Stanley D. Hoehn, M.D.
Robert J. Aragon, M.D.

The Bariatric Center OF KANSAS CITY
Providing Surgical Solutions to Obesity

G. Brice Hamilton, M.D.
Ryan A. Strain, M.D.

23401 Prairie Star Parkway, Suite B300, Lenexa, Kansas 66227
Phone: (913) 677-6319 Fax: (913) 677-1540

Seminar Attendance Verification & Return of Medical Records Policy

By signing this form, I verify that I have attended the free patient informational Seminar presented by Dr. Stanley Hoehn, Dr. G. Brice Hamilton, Dr. Robert Aragon and Dr. Ryan Strain. Attendance includes **arrival at the scheduled beginning of the Seminar and presence until the end of the Power Point presentation by the Surgeon.** With my signature, I agree that my questions about the procedure(s) have been answered and my expected participation with the Program Guidelines is understood. With my signature, I agree that it is understood that any medical records obtained for determination of qualification for surgery **will not be returned to me** if I am not a candidate for surgery with this Program. The records will be destroyed 30-days after notification of non-candidacy.

Upon determination by you and your surgeon to proceed with surgery, services **REQUIRED** by your Program that your insurance **MAY** cover include, but are not limited to the following:

- Physician and Dietitian appointment(s)
- Psychology appointment(s)
- Upper Endoscopy (EGD)
- Home Sleep Testing (HST)
- Laboratory testing
- Physical Therapy Evaluation

A $250 Program Fee applies to ALL bariatric surgery patients. See Page 5 for a full description of the Program Fee.

Last Name (print): _____ **First Name (print):** _____

Signature: _____ **Today's Date:** _____

Date of Seminar Attendance: _____

Surgeon Preference (chose one): □ **Stanley Hoehn** □ **G. Brice Hamilton** □ **Robert Aragon** □ **Ryan Strain**

How did you hear about The Bariatric Center of Kansas City?

□ Physician Referral □ Personal Referral □ Google Ad □ Facebook Ad □ Internet Search □ Shawnee Mission Website

Name of the person / entity that referred you: _____

OFFICE USE ONLY: □ SDH □GBH □RDA □RAS Date Received: _____ Case Manager: _____

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Patient Demographics

To expedite the process of new patient information, please be sure to include a ***CLEAR*** copy of the front & back of your INSURANCE CARD(S) and a copy of the front of your DRIVER'S LICENSE. Be sure to ***FULLY COMPLETE*** this new patient informational / medical history packet. *Incomplete information may delay our ability to process new patient intake.*

~ Please complete using blue or black ink only – thank you! ~

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ **Social Security Number** _____ □ Male □ Female

Address _____ **Apartment** _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email Address _____

Age _____ **Height** _____ **Weight** _____ **BMI** _____ **Neck Circumference** _____

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed □ Undisclosed

Ethnicity: □ Caucasian □ African American □ Native American □ Asian □ Hispanic □ Pacific Islander / Hawaiian

Employment: □ Employed/Self Employed □Domestic Engineer □Student □ Retired □Disabled □Unemployed

Employer _____ **Occupation** _____ □ Full Time □ Part Time

Do you have health insurance? □ Yes □ No **Have you had a previous bariatric surgery?** □ Yes □ No

Surgical Interest: _____

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Consent to Release & Authorize Insurance Information

Insurance information is required, even if privately paying for surgery; Please be sure to ***FULLY*** *complete* this form.

Primary Insurance

PRIMARY Insurance Company _____ Policy Subscriber's Full Name _____ ☐ Patient is Primary Subscriber

Policy Number _____ Group Number _____

Subscriber's Social Security Number _____ Subscriber's Birth Date _____ Subscriber's Employer _____

Customer Service Phone Number _____ **Relationship:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

****

Secondary Insurance

SECONDARY Insurance Company _____ Policy Subscriber's Full Name _____ ☐ Patient is Primary Subscriber

Policy Number _____ Group Number _____

Subscriber's Social Security Number _____ Subscriber's Birth Date _____ Subscriber's Employer _____

Customer Service Phone Number _____ **Relationship:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

****

Tertiary Insurance

Please include a clear copy of the front & back of tertiary insurance card, if applicable

****

I authorize the office of Stanley D. Hoehn, M.D., G. Brice Hamilton, M.D., Robert D. Aragon, M.D. and Ryan Strain, M.D. (KC Bariatric, LLC) to release my personal and confidential information to my health insurance carrier for the purpose of verifying my coverage, benefits, payment information and researching coverage criteria &/or requirements.

