Dayton Bariatric & General Surgery Center

A Member of Kettering Physicians Network

Our Surgeons:
David E. Bruce, D. O.
Stephen R. Fleischer, D. O.

Our Locations:

7740 Washington Village Drive, Suite 110, Dayton OH 45459
(937) 439-4145 phone ✧ (937) 439-4371 fax ✧ 877-298-0200 toll free

Victor J. Cassano Health Center 165 S. Edwin C. Moses Blvd. Dayton OH 45402
(937) 558-0156 phone ✧ (937) 558-0158 fax

Demographic Packet

Your personal & family history

NOTE: This packet to be filled out COMPLETELY prior to your 1st appointment (H & P) with the surgeon

ATTACHED INFORMATION MUST BE COMPLETED FOR 1ST OFFICE VISIT WITH THE DOCTOR (Step 1)

TO ALL PATIENTS:

Thank you for your attendance at our surgical weight loss seminar. The attached information you complete will be reviewed by our physicians to determine if you qualify for weight loss surgery. This will help to insure that you receive the correct care.

This information is also used for submission to your insurance company for approval and for the hospital to have up-to-date information to care for you before, during and after your surgery. ***PLEASE FILL OUT FORMS COMPLETELY OR YOU MAY RISK DELAYING YOUR SURGERY FROM BEING SCHEDULED.***

Due to the importance of this information, **be sure to notify us IMMEDIATELY of any health condition updates and/or medication changes.** This will enable us to keep accurate and up-to-date health information on you. Also, if your surgery is not scheduled within 1 year of your attendance at this seminar, **you will be required to attend the seminar again.** We apologize for any future inconvenience that this may cause, but we do want your healthcare to have the best outcome possible!

PERSONAL & FAMILY HISTORY DISCLOSURE

- I have been educated as to the risk and benefits associated with a surgical weight loss alternative.
- I understand that it is very important to communicate to my doctor my personal and family medical history.
- I have communicated my personal and family medical history with the doctor on my paperwork.
- I understand that my care is affected by my personal and family medical history.
- I have notified the doctor of any previous weight loss surgeries that have been performed on me.
- I understand that if I have not notified the doctor of my previous information that it is my responsibility to notify the doctor immediately to keep my medical information up to date.
- I understand that if the doctor becomes aware of undisclosed medical information, that I risk my surgery being cancelled and/or being released from the practice.

_____**NO**, I DO NOT HAVE A HISTORY OF ANY SURGICAL WEIGHT LOSS PROCEDURE
_____**YES**, I HAVE HAD A PREVIOUS SURGICAL WEIGHT LOSS PROCEDURE

I am interested in the following procedure.

_____Adjustable Gastric Banding
_____ Roux-en-Y (Gastric Bypass)
_____Gastric Sleeve

I have read the above and understand the risks and benefits associated with a surgical weight loss alternative.

_____
Print Patient Name

_____
Patient Signature or responsible party

Forms provided at the end of this packet: Medical Records Release; PCP Clearance Form; Supervised Diet History Chart May be removed to take to your Physician to be completed for Insurance & Surgery Purposes

PERSONAL & FAMILY HISTORY DISCLOSURE

Patient Registration Form

Please **PRINT** Clearly (Use **ONLY** black or blue Ink)

PATIENT

LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE

EMAIL ADDRESS:	OCCUPATION	PRIMARY DUTIES

STREET ADDRESS	APARTMENT # OR P.O. BOX	PHONE #

CITY	STATE	ZIPCODE	CELLPHONE#

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	AGE	❑Married ❑Single ❑Widowed ❑Divorced

ETHNICITY (PLEASE CHECK ONE) ○ African Amer ○ Asian ○ Caucasian ○ Hispanic ○ Native Amer ○ Pacific Islander/Hawaiian ○ Other

YOUR EMPLOYER	❑Full-time ❑ Part-time ❑Self-employed ❑Homemaker ❑Retired ❑ Disabled ❑ Unemployed ❑Student

EMERGENCY CONTACT NAME:	Relationship to patient	EMERGENCY CONTACT NUMBER:

REFERRING PHYSICIAN NAME:	*REFERRING* PHYSICIAN #:	PRIMARY CARE PHYSICIAN **(PCP)** NAME:	PRIMARY CARE PHYSICIAN #:

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT ❑ CHECK HERE IF SAME AS ABOVE INFORMATION
❑CHECK HERE ***AND*** FILL OUT BELOW INFORMATION IF PATIENT IS UNDER 18

LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE

STREET ADDRESS	APARTMENT # OR P.O. BOX

ZIP CODE	STATE	ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	❑MARRIED ❑SINGLE ❑DIVORCED ❑WIDOWED

RESP PARTY EMPLOYER:	RESP PARTY OCCUPATION:	EMPLOYER PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME:	EFFECTIVE DATE:	IDENTIFICATION/SUBSCIBER#

SUBSCRIBER NAME(PERSON THAT HOLDS INSURANCE): ❑*CHECK HERE IF SAME AS PATIENT NAME*	GROUP NUMBER:

SUBSCRIBER SOCIAL SECURITY NUMBER:	**SUBSCRIBER** DATE OF BIRTH:	**SUBSCRIBER** EMPLOYER:

INSURANCE CLAIMS MAILING ADDRESS:	INSURANCE PHONE NUMBER:

SECONDARY INSURANCE COMPANY COVERAGE

INSURANCE COMPANY NAME:	EFFECTIVE DATE:	**IDENTIFICATION /SUBSCRIBER#**

SUBSCIBER NAME(PERSON THAT HOLDS INSURANCE): ❑CHECK HERE IF SAME AS PATIENT NAME	GROUP NUMBER:

SUBSCRIBER SOCIAL SECURITY NUMEBR:	**SUBSCRIBER** DATE OF BIRTH:	**SUBSCRIBER** EMPLOYER:

INSURANCE CLAIMS MAILING ADDRESS:	INSURANCE PHONE NUMBER:

RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as shown above. I assign all insurance payments to be made directly to this office. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions,. I agree that should this account be referred to an outside agency or an attorney for collections, I will be responsible for all collection cost , attorney fees and court cost. I have read and understand all of the above and have agreed to these statements.

_____ _____

PATIENT SIGNATURE (FULL NAME) DATE

PATIENT REGISTRATION

Patient Registration Form Part 2

PATIENT NAME:		DATE OF BIRTH	AGE
CURRENT HEIGHT	CURRENT WEIGHT	DATE OF LAST PHYSICAL EXAMINATION:	

REASON FOR TODAYS VISIT:
❑**H&P** (CONSULT) FOR A WEIGHT LOSS SURGERY PROCEDURE (LAP BAND OR GASTRIC BYPASS)
❑ **CONSULT FOR A GENERAL SURGERY** (EX: GALLBLADDER, HERNIA, BREAST, COLON, APPENDIX, CYST)
❑ **OTHER** (PLEASE EXPLAIN)

Drug Allergies (list all)		

Medications & Dosages (attach list if necessary)		
Medication Name	Medication Dosage	What condition is medicine take for?
1		
2		
3		
4		
5		
6		

Surgical History		
Surgery	*Month/Year*	*Hospital Name*

Medical History

Please circle yes or no if you have been treated for any of the following

AIDS OR HIV	YES NO	**EPILEPSY**	YES NO	**LOW BLOOD PRESSURE**	YES NO	**SEIZURE DISORDER**	YES NO
ANEMIA	YES NO	**GLAUCOMA**	YES NO	**MEASLES**	YES NO	**SLEEP APNEA**	YES NO
ASTHMA	YES NO	**HEART DISEASE**	YES NO	**MIGRAINES**	YES NO	**SMALL POX**	YES NO
BACK TROUBLE	YES NO	**HEMORRHOIDS**	YES NO	**MITRAL VALVE PROLAPSE**	YES NO	**STROKE**	YES NO
BLADDER INFECTIONS	YES NO	**HEPATITIS**	YES NO	**MUMPS**	YES NO	**THYROID DISEASE**	YES NO
BRONCHITIS	YES NO	**HERNIA**	YES NO	**OSTEOARTHRITIS**	YES NO	**TRANSFUSIONS**	YES NO
CANCER	YES NO	**HIGH BLOOD PRESSURE**	YES NO	**PNEUMONIA**	YES NO	**TUBERCULOSIS**	YES NO
CHICKENPOX	YES NO	**HIVES OR ECZEMA**	YES NO	**POLIO**	YES NO	**ULCERS**	YES NO
DIABETES	YES NO	**INFECTION MONO**	YES NO	**RHEUMATIC FEVER**	YES NO	**VENEREAL DISEASE**	YES NO
DIPTHERIA	YES NO	**KIDNEY DISEASE**	YES NO	**RHEUMATOID ARTHRITIS**	YES NO	**OTHER:** _____	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT REGISTRATION

