SCOTTSDALE HEALTHCARE®

Center of Excellence
BARIATRIC SURGERY℠

Robin Blackstone, MD, FACS

Mail completed packet to:
10200 North 92nd Street, Suite 225
Scottsdale, Arizona 85258

800.504.9567

www.ScottsdaleBariatric.com

Seminar is held at:

Scottsdale Healthcare Shea Hospital

9003 E Shea Blvd.

Scottsdale, AZ 85260

Located in the Conference Center

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Patient Name ____________________________________

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://scottsdalebariatric.com/2007/seminars/ or call 480-391-3885.

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 Dr. Emershad, Bariatrician 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.

You may bring the completed packet with you to the public seminar to submit to our office.

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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
        10200 North 92nd Street, Suite 225
        Scottsdale, Arizona 85258

    Please do not fax your completed new patient packet

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6. **When that 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 by our Licensed Clinical Psychologist specializing in Bariatric surgery.**
   - **Exercise Consultation**

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.***

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Patient Name ______________________________________

Please complete in ink.

New Patient Information	**Name**	**Date of Birth**	**Gender (circle one)** Male · Female
Address/City/State/Zip			
Home Phone	**Cell Phone**	**Social Security No.**	
Marital Status (circle one) Single · Married · Divorced · Widow · Other	**E-mail Address***		
Employer	**Work Phone**		
Emergency Contact	**Emergency Contact Phone**		
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Google · Direct Mailer · Other			

Insured Party Information	**Responsibility Party Name** **(if patient is under 18 OR other than patient)**	
Address/City/State/Zip		**Social Security No.**
Phone	**Date of Birth**	**Employer Name** **& Phone No.**

Physician Information	**Referring Physician/PCP** **(First Name, Last Name)**	**Phone**
Address/City/State/Zip		**Fax**
Pharmacy:		**Phone**

Insurance Information	**Primary Insurance**	
Primary Insurance **Address/City/State/Zip**		
Policyholder Name (if other than patient)		**Social Security no**
ID/Policy No	Group No	**Primary Insurance Phone**
Secondary Insurance		**Phone**
Policy holder name(if other than patient)	**Social security no**	
ID/Policy No		**Group #**

A copy of both sides of the insurance cards needs to accompany this form.

I authorize my insurance company to pay directly any and all claims submitted Scottsdale Healthcare Bariatric Center, PLC. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

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.

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Patient Name ____________________________________

AUTHORIZATION TO RELEASE RECORDS

The following information is required:

Patient Name: _________________________________ Social Security # ______________________

Address: _____________________________________ Date of Birth: _________________________

_______________________________________ Phone (Day): _________________________

I herby authorize release of my medical records:

TO: ____ **Phone:** _______________________________

Address: ___________________________________ **Fax:** _________________________________

FROM: ____ **Phone:** _______________________________

Address: ___________________________________ **Fax:** _________________________________

At my request, purpose for release:

☐ Personal ☐ Continuing Care ☐ Insurance ☐ Legal
☐ Research ☐ Marketing ☐ Other: ______________________________

☐ **All Records**
☐ **Other (please specify)** ____

Medical record reports covering date(s): ___________________________ **to** _______________________

- I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information.
- This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without prejudice.
- I may revoke this authorization at any time providing I notify Scottsdale Healthcare Bariatric Center, in writing to this effect.
- I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.
- I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

<u>This form must be completely filled out to process</u>

____ _____________________
Patient Signature Date

____ _____________________
Parent/Guardian/Power of Attorney/Personal Representative Date

____ _____________________
Records prepared and transmitted/Mailed by Date

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Patient Name ____

Patient History Questionnaire

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

Name		**Date**
Age	**Gender (circle one)** Male · Female	**Occupation**

	Patient Measurement	*Nurse Consult Measurement*	*Pre-Operative Measurement*
Height			
Initial Body Weight			
Ideal Body Weight			
Excess Body Weight			
10% Pre-op Excess Body Weight Loss Goal			
Target Weight			
Body Frame (circle one) Small Medium Large		*BMI*	*BMI*
		Waist	*Waist*
		Hips	*Hips*

Weight History

Please estimate as closely as possible for all that applies.

