SURGICAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (If applicable)

_____
Signature

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____(patient) _____(date of birth)
hereby give Surgical Associates, Inc. permission to discuss my medical and/or billing information with the following person/persons:

_____

_____

_____

Either by oral communication or written communication,
whichever is appropriate at the time.

I, _____(patient) _____(date of birth)
hereby give Surgical Associates, Inc. permission to leave messages on my voice mail_____.
e-mail_____or cell phone_____.

_____ _____
Patient Signature Date

Privacy Practice:
_____Individual Refused to Sign
_____Communication Barriers Prohibited Obtaining the Acknowledgment
_____ An Emergency Situation Prevented Us from Obtaining Acknowledgment
_____ Other

SURGICAL ASSOCIATES
Board Certified · General Surgery · Surgical Critical Care · Colon & Rectal Surgery
Suite 900, Warren Prof. Bldg., 6465 South Yale, Tulsa, OK 74136-7822 • 2950 South Elm Place, Suite 215, Broken Arrow, OK 74012-7816 • T. 918/481-4800 • 800/511-4377 • Fax 918/481-4826

PATIENT REGISTRATION AND AUTHORIZATION

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER	
DATE OF BIRTH	AGE	SEX ☐ M ☐ F	LANGUAGE ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Spanish ☐ Portuguese ☐ Other	MARITAL STATUS ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Never Married ☐ Single ☐ Widowed	
RACE ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other_____				ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
ADDRESS			CITY, STATE		ZIP CODE
TELEPHONE		PAGER/CELL PHONE		REFERRING PHYSICIAN	
EMPLOYER		EMPLOYER ADDRESS		CITY, STATE	ZIP CODE
EMPLOYER TELEPHONE		EXTENSION	PATIENT'S E-MAIL		

GUARANTOR

RELATIONSHIP TO PATIENT	GUARANTOR NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE / SEX ☐ M ☐ F
ADDRESS			CITY, STATE		ZIP CODE
TELEPHONE	PAGER/CELL PHONE		EMPLOYER		
EMPLOYER TELEPHONE					

EMERGENCY CONTACT			PHARMACY	
NAME		RELATIONSHIP TO PATIENT	NAME	
TELEPHONE	EMPLOYMENT TELEPHONE		LOCATION/ADDRESS	

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
ID#		ID#	GROUP#
PATIENT'S RELATIONSHIP TO SUBSCRIBER			
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
	DOB	SUBSCRIBERS SS#	DOB

FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION & FINANCIAL DISCLOSURE:

I assign to Surgical Associates, Inc., any and all health insurance benefits and other public and private benefits covering the medical treatment provided to me, and I direct that all payments for such services be made directly to Surgical Associates, Inc. I understand that I am financially responsible for all insurance deductibles, coinsurance payments and for the cost of all medical treatment that is not covered by insurance or for which there are no other benefits available.

Surgical Associates' physicians have an ownership interest in *Oklahoma Surgical Hospital, LLC, Artesian Cancer Center LLC, Breast PET, LLC and Sleep Solutions, LLC,* and your physician may refer you to one or more of these facilities for medical treatment. Please let your physician know if you have any questions about these medical facilities. By signing below, you acknowledge the disclosure of your physician's ownership interest in these medical facilities and you consent to treatment at these facilities.

I consent to the disclosure of my Protected Health Information to my health insurance provider, and to all other public and private providers of benefits, if any, for my medical treatment. I additionally consent to the disclosure of my Protected Health Information to all medical providers that are necessary for my medical treatment.

SIGNATURE_____ DATE_____

NAME_____ D.O.B._____

HISTORY AND PHYSICAL

PCP_____ Previous Gastric Surgery_____

REVIEW OF CO-MORBID CONDITIONS (Please complete in detail)

Pulmonary

Drowsy Days ☐Yes ☐No Shortness of Breath ☐Yes ☐No Asthma ☐Yes ☐No Age of Onset_____
Snoring ☐Yes ☐No Choking at night ☐Yes ☐No # of Pillows_____ Awake at night ☐Yes ☐No
Sleep Apnea ☐Yes ☐No Require Machine ☐Yes ☐No

