

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

THE Bariatric Center OF KANSAS CITY

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 Internet Search Advent Health Website Social Media

Other Referral Source: _____

Name of the person/entity that referred you: _____

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

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
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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	

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

Surgical Interest: _____

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

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
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Today's Date

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

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

Patient Name: _____ Date of Birth: _____

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.

<u>CARDIOVASCULAR</u>	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	_____	_____	_____

<u>METABOLIC</u>	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	_____	_____	_____

<u>PULMONARY</u>	YES	NO	Physician Notes (Office Use Only)
Oxygen use at home	_____	_____	_____
Pulmonary Hypertension	_____	_____	_____
Asthma	_____	_____	_____
Inhaler use due to Asthma	_____	_____	_____

Patient Name: _____

Date of Birth: _____

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)	_____	_____	_____

Patient Name: _____

Date of Birth: _____

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 |

Patient Name: _____ Date of Birth: _____

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: _____

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:

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: _____