	Age	Weight
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight. ____

____

____

____

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Patient Name ___________________________

Dietary History

Approximate age when you first seriously dieted. ___________________________

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	
Fen/Phen/Redux	Yes · No			Yes · No	
Meridia	Yes · No			Yes · No	
Lindora	Yes · No			Yes · No	
T.O.P.S.	Yes · No			Yes · No	
O.A.	Yes · No			Yes · No	
Acupuncture	Yes · No			Yes · No	

List any physician-supervised and documented weight loss attempt. ___________________________

List all other diets and/or weight loss attempts. ___________________________

____

FOR FEMALE PATIENTS ONLY.	Year	Weight at Start	Weight at Delivery
Pregnancy #1			
Pregnancy #2			
Pregnancy #3			
Pregnancy #4			

Food Preferences

Indicate which foods you prefer (which foods would most likely make you go off a diet).
Rank each selection from **1–like very much** to **4–don't care**.

_____ **candy** _____ **ice cream** _____ **cakes/pies** _____ **steaks/chops**

_____ **pizza** _____ **potatoes** _____ **fried foods** _____ **salad dressings**

_____ **pasta** _____ **chocolate** _____ **chips/snacks** _____ **soda/soft drinks**

_____ **cookies** _____ **french fries**

How many times per week do you eat out: 1 2 3 4 5 6 7 or more

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Patient Name ___________________________________

Weight Related Illnesses

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease ☐ Yes ☐ No Year diagnosed. ______
(check all that apply to you)

- ☐ Angina ☐ M.I. (myocardial infarction)
- ☐ Abnormal EKG ☐ CABG (coronary artery bypass graft)
- ☐ Palpitations ☐ Stress test to rule out cardiac problems

2. High Cholesterol ☐ Yes ☐ No Year diagnosed. ______
(check all that apply to you)

- ☐ High triglycerides

3. High Blood Pressure ☐ Yes ☐ No Year diagnosed. ______

Average pressure. ___________________________________

List dietary restrictions. ___________________________________

4. Pre-Diabetes ☐ Yes ☐ No Year diagnosed. ______

5. Diabetes ☐ Yes ☐ No Year diagnosed. ______

Gestational .... ☐ Yes ☐ No

Neuropathy .... ☐ Yes ☐ No

Controlled with..................... ☐ Diet ☐ Insulin

Last fasting blood sugar. ____________________

6. Asthma ☐ Yes ☐ No Year diagnosed. ______

ER visits in last 2 years. ___________________________________

Hospitalizations in last 2 years. ___________________________________

Steroids used in last 2 years .... ☐ Yes ☐ No

7. Shortness of Breath ☐ Yes ☐ No

Can walk on level ground – how long? __________________________blocks

How many stairs? ____flights

8. Sleep Apnea Syndrome ☐ Yes ☐ No Year diagnosed. ______

Last sleep study (month/year). ___________________________________

CPAP used .... ☐ Yes ☐ No Setting. ____________

Morning headaches .... ☐ Yes ☐ No

Daytime drowsiness .... ☐ Yes ☐ No

Restless sleep .... ☐ Yes ☐ No

Snoring .... ☐ Yes ☐ No

Awakenings at night .... ☐ Yes ☐ No

Observed apnic episodes .... ☐ Yes ☐ No *Sleep study ordered.* ______ *(initials)*

Provider Comments

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Patient Name ____________________________________

9. **Obesity hyperventilation syndrome** ☐ Yes ☐ No

10. **Coughing or choking at night** ☐ Yes ☐ No

11. **Heartburn/esophagitis/hiatus hernia** ☐ Yes ☐ No
    Year diagnosed. _________
    Upper GI series .... ☐ Yes ☐ No
    Endoscopy.......................... ☐ Yes ☐ No *UGI/endoscopy ordered.* ______ *(initials)*