Cardiovascular

Congestive Heart Failure ☐Yes ☐No Heart Attack ☐Yes ☐No Chest Pain ☐Yes ☐No
Hypertension☐Yes ☐No Take Meds ☐Yes ☐No Swelling of Ankles ☐Yes ☐No

Gastrointestinal

Ulcer/Gastritis ☐Yes ☐No Aspiration/Choking ☐Yes ☐No Heartburn ☐Yes ☐No Hiatal Hernia ☐Yes ☐No
Diagnosed GERD ☐Yes ☐No Nissen Procedure ☐Yes ☐No Gallbladder Disease ☐Yes ☐No
Frequency of Attacks_____ Year Removed_____

Genitourinary

Urinary Stress Incontinence ☐Yes ☐No How Often_____ Wear Pad ☐Yes ☐No

Diabetes

☐Yes ☐No Age of Onset_____ Physician_____ Control Good_____ Poor_____

Hyperlipidemia

☐Yes ☐No Age of Onset_____ Physician_____ Take Meds ☐Yes ☐No

Musculoskeletal

Arthritis ☐Yes ☐No Pain of Wt Bearing Joints: Back_____ Hips_____ Knees_____ Feet_____
Exercise Limitations: Mild_____ Moderate_____ Severe_____
Physical Limitations/Disabilities *(check all that apply)*

☐Climbing Stairs ☐Use of Public Seating ☐Airline Travel
☐Tying Shoelaces ☐Lifting Objects from Floor ☐Playing with Children
☐Caring for Personal Needs ☐Unusual Fatigue

Psychosocial

Depression ☐Yes ☐No Low Self-Esteem ☐Yes ☐No Social Behavior ☐Good ☐Poor

Weight Loss History

Age Obesity First Noted_____ Current Weight_____ Maximum Weight_____

Diet	Year	Wt Loss	# of months on program
Fen-Phen			
Redux			
Meridia			
Xenical			
Injections			
Weight Watchers			
Jenny Craig			
Richard Simmons			
Behavior Modification			
Overeaters Anonymous			
Hypnosis			
Acupuncture			
Nutritionist/Dietitian			
Psychiatrist/Therapy			
Exercise			
Opti-fast			
Physician Directed Diet Plan (List)			
Self Monitored Diets (List)			

NAME_____ D.O.B._____

Current Medications *(use separate sheet if necessary)*

		Drug	Dosage	Reason Prescribed
Aspirin	☐Yes ☐No	1._____	_____	_____
NSAIDS	☐Yes ☐No	2._____	_____	_____
Coumadin	☐Yes ☐No	3._____	_____	_____
		4._____	_____	_____
		5._____	_____	_____

Drug Allergies

_____Check if NONE

Drug	Reaction
1._____	_____
2._____	_____

Allergies

Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following:

Dye ☐Yes ☐No Iodine ☐Yes ☐No

Latex ☐Yes ☐No Rubber ☐Yes ☐No (Band-Aids, tape, spandex, balloons)*

Describe_____

_____

Operations

_____Year_____

_____Year_____

_____Year_____

_____Year_____

History of Surgical Complications

Bleeding ☐Yes ☐No

Anesthesia Problems ☐Yes ☐No

Blood Transfusion ☐Yes ☐No

Infections ☐Yes ☐No

Other Significant Conditions or Hospitalizations

_____Year_____

_____Year_____

Social History

Marital Status S:____ M:____ D:____ W:____ Feeling of Spouse about Surgery_____

Alcoholic Beverages: ☐None ☐Light ☐Moderate ☐Heavy

Smoking History ☐Never ☐Former Smoker Year quit_____

CURRENTLY Smoking: Packs per Day_____

When do you plan to stop smoking permanently?_____

Drug Use: ☐Yes ☐No Describe_____

Coffee/Caffeine Use: None_____ or _____Cups per day

Carbonated Beverages: None_____ or _____Sodas per day

NAME_____ D.O.B._____

Past Medical History

Rheumatic Fever	☐Yes ☐No	Diabetes	☐Yes ☐No	Hx of alcohol abuse	☐Yes ☐No
Scarlet Fever	☐Yes ☐No	Hepatitis	☐Yes ☐No	Hx of bleeding	☐Yes ☐No
TB	☐Yes ☐No	AIDS/HIV	☐Yes ☐No		