Patient Registration Form Part 3

Please **PRINT** Clearly

PATIENT NAME:	**DATE OF BIRTH:**

FAMILY HISTORY

ANY BLOOD RELATIVE THAT HAVE HAD THE FOLLOWING LISTED BELOW:

ALLERGIES	YES NO, **RELATIONSHIP**:	**EPILEPSY**	YES NO, **RELATIONSHIP**:
ANEMIA	YES NO, **RELATIONSHIP**:	**HEART DISEASE**	YES NO, **RELATIONSHIP**:
BLEEDING	YES NO, **RELATIONSHIP**:	**HIGH BLOOD PRESSURE**	YES NO, **RELATIONSHIP**:
CANCER	YES NO, **RELATIONSHIP**:	**STROKE**	YES NO, **RELATIONSHIP**:
DIABETES	YES NO, **RELATIONSHIP**:	**TUBERCULOSIS**	YES NO, **RELATIONSHIP**:

SOCIAL HISTORY

Do you smoke? (cigars, cigarettes, marijuana)	YES	NO	If yes, quantity per day?
Do you drink alcohol?	YES	NO	If yes, quantity per day?
Do you drink caffeine?	YES	NO	If yes, quantity per day?
Do you or have you in the past used illegal drugs?	YES	NO	If yes, quantity per day?

OTHER HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING:

Psychological Evaluation	YES NO	**IF YES, When?**	**Physician Name**:_____		
EGD	YES NO	**IF YES, When?**	**Rubella Vaccine**	YES NO	**IF YES, When?**
Colonoscopy	YES NO	**IF YES, When?**	**Rectal Exam**	YES NO	**IF YES, When?**
Flu Vaccine	YES NO	**IF YES, When?**	**Stool in blood test**	YES NO	**IF YES, When?**
Tetanus Shot	YES NO	**IF YES, When?**	**Eye Exam**	YES NO	**IF YES, When?**
Hepatitis Vaccine	YES NO	**IF YES, When?**	**Cholesterol Test**	YES NO	**IF YES, When?**
Heart Cath	YES NO	**IF YES, When?**	**Prostate Exam (MEN ONLY)**	YES NO	**IF YES, When?**

WOMEN ONLY:

Age at onset of menstrual cycle?		**Date of last menstrual Cycle**?	
Do you use birth control?	Yes No	**If YES**, what type:	
Number of Pregnancies	**Number of Live Births**		
Number of Abortions	**Number of Miscarriages**		
Breast Exam	Yes No	**If YES**, when?	Doctor's Name
Mammogram	Yes No	**If YES**, when?	Doctor's Name
Pap smear	Yes No	**If YES**, when?	Doctor's Name

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT REGISTRATION

PATIENT PHYSICIAN HISTORY FORM

Please fill out the information below INCLUDING FAX #.

If the physician information does not pertain to you, please check the N/A box for that type of Physician.