12. **Belching acid or sour fluid in back of throat** ☐ Yes ☐ No

13. **Gallbladder disease** ☐ Yes ☐ No
    How was it diagnosed? .... ☐ Ultrasound ☐ Physical exam Year. _______

14. **Leakage of urine with laughing/coughing/sneezing** ☐ Yes ☐ No
    Wear pads frequently .... ☐ Yes ☐ No

15. **Low back strain/pain/sciatica** ☐ Yes ☐ No
    Seen by chiropractor .... ☐ Yes ☐ No
    Seen by orthopedic surgeon .... ☐ Yes ☐ No
    Seen by family doctor .... ☐ Yes ☐ No

16. **Pain in hips** ☐ Yes ☐ No
    Pain in knees ☐ Yes ☐ No
    Pain in ankles ☐ Yes ☐ No
    Pain in feet ☐ Yes ☐ No
    Seen by chiropractor .... ☐ Yes ☐ No
    Seen by orthopedic surgeon .... ☐ Yes ☐ No
    Seen by family doctor .... ☐ Yes ☐ No

17. **Walk Unassisted** ☐ Yes ☐ No
    If **no**, do you use a: cane .... ☐ Yes ☐ No
    walker..................... ☐ Yes ☐ No
    wheelchair.............. ☐ Yes ☐ No

18. **Weight related injuries and trauma** ________________________________

19. **Swelling in legs** ☐ Yes ☐ No

20. **Thyroid disease** ☐ Yes ☐ No
    Are you presently taking medications? ... ☐ Yes ☐ No

21. **Irregular period or infertility** (FOR FEMALE PATIENTS ONLY) ☐ Yes ☐ No
    If yes, please explain: ____

Provider Comments

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Patient Name ______________________________________

Provider Comments

22. Do you have a personal history of blood clots in your arms, legs or lungs?

☐ Yes ☐ No

23. Have you ever been on a blood thinner to prevent or treat the formation of blood clots?

☐ Yes ☐ No

If yes, please list the medication:

Warfarin ☐
Coumadin ☐
Lovenox ☐
Heparin ☐

24. Do you have any personal history of problems with your blood being too thin or too thick?

☐ Yes ☐ No

Other Major Illness:

☐ Deep Venous Thrombosis ☐ Pulmonary Embolism

☐ Hepatitis A B C Unknown (**circle one)** ☐ Cancer

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Patient Name ______________________________

Past Medical History

Please identify which of the following **childhood** illnesses and operations you have experienced.

	Age	Year
Rheumatic fever		
Appendectomy		
Tonsillectomy		

FOR FEMALE PATIENTS ONLY.		Number of pregnancies	
Age at first period		**Number of live births**	
Date of last period		**Miscarriages/abortions**	

What were the birth weights of your children: Child #1: ______________ Child #2: ____________________

Obstetric complications. : ____

____

____

Preeclampsia: ______________ Hypertension during Pregnancy: __________ HELP syndrome: __________

Tachycardia of pregnancy? ____

Do you have Polycystic Ovarian Syndrome? Y N Age at diagnosis:______________________________

Do you consider yourself infertile? Y N Have you undergone any treatment for infertility? Y N

Do you presently use: Birth control pills.........☐ Yes ☐ No List type. ______________________

Estrogens ....☐ Yes ☐ No List type. ______________________

Please list below all serious illnesses and hospitalizations you have experienced in **adulthood**.