Family History (Have any Blood Relatives had)

Cancer ☐Yes ☐No Describe_____

Diabetes ☐Yes ☐No _____

Heart attack before Age 40 ☐Yes ☐No _____

Morbid Obesity ☐Yes ☐No _____

Hypertension ☐Yes ☐No _____

Review of Systems

OB/GYN Last Menstrual Period_____ Current Contraceptive Method_____

is it possible you are currently pregnant?_____

Pregnancies: Number of Pregnancies: _____ Number of Live Births:_____

☐1st pregnancy Age_____ Wt Gain_____

☐2nd pregnancy Age_____ Wt Gain_____

☐3rd pregnancy Age_____ Wt Gain_____

General

Hypertension	☐Yes ☐No	Fevers	☐Yes ☐No
Sweats	☐Yes ☐No	Fatigue	☐Yes ☐No
Rectal Bleeding	☐Yes ☐No	Loss of Appetite	☐Yes ☐No
Bloody Sputum	☐Yes ☐No	Persistent Cough	☐Yes ☐No
Deep Vein Thrombosis	☐Yes ☐No	Pulmonary Embolism	☐Yes ☐No
Emphysema/COPD	☐Yes ☐No	Coronary Artery Disease	☐Yes ☐No
Liver Disease	☐Yes ☐No	Heart Murmur	☐Yes ☐No
Varicose Veins	☐Yes ☐No	Thrombophlebitis	☐Yes ☐No
Colitis/Enteritis	☐Yes ☐No		

Skin

Rashes	☐Yes ☐No	Skin Cancer	☐Yes ☐No

Special Senses

Visual Problems	☐Yes ☐No	Hearing Problems	☐Yes ☐No
Ear Ringing	☐Yes ☐No	Dizziness	☐Yes ☐No

Neurologic

Headaches	☐Yes ☐No	Migraines	☐Yes ☐No
Seizures	☐Yes ☐No	Strokes	☐Yes ☐No
Memory Loss	☐Yes ☐No	Shaking	☐Yes ☐No
Numbness	☐Yes ☐No	In-coordination	☐Yes ☐No

Infections

AIDS contact	☐Yes ☐No	TB Exposure	☐Yes ☐No
Swollen Glands	☐Yes ☐No	Recurring Infections	☐Yes ☐No
Immunocompromised (HIV, Asplenia, Other)	☐Yes ☐No		

NAME_____ D.O.B._____

PSYCHOSOCIAL ASPECTS

Self-Esteem/Insecurities: _____

Social Behavior:_____

Family Interactions:_____

Sexual Activity:_____

Work Relations or Discrimination:_____

CONFIDENTIAL INFORMATION USED FOR PSYCHIATRIC EVALUATION

Have you ever had a time in you life when you felt depressed or down almost every day for at least 2 weeks?_____

_____

Any suicidal episodes?_____

_____

Have you ever had a problem with vomiting, fasting, excessive exercise or laxative use?_____

_____

_____

Do you overeat in reaction to feelings? (i.e. anxiety, anger, loneliness)_____

_____

_____

Is your family supportive?_____

_____

_____

Have you ever been treated or hospitalized for psychiatric reasons?_____

_____

_____

CURRENT PRESCRIBED PSYCHIATRIC MEDICATIONS: (Please list drug and dosage)

_____ _____

_____ _____

_____ _____

_____ _____

NAME_____ D.O.B._____

NUTRITIONAL HISTORY

Number of meals per day:_____ Eat between meals: ☐Yes ☐No

Do you drink sodas? ☐Yes ☐No (If yes, how many per day) Diet:_____ Regular:_____

How many glasses of water per day?_____

Food Preferences:	☐Candy	☐Fried Food	☐Fast Food
	☐Chocolate	☐Steak/Red Meat	☐Pizza
	☐Cakes/Pies	☐Seafood	☐Dairy Products
	☐Cookies	☐Chips/Snacks	☐Vegetables