PATIENT NAME:	**DATE OF BIRTH:**

Type of Physician	*Type of Physician*
Primary Care Physician (Family Doctor): ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Referring Doctor:** ☐ **n/a** __ ***check here if same as PCP*** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____
Cardiologist: ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Endocrinologist or Internal Medicine Doctor:** ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____
Psychologist or Psychiatrist: ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Pulmonologist:** ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____
Nephrologist: ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Oncologist:** ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____
Neurologist: ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Orthopedic Surgeon:** ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____
Pediatrician (17-21 ONLY) ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____	**Other Physician: Type: _____** ☐ **n/a** Name: _____ Address: _____ City/ST/ZIP: _____ Phone: (___) _____ fax (___) _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT PHYSICIAN HISTORY FORM

DIET HISTORY FORM PART 1

PATIENT NAME:	DATE OF BIRTH:

Were you heavy as a child?			
Do you snack between meals?			
Do you eat large meals?			
Do you eat a lot of sweets?			
How long have you been overweight?			
List all diet pills tried:			
Doctors seen for weight loss:			
List any injections:			
Have you used acupuncture?			
Do you go to a chiropractor?			
Do you use herbs of any sort?			
Do you smoke?		How many packs?	
Do you drink alcohol?		How many drinks per week?	
Are you chemically dependent?			
Have you ever had psychiatric care?			
What is your usual occupation?			
Are you currently employed?		Employer?	

Do you have any of the following conditions?

Diabetes		Ulcer	
High Blood Pressure		Kidney Disease	
Heart Disease		Arthritis	
Lung Problems		Gout	
Liver Disease		Neurological Problems	
Gallbladder Disease		Other Problems	

List any surgeries	
Allergies	

How being overweight bothers me:

Shortness of breath?	
Joint pains? If yes, please list.	
Leakage of urine?	
Social problems?	
Trouble fitting in chairs and/or finding clothes that fit?	
Other reasons why you feel weight loss surgery would benefit you:	
Do you suffer from any eating disorder?	
If yes, please list.	

Other:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

DIET HISTORY FORM – PART 1

DIET HISTORY FORM PART 2

Fill in the information requested below if you have participated in any of the following programs.

PATIENT NAME:	**DATE OF BIRTH:**

Name of Program	**Dates Followed Program**		**Doctor Supervised** *Yes or No*	**Pounds Lost**	**Pounds Regained**
	From	**To**			
Acupuncture					
Adipex					
Atkins					
American Heart Association					
Cabbage Diet					
Calorie Counting					
Carefast					
Diet Center					
Dexatrim					
Exercising					
Fasting					
Grapefruit Diet					
Herbal Diets					
Hypnosis					
Inpatient Psychiatric Program					
Ionamin					
Jenny Craig					
LA Weight Loss					
Low Fat					
Medifast					
Meridia					
Nutrisystem					
Overeaters Anonymous					
Outpatient Psychiatric Program					
Optifast					
Phenteramine/Fenfluramine					
Physicians Weightloss Center					
Pritikin					
Radar Institute					
Rice Diet					
Richard Simmons					
Redux					
Scarsdale					
Slim Fast					
South Beach					
Structure House					
Tops					
Teeth Wiring					
Ultimate Weight Loss Solutions					
Weight Watchers					
Xenical					
Zone					
Any other weight loss attempts not mentioned above (including surgical means):					

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

DAYTON BARIATRIC & GENERAL SURGERY CENTER
PHYSICIAN PROGRAM PROCEDURES & GUIDELINES
Page 1 of 2

1. Patients considering SURGICAL WEIGHT LOSS procedures are required to attend and sign in for our **INFORMATION SESSION on the SURGICAL WEIGHT LOSS.** This presentation includes risks and benefits of SURGICAL WEIGHT LOSS procedures and the expected outcome. This presentation is given by one of our doctors or representative of the program. The presentation is followed by a question and answer session. A packet is given that outlines the program along with forms that will need to be filled out and taken to the History & Physical appointment.
2. A **History & Physical appointment** is scheduled with one of our doctors. This is a one on one office visit with one of our doctors to discuss your information that is filled out in the packet you received from the information session and the possible medical necessity of the procedure. Medical necessity is determined by a number of factors; BMI risk, medical problems, personal and family history, or any other area the doctor feels needs addressed. Please alert the doctor to any problems you anticipate following surgery.
3. **Questions** are a valuable tool to understand what is expected and what your care will be. Ask the doctor questions.
4. Please bring a **list of all medications** you are currently taking and a **listing of any known allