Hernia Repair Liver Biopsy		\$ \$	750.00 350.00	
Payment for the <i>Hospital only</i> will be made at the tusually two to three weeks prior to surgery. Contact			•	
Scottsdale Healthcare	480-323	3-3168		
Valley Anesthesia	480-748	3-2812		
A deposit of \$2,610.00 is required to reserve a surgivisit with the surgeon. Total payment for the surgica necessary, the remaining amount will be billed to yo representative of Scottsdale Healthcare Bariatric Cehospital.	I fees is due prior to surgery. Should a ou post-operatively and is due upon red	ny addition ceipt. Fees	nal procedu s quoted are	res be
When a laparoscopic procedure is converted to an of the medical need for a secondary surgical procedure occur and an additional surgery is required, that sur	re cannot always be predicted prior to gery is billed separate and you will be	surgery. If responsib	a complica le for your p	tion may portion.
I acknowledge the above and agree to the st	tated fees and wish to move ahe	ad with c	consultatio	on.
Signature	 Date			