YOUR FOOD PATTERN

Instructions:
PRODUCTS
Record the food and amount you've eaten over the last **two** days

	Food and Amount
Milk and Other Dairy	_____
Meat and Meat Alternatives	_____
Vegetables and Fruit	_____
Breads and Cereals	_____
Extra Foods	_____

PATIENT SIGNATURE:_____ DATE:_____

SURGICAL ASSOCIATES

Patient Name: _____ **BD:** _____

BARIATRIC SURGERY CONTRACT

This contract is to assist our patients with the surgery scheduling process. Our physicians and staff are committed to do everything possible to minimize the often frustrating experience of waiting for insurance authorization. Please read each statement carefully and initial the corresponding box to indicate that you have read and understand the contract.

1. ____I have attended a patient education lecture, received, read and understand the Bariatric Patient Protocol.
2. ____The risks and benefits of Roux-en-Y Divided Gastric Bypass and Laparoscopic Banding were explained at the lecture I attended.
3. ____I understand, based on my insurance, there may be a deposit or co-pay required and that there will be an assistant surgeon with a fee separate and additional to the surgeon's fee.
4. ____I understand there are additional fees for any other surgery performed at the same time as the RGB or Lap band (Removal of gallbladder, hernia repair, etc).
5. ____I understand fees for all preoperative evaluations, radiology and/or laboratory fees, hospital charges and anesthesia fees are billed separately, and I am responsible to provide billing and insurance information to these other providers. A deposit or co-pay may be required by some offices.
6. ____I understand all medical records over the last 5 years and a PCP support letter must be obtained and provided to my surgeon prior to the preoperative history and physical examination by my surgeon.
7. ____Operative records are required from any previous obesity surgery. I will obtain these records before the preoperative examination by the surgeon.
8. ____I understand insurance pre-authorization takes from two to eight weeks. If I wish surgery earlier, I understand a cash alternative is available.
9. ____I understand managed care pre-authorization must be obtained through my primary care physician or network and may take longer than eight weeks.
10. ____ I understand my surgeon must receive written insurance predetermination authorization before scheduling surgery with the hospital.
11. ____ I understand cash payments must be made and the financial agreement signed and returned one week prior to my scheduled surgery date.
12. ____ I understand it is my responsibility to be aware of my insurance benefits and to know which providers of services are covered by my insurance. I understand if I use facilities not covered under my insurance, I WILL BE RESPONSIBLE FOR ANY FEES INCURRED. I will provide my surgeon the name of participating labs and x-ray facilities BEFORE testing is ordered and/or obtained.
13. ____ I understand routine office visits with my surgeon are provided at no charge for the first three months unless otherwise contractually agreed. I further understand there will be charges for any blood tests or x-rays ordered by my physician.
14. ____ I understand and agree to comply with my surgeon's postoperative follow-up protocol. I agree to see my surgeon and family physician accordingly. It is my responsibility to provide both my surgeon and family physician with records from these visits.
15. ____ I agree to complete and return a yearly questionnaire with labs to my surgeon.
16. ____ Any medical condition that exists or develops, not in direct relationship to Gastric Bypass Surgery or Lap Banding, must be treated by my primary care physician, and I agree to coordinate my care with my surgeon. I understand my surgeon cannot treat me or fill prescriptions for other medical problems.
17. ____ I understand out-of-town patients may be required to make arrangements to stay in the area until released by their surgeon to return home.
18. ____ I understand that successful long-term weight loss is contingent upon compliance with the principles and guidelines of the Program.
19. ____ I understand this document.

PATIENT SIGNATURE:_____ DATE:_____

STAFF SIGNATURE:_____ DATE:_____

SAMPLE PCP SUPPORT LETTER

January 10, 2002

Steven Katsis, M.D./Kevin Fisher, D.O./Christopher Cole, D.O./Brandon Varnell,M.D.
Surgical Associates
6465 S. Yale, Suite 900
Tulsa, Ok 74136

Dear Dr. Katsis/Dr. Fisher/Dr. Cole/Dr.Varnell:

Jane Doe is a 42 year old patient of mine that I have seen for the past 5 years. She is 5' 6" and weighs 325 pounds. She has been medically managed on multiple diets and exercise programs over the last 5 years but has been unable to stabilize her weight. She suffers from hypertension and diabetes. I certainly agree that she would be a good candidate from her past history and review of systems for gastric bypass surgery or the gastric banding procedure. I will continue to follow her as her Primary Care Physician. Please let me know if I can be of any assistance.

