KC BARIATRIC, LLC

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## Online Seminar Verification and Application for Bariatric Surgery

Thank you for your interest in our program. Please submit the form and upload your driver's license and the front and back side of your insurance card if applicable as part of the application.

For questions, call our Bariatric Initial Care Specialist at 913-948-5370 or email us at: packet@kcbariatric.com

## Personal Information

**Last Name:** _____ **First Name:** _____ **MI:** _____

**Date of Birth:** _____ **Social Security #** _____

□ **Male**
□ **Female**

**Address** **Apartment**

_____ _____

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

_____ _____

_____ _____ _____

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

_____

**Email Address**

_____ _____ _____ _____ _____

**Age** **Height** **Weight** **BMI**

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

**Ethnicity**: □ Caucasian □ African American □ Native American □ Asian □ Hispanic □ Pacific Islander

**Employment**: □ Employed/Self Employed □Domestic Engineer □Student □ Retired □Disable □Unemployed

□ Full Time □ Part-Time

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**Employer** **Occupation**

**Have you had a previous bariatric surgery?**

□ No □ Yes □ gastric by-pass □ gastric sleeve □ lap-band

**Surgical Interest**: □ gastric by-pass □ gastric sleeve

**Surgeon Preference:** □ Stanley Hoehn □ G. Brice Hamilton □

Robert Aragon **How did you hear about KC Bariatric?**

□ Physician Referral □ Personal Referral □ Google Ad □ Internet Search □ Instagram □ Facebook □ Advent Health □ Other: _____

**Would you be using your health insurance for bariatric surgery?**

□ Yes

□ No, I would like to pay cash or with a non-cash payment such as care credit, credit card, cashier's check, etc.

**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: _____

## Program Fee

A Program Fee of $250 applies to all bariatric surgery patients. This program fee is a separate charge for services not covered by your insurance carrier for bariatric surgery and the fee will not be billed to your insurance. 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 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

**Select the following:**

□ I would like to pay the $250 Program Fee in full at my first surgeon visit.

□ 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.

□ I understand my case will not be submitted until program fee is paid.

Once you and your surgeon decide to proceed with weight loss surgery, the services listed below are required to provide for your safety and our quality standards. Your Insurance may cover the following:

- Physician and Dietitian appointment (s)
- Psychology appointment (s)
- Upper Endoscopy (EGD)
- Home Sleep Testing (HST) and DME equipment
- Laboratory testing

By signing this application,

□ I verify that I have watched the patient informational seminar presented by our doctors. I agree that the information presented to me throughout the online seminar is understood.

□ I agree 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.

□ I authorize the 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.

□ 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** **Full Name of Patient or Authorized Representative**

**Date Online Seminar Viewed: _____** **Today's Date: _____**