☐ No Major Illness ☐ No Major Surgery

Major Illness	Date	Treatment

Major Surgery	Date	Open or Laparoscopic

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Patient Name ______________________________

Allergic to any medications. ☐ Yes ☐ No
If **yes**, please list medication and reaction. ______________________________

Allergic to surgical tape. ☐ Yes ☐ No
If **yes**, please list reaction. ______________________________

Allergic to latex. ☐ Yes ☐ No
If **yes**, please list reaction. ______________________________

Current Medications ☐ Not on any medications
Please list **ALL** medications you currently use, including dose, frequency and reason for use. Please be accurate and use your prescription bottles to assist you with the spelling.

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

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Patient Name ____________________________________

	Living (circle one)	Current Age (if living)	Deceased at Age	Illness/ Cause of Death
Mother	Yes · No			
Father	Yes · No			
Maternal Grandmother	Yes · No			
Maternal Grandfather	Yes · No			
Fraternal Grandmother	Yes · No			
Fraternal Grandfather	Yes · No			
Sibling	Yes · No			
Sibling	Yes · No			
Sibling	Yes · No			
Sibling	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
- ☐ heart disease
- ☐ kidney disease
- ☐ lung disease, asthma or emphysema
- ☐ deep vein thrombosis
- ☐ pulmonary embolism
- ☐ 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
Primary Care Physician			
Internist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Therapist			
Other			

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System Review

Please check all symptoms that you have or have had. Write in any additional problems.

Head, Eye, Ear, Nose, and Throat. ☐ None

☐ vertigo	☐ headache	☐ sinus trouble	☐ loss of hearing	☐ trouble swallowing
☐ earache	☐ stuffy nose	☐ double vision	☐ buzzing in ears	☐ discharge from ear
☐ dizziness	☐ runny nose	☐ lump in throat	☐ loss of balance	☐ haloes around light
☐ hay fever	☐ hoarseness	☐ ringing in ears	☐ loss of night vision	☐ pain with swallowing
☐ sore throat	☐ blurry vision	☐ ____________________		

Respiratory ☐ None

☐ cough	☐ bronchitis	☐ blood in sputum	☐ wake up at night short of breath
☐ asthma	☐ emphysema	☐ out of breath with exertion	☐ wake up at night coughing or choking
☐ wheezing	☐ use two pillows	☐ shortness of breath at night	☐ ____________________

Cardiovascular ☐ None

☐ cold feet	☐ heart attack	☐ heart murmur	☐ squeezing of chest
☐ blue toes	☐ pains in neck	☐ loss of pulses	☐ skipping of heartbeat
☐ blue finger	☐ pains in arms	☐ pounding of heart	☐ high blood pressure
☐ palpitations	☐ pains in chest	☐ irregular heartbeat	☐ abnormal electrocardiogram
☐ pain in legs	☐ ____________________		

Gastrointestinal ☐ None

☐ colitis	☐ vomiting	☐ irritable colon	☐ burning in stomach
☐ cramps	☐ heartburn	☐ acid stomach	☐ food sticking in chest
☐ nausea	☐ gassiness	☐ blood in stools	☐ belching fluid in throat
☐ fissures	☐ constipation	☐ burning in throat	☐ pain with bowel movement
☐ diarrhea	☐ hemorrhoids	☐ pains in stomach	☐ ____________________

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Patient Name ______________________________________

Genitourinary ☐ **None**

☐ 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 with cough or sneeze ☐ ______________________________________

Men ☐ **None**

☐ loss of erection ☐ painful erection ☐ discharge from penis ☐ ____________________

Women ☐ None

☐ irregular periods ☐ vaginal bleeding ☐ vaginal discharge ☐ pain with intercourse
☐ ____

Endocrine (Glandular) ☐ None

☐ goiter ☐ hyperthyroid ☐ grave's disease ☐ adrenal gland tumor
☐ diabetes ☐ x-ray to thyroid ☐ frequent flushing ☐ frequent heavy sweating
☐ low thyroid ☐ thyroid nodules ☐ ______________________________________

Musculoskeletal ☐ None

☐ 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 ☐ None

☐ 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
☐ ____

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Patient Name ______________________________

Psychological ☐ **No symptoms**

☐ major depression (once)
when? ______________________________
☐ major depression (twice or more)
last episode? ______________________________
☐ posttraumatic stress disorder
☐ borderline personality disorder
☐ schizophrenia
☐ schizoaffective disorder
☐ bipolar disorder
☐ manic depression
☐ dissociative disorder
☐ dissociative identity disorder
☐ multiple personality disorder
☐ alcohol abuse/dependency

☐ drug abuse/dependency
☐ psychotic disorder
☐ anorexia
☐ bulimia
☐ generalized anxiety disorder
☐ panic disorder
☐ panic attacks
☐ obsessive compulsive disorder
☐ in-patient hospitalization
when? ______________________________
condition? ______________________________
☐ psychotherapy
when? ______________________________
condition? ______________________________

How did you hear about Scottsdale Healthcare Bariatric Center (please check one).

☐ Electronic Newsletter
☐ Family
☐ Friend
☐ Magazine
☐ Newspaper

☐ Physician referral
☐ Radio
☐ Search Engine
☐ T.V.
☐ Website

☐ Other (please explain) ______________________________

Have you attended a Scottsdale Healthcare Bariatric Center Weight Loss Surgery Seminar?

☐ No
☐ Yes
☐ When and Where? ______________________________

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Race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Radio
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Clinical Study Participation:

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 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.**

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Patient Name ______________________________________

Exercise

What kinds of exercise, if any, do you do?

Type of Exercise	Duration (how long each time)	Frequency (times per week)

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					

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Patient Name ___________________________________

Scottsdale Healthcare Bariatric Center
What Procedure is Right for you?

1. Are you a large volume eater at mealtimes with minimal snacking between?
YES NO

2. Do you react to stress by eating or snacking? YES NO

3. Do you consider yourself typically well disciplined and focused? YES NO

4. Name your top three favorite foods?

a.___________ b. ____________ c.______________

5. Do you like to eat after 7 pm? YES NO

6. Do you have either diabetes or insulin resistance? YES NO

7. Have you had successful weight loss in the past? YES NO
   a. If so, your maximum weight loss? ______ lbs.
   b. How long did it take you? __________

8. Can you refrain from drinking alcohol**?** YES NO

9. Are you dependant on anti-inflammatory agents**?** YES NO

10. Name stressors or triggers which may cause inappropriate eating?

_____________, ___________, ____________, ____________

11. Which procedure are you most interested in?

___Adjustable Gastric Band, ___ Lap Gastric Bypass, ___ Revision

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Patient Name ______________________________________

Sample letter of medical necessity

(*INSERT LETTERHEAD HERE*)

(*Date*)

Robin Blackstone MD
10200 N. 92nd St #225
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*)

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Patient Name ____________________________________

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

New Patient Consultation includes:	
Physician consult	$ 350.00
Nutrition consults	$ 0.00
Psychological testing/evaluation	$ 325.00
Surgical Fee-gastric bypass	$ 7,700.00
(Surgery fee includes 1 year of follow-up appointments in office)	
Office visits –beyond one year	$ 75.00
Hospital Fee (no personal checks)	$ 14,500.00
(This payment is due the hospital 1 month prior to surgery)	
Anesthesiologist (no personal checks)	$ 1,500.00
(Valley anesthesia will contact you within two weeks of surgery)	
Miscellaneous - (estimate)	$ 1,000.00
(This is an estimate of lab work, chest x-ray and EKG required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary car doctor)	
Additional Procedures, should you need them:	
Removal of Gallbladder	$ 750.00
(The hospital may have additional fees also)	
Hernia Repair	$ 750.00
Liver Biopsy	$ 350.00

The medical need for a secondary surgical procedure cannot always be predicted prior to surgery.

A deposit of $4500 is required to schedule a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon.

Payment for the Hospital and Anesthesiologist will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Kijuana Wright – Bariatric Surgical Coordinator -Scottsdale Healthcare **480-355-6867**

Pat -Valley Anesthesia **480-323-3441**

Total payments for the surgical fees are due 30 days prior to surgery. Cancellation after that date will result in a 50% cancellation fee. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital.

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure.

I acknowledge the above and agree to the stated fees and wish to move ahead with consultation.

______________________________ ______________________
Signature **Date**

©2007 Scottsdale Healthcare Bariatric Center

Patient Name ____________________________________

Scottsdale Healthcare Bariatric Center, PLC

Surgical Fee Disclosure/Laparoscopic Gastric BAND
Self pay Discount Prices

New Patient Consultation: includes

Physician consult		$ 350.00
Nutrition		$ 0.00
Psychological testing/evaluation		$ 325.00
Surgical Fee-gastric BAND	Piper OP	$ 5,000.00
(surgery fee includes 1 year of follow-up appointments in office)	Hospital OR	$ 5,500.00
Office visits -beyond one year		$ 75.00
Fills -beyond one year		$ 250.00
Facility Fee (includes anesthesia)	Piper OP	$ 11,500.00
(no personal checks)	Hospital OR	$ 12,000.00
Miscellaneous -(estimate)		$ 1,000.00

(This is an estimate of lab-work, chest x-ray and EKG required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary care doctor.)

Additional Procedures, should you need them:

Removal of Gallbladder	$ 750.00
(The hospital may have additional fees also) (This may be billable to your insurance)	
Hernia Repair	$ 750.00
Liver Biopsy	$ 350.00

The medical need for a secondary surgical procedure cannot always be predicted prior to surgery.

A $3500 deposit is required to schedule a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon. In addition to the $3500 deposit made to Scottsdale Healthcare Bariatric Center, a deposit of $5750.00 for Piper and $6750.00 for Hospital OR is due to Scottsdale HealthCare Shea. This can be paid by contacting Alex Blake at (480) 323-1025. The second half of the facility fee will be due at the time of your Pre-operative Education Class (about 30 days prior to surgery). Failing to pay any of these deposits/balances at the time specified will result in rescheduling your surgery date.

Payment for the Hospital and Anesthesiologist will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Kijuana Wright –Bariatric Surgical Coordinator-Scottsdale Healthcare	480-355-6867
Pat-Valley Anesthesia	480-323-3441

Total payment for the surgical fees is due 30 days prior to surgery. Cancellation after that date will result in a 50% cancellation fee. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital.

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure.

I acknowledge the above and agree to the stated fees and wish to move ahead with Consultation.

______________________________ ____________________
Signature Date

©2007 Scottsdale Healthcare Bariatric Center

Patient Name ______________________________________

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

New Patient Consultation includes:	
Physician consult	$ 350.00
Nutrition consults	$ 0.00
Psychological testing/evaluation	$ 325.00
Surgical Fee-gastric bypass (Surgery fee includes 1 year of follow-up appointments 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 surgery)	$ 13,500.00
Anesthesiologist (no personal checks) (Valley anesthesia will contact you within two weeks of surgery)	$ 1,500.00
Miscellaneous - (estimate) (This is an estimate of lab work, chest x-ray and EKG required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary car doctor)	$ 1,000.00
Additional Procedures, should you need them:	
Removal of Gallbladder (The hospital may have additional fees also)	$ 750.00
Hernia Repair	$ 750.00
Liver Biopsy	$ 350.00

The medical need for a secondary surgical procedure cannot always be predicted prior to surgery.

A deposit of $4500 is required to schedule a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon.

Payment for the Hospital and Anesthesiologist will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Kijuana Wright – Bariatric Surgical Coordinator -Scottsdale Healthcare **480-355-6867**

Pat -Valley Anesthesia **480-323-3441**

Total payments for the surgical fees are due 30 days prior to surgery. Cancellation after that date will result in a 50% cancellation fee. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital.

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure.

I acknowledge the above and agree to the stated fees and wish to move ahead with consultation.

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