Sincerely,

Dr. Who, M.D.

SA SURGICAL ASSOCIATES

FINANCIAL POLICY FOR BARIATRIC SURGERY

Financial planning is an important part of the Surgical Associates' Bariatric program. The following is a description of Surgical Associates' financial policy.

After you have attended an educational group meeting, you may wish to schedule an initial visit with the surgeon. If you have insurance coverage, Surgical Associates will file your insurance for your visit. You will be asked to pay your office visit co-pay at the time of service. If you do not have insurance coverage, you will be asked to pay for your office visit at the time of service.

Following your initial visit with the surgeon, our business office will begin the verification process with your insurance company. We will verify your specific insurance coverage for the bariatric procedure and determine what deductible and co-pay or "out of pocket" expenses you will be responsible for. These "out of pocket" expenses will need to be paid at your pre-operative appointment with the doctor. Someone from our business office will call you with the total amount due once this information has been collected. **Please note that this is an estimate only and is subject to change.**

In the event that you do not have insurance coverage, the fee for the bariatric procedure must be paid in full at least 7 days prior to your scheduled surgery date or your surgery may be postponed. Please contact our business office for these specific fees.

The above financial policy pertains to Surgical Associates fees only. Please understand that you will need to make separate financial arrangements with the other providers that are involved in your care.

If you have any questions about our financial policy, please feel free to call the Surgical Associates' business office at (918) 481- 4807.

Rev 09/15/2010

Surgical Associates Bariatric Program
Helpful Tips

1) Learn as much as you can about the surgery you want to have performed and the bariatric program.

Helpful websites:
www.satulsa.com
www.bariatricedge.com
www.realizeband.com

2) Determine if your insurance covers bariatric surgery. Call your insurance company by using the number on the back of your insurance card and ask if they cover gastric bypass surgery or gastric adjustable banding surgery. You can also call 1.866.REALIZE (732-5493) and they will help you determine your insurance coverage or discuss financing options with you.

3) If you don't have a 6 month diet within the last 2 years noted in your medical records, get started NOW and make sure it is noted in your PCP's records with monthly weigh-ins. This will ensure a quicker process through the program when its time.

4) ***Be patient***. This is not a quick process and Surgical Associates want to ensure that everything is in place so we can help you reach your goal of a ***healthier you***.

SURGICAL ASSOCIATES

Surgical Associates Bariatric Program

Discuss the surgery with your Primary Care Physician (PCP) and obtain a letter in support of you having the surgery. You must have this to see the Surgeon for a consult appointment. If your PCP does not support you for surgery, please contact us for a referral.

Obtain all Medical Records from the last 3 years documenting anything related to your obesity, including weight and diet history and documentation of co-morbid conditions, such as high blood pressure, diabetes, sleep apnea, etc. This can include any outside diet plans, such as Weight Watchers, Tops, Nutri-System, etc. Your surgeon, as well as your insurance company, will want to see a documented 3 – 6 month diet plan within the last 2 years. Some insurance companies are more strict than others. Please check in with your plan on specific requirements. It is advised to get on a documented diet now, including monthly weigh-ins, with your PCP, so you are that much further ahead if your insurance denies due to diet history.

Mail, fax or bring by your PCP support letter and medical records. Obtain any necessary insurance authorization from your PCP, if needed, for your consult appointment with the Surgeon.

Start attending Support Group Meetings. You are required to attend at least one before surgery, but are encouraged to attend as many as possible both before and after surgery. The meetings are the second Tuesday of each month at 6:00 p.m. at the address below.

Please be sure and send all info to:
Surgical Associates
Bariatric Program
6465 So Yale Ave., Suite 900
Tulsa, Oklahoma 74136
Fax – 918-481-4973

We hope to see you soon!
Please call one of our bariatric staff with questions (918-481-4800).