Patient or Authorized Representative Signature _____ **Patient** (and Authorized Representative) **Name Printed** _____

Patient's Date of Birth _____ **Today's Date** _____

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Privacy Release Authorization

I, ______________________________, hereby give permission for KC Bariatric, LLC physician(s) and office staff to discuss my **medical condition and care** &/or **billing information** with the following person(s):

Name	**Relationship**	**Phone Number**

□ *Authorized to discuss MEDICAL CONDITION AND CARE* □ *Authorized to discuss BILLING INFORMATION*

Name	**Relationship**	**Phone Number**

□ *Authorized to discuss MEDICAL CONDITION AND CARE* □ *Authorized to discuss BILLING INFORMATION*

Name	**Relationship**	**Phone Number**

□ *Authorized to discuss MEDICAL CONDITION AND CARE* □ *Authorized to discuss BILLING INFORMATION*

* *

I, ______________________________, hereby give permission for KC Bariatric, LLC physician(s) and office staff to contact me at my listed phone number(s) and authorize the following (initial all that apply):

☐ You have my permission to identify your office when calling my □ **HOME** □ **CELL** □ **WORK** phone number(s) and to leave an abbreviated message on my voicemail or with a person identified above. ____________(INITIAL HERE)

☐ You have my permission to identify your office when calling my **WORK PHONE NUMBER** and leave the caller's name and phone number on my □ **WORK VOICEMAIL** (and / or) □ **WITH A CO-WORKER**. ____________(INITIAL HERE)

☐ **DO NOT** leave a message indicating any other information besides □ **PHYSICIAN'S NAME** □ **PRACTICE NAME** and CALLER'S NAME AND RETURN PHONE NUMBER ONLY. ____________(INITIAL HERE)

☐ **DO NOT LEAVE ANY KIND OF MESSAGE AT ALL.** ____________(INITIAL HERE)

* *

I, ______________________________, hereby understand that medical records must be requested in person or in writing which will require my signature or the signature of my authorized representative. I am acknowledging my accurate completion of this authorization.

______________________________ ______________________________

Patient or Authorized Representative Signature **Patient** (and Authorized Representative) **Name Printed**

______________________________ ______________________________

Patient's Date of Birth **Today's Date**

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Bariatric Program Fee

A Program Fee of $250 applies to ALL bariatric surgery patients. This Program Fee is for services not covered by your insurance carrier for bariatric surgery and the Fee will NOT be billed to your insurance. However, if you have a Flexible Spending Account, you may be able to use those funds to apply towards the Program Fee. The Program Fee is a separate charge not applicable to co-pays, deductibles and co-insurance charges required by your health insurance plan.

The services that your insurance carrier will not cover include, but are not limited to the following:

- 24 hour access to KC Bariatric medical providers
- Ongoing dietary support and materials
- Monthly support groups
- Special bariatric conferences and events
- KC Bariatric newsletters, continuing education and other materials

****

Please check and initial one option for payment. You will be expected to comply with the option that you choose:

☐ *I would like to pay the $250 Program Fee in full at my first surgeon visit* _____(INITIAL HERE)

☐ *I would like to pay the $250 Program Fee in three (3) installments with my first payment in the amount of $83.34 due on the first surgeon visit. The remaining two (2) payments of $83.33 will be set up on a payment plan.* _____(INITIAL HERE)

****

☐ **I UNDERSTAND MY CASE WILL NOT BE SUBMITTED UNTIL PAYMENT OF $250 IS PAID** _____(INITIAL HERE)

****

Please note: This form must be signed prior to your initial consultation with your surgeon. Without this form, you will not be able to continue in the KC Bariatric Program.

By signing this agreement, I am acknowledging my understanding of the Program Fee and my intention to follow through with the arranged payment plan.

_____ _____

Patient or Authorized Representative Signature **Patient** (and Authorized Representative) **Name Printed**

_____ _____

Patient's Date of Birth **Today's Date**

Revised 10/2017

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Current Medical Care

To expedite the process of new patient information and to give our physician(s) an opportunity to review your current medical condition(s) and case, please be sure to ***FULLY COMPLETE*** each question in the current medical care section.

Primary Care Physician & Preferred Pharmacy

PCP Name: _____ **Degree:** _____

Address: _____ **Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Office Phone: _____ **Office Fax:** _____ **Years of Care:** _____

Pharmacy Name: _____ **Pharmacy Phone:** _____ **Location:** _____

Current Prescription Medication List

Medication Name	Dose	Frequency	Purpose	Date Started

Current Non-Prescription Medication List

Vitamin / Mineral / Item Name	Dose	Frequency	Purpose	Date Started

Medication & Substance Allergies

Allergic Substance Name	Reaction to Substance
□ No Known Drug Allergies (NKDA)	□ Latex Allergy

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Medical History for Bariatric Surgery

To expedite the process of new patient information, please be sure to ***FULLY COMPLETE*** each question in the medical history section. Answers should be accurate and honest, as inaccurate or incomplete answers may *delay our ability to process new patient intake &/or obtain insurance authorization.*

Disease History

How many years have you been overweight? _____ How many years have you been trying to lose weight? _____

How long have you been researching or thinking about weight loss surgery? _____ Research Source: _____

Past Medical History Assessment

*Please answer all questions about your current &/or past history. Mark an "X" beside Yes or No for **every** question.*

CARDIOVASCULAR	**YES**	**NO**	**Physician Notes** (Office Use Only)
High Blood Pressure			
Congestive Heart Failure			
Ischemic Heart Disease			
Heart stress test			
Heart attack			
Stents placed in Heart			
Heart catheterization			
Angina chest pain			
Peripheral Vascular Disease			
Stroke			
Lower Leg Edema / Swelling			
Blood clot in leg or lung			
Vena Cava heart filter			

METABOLIC	**YES**	**NO**	Physician Notes (Office Use Only)
Diabetes Mellitus, Type 1			
Diabetes Mellitus, Type 2			
Fasting Glucose > 99 mg/dL			
Oral medication for Diabetes			
Insulin use			
Eye / Kidney problems			
High Cholesterol or Lipids			
Gout / High Uric Acid levels			
Thyroid			

PULMONARY	**YES**	**NO**	Physician Notes (Office Use Only)
Oxygen use at home			
Pulmonary Hypertension			
Asthma			
Inhaler use due to Asthma			

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Past Medical History Assessment *(continued)*

GASTROINTESTINAL	**YES**	**NO**	**Physician Notes** (Office Use Only)
Heartburn / Reflux / GERD			
Heartburn medication use			
Past anti-reflux surgery			
Barrett's Esophagus			
Crohn's Disease or Colitis			
Gallstones			
Gallbladder removal			
Abnormal liver tests			

MUSCULOSKELETAL	**YES**	**NO**	Physician Notes (Office Use Only)
Back Pain			
Back Pain requiring medication			
Hip / Knee / Ankle pain			
Joint pain requiring medication			
Fibromyalgia			
Joint replacement			
Back surgery			

REPRODUCTIVE (female)	**YES**	**NO**	Physician Notes (Office Use Only)
Polycystic Ovarian Syndrome			
Infertility			
Menstrual irregularities			
Hysterectomy			

GENERAL	**YES**	**NO**	Physician Notes (Office Use Only)
Stress urinary incontinence			
Sanitary pad use for leakage			
Pseudo tumor Cerebra			
Abdominal hernia			
Hernia repair			
Cane / Walker use			
Sores / rash in skin folds			
Previous weight loss surgery			
MRSA			
VRE			
Lupus / Autoimmune disease			

PSYCHOLOGICAL	**YES**	**NO**	Physician Notes (Office Use Only)
Anxiety			
Depression			
Bipolar disease			
Thoughts of suicide			
Suicide attempts			
Psychiatric treatment			
Psychological counseling			
Hospitalized for psychological issue(s)			

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Sleep Testing Assessment

*Testing for Sleep Apnea may be required to obtain clearance for bariatric surgery. Please be sure to **FULLY COMPLETE** each question in this section. Answers should be **accurate**, as inaccurate or incomplete answers may delay our ability to process &/or obtain insurance authorization.*

Sleep Testing & Treatment

* Have you had a previous sleep study? □ Yes □ No

If yes, approximately when & where: _____

* Have you had a prior diagnosis of Sleep Apnea? □ Yes □ No

* Do you currently use PAP therapy? □ Yes □ No

If yes: □ CPAP □ BiPAP □ AutoPAP □ Other: _____ Pressure: _____ cm H2O

* Who is your current Sleep Medicine Physician? _____

* Who provider your PAP therapy and supplies? _____

Notes: _____

_____

_____

****

Family Medical History Assessment

Please mark any condition(s) that have been diagnosed in biological relation(s) such as parents, grandparents, siblings. Please check all that apply:

□ High Blood Pressure □ Stroke □ Heart Disease / Heart Attack □ Obesity

□ Bleeding Disorder □ Cancer □ Clotting Disorder □ Diabetes

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Physical Exercise Assessment

Do you have any physical limitation(s) that make physical exercise difficult or impossible? ☐ Yes ☐ No ☐ Sometimes

If yes, please explain: ____________________

Do you have difficulty with basic mobility or self-care? ☐ Yes ☐ No **Do you use assistive devices to transport?** ☐ Yes ☐ No

Devices currently used (check all that apply): ☐ Cane / Walker ☐ Wheelchair / Scooter ☐ Crutches / Brace ☐ Prosthetic Device ☐ Oxygen

History of falls within last 12 months: ☐ Yes ☐ No How did it happen? ____________________

* *

Social Assessment

Do you use tobacco products / nicotine? ☐ Yes ☐ No **Have you used tobacco products / nicotine in the past?** ☐ Yes ☐ No

If Yes, type of tobacco / nicotine: ☐ Cigarettes / __________ packs per day ☐ Chewing tobacco ☐ Smokeless tobacco / vaping

Tobacco Use (frequency)**:** ☐ Rare (1-2 times / month) ☐ Occasionally (3 or less / week) ☐ Frequently (4+ / week or daily)

Have you quit using tobacco products / nicotine? ☐ Yes ☐ No **If yes, what / when was your quit date?** ____________________

Do you use alcohol? ☐ Yes ☐ No **If yes, what type?** ____________________

Alcohol Use (frequency)**:** ☐ Rare (1-2 times / month) ☐ Occasionally (3 or less / week) ☐ Frequently (4+ / week or daily)

Do you recreationally use drugs / medication(s) / substance(s)? ☐ Yes ☐ No **Have you used in the past?** ☐ Yes ☐ No

If yes, what type? ____________________

Recreational Drug Use (frequency)**:** ☐ Rare (1-2 times / month) ☐ Occasionally (3 or less / week) ☐ Frequently (4+ / week or daily)

Have you quit using recreational drug(s)? ☐ Yes ☐ No **If yes, what / when was your quit date?** ____________________

* *

Past Surgical History

SURGERY	METHOD (Note if done laparoscopically)	DATE	PHYSICIAN / LOCATION

Please list ANY OTHER medical problem(s) / surgical procedure(s) not listed in the Past Medical History Assessment: ____________________

____

Patient Name: ____________________ **Date of Birth:** ____________________

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Diet History

Please fill out the diet history form completely, with as much detail as possible. The information on this form is used for your Medical Necessity letter that is submitted to your health insurance provider. Documentation should reflect ALL weight loss efforts attempted, including but not limited to the following: Doctor Supervised, commercial programs, prescription diet pills, behavior modification, unsupervised diets and over-the-counter diet aides.

* *

Weight History

Please provide your highest weight, each year, in pounds:

2012 _______________ 2013 _______________ 2014 _______________ 2015 _______________ 2016 ______________

* *

History of Diet Program(s)

PROGRAM	DATE RANGE	DURATION	DOCTOR SUPERVISED	TOTAL WEIGHT LOSS
Acupuncture			YES / NO	
Alli			YES / NO	
Anorexia			YES / NO	
Atkins			YES / NO	
Beverly Hills Diet			YES / NO	
Bulimia / Purging (after eating)			YES / NO	
Doctor Supervised Diet(s)			YES / NO	
Fen-Phen / ReDux			YES / NO	
Grapefruit Diet			YES / NO	
Jenny Craig			YES / NO	
Low-Fat Diet			YES / NO	
Meridia			YES / NO	
Metabolife			YES / NO	
Nutri-System			YES / NO	
O. A.			YES / NO	
OptiFast / MediFast			YES / NO	
Pritikin			YES / NO	
South Beach Diet			YES / NO	
T.O.P.S.			YES / NO	
Weight Watchers			YES / NO	
Zone Diet			YES / NO	

Additional Diet Notes: ____

____

____

Patient Name: ____ **Date of Birth:** ___________________________

Revised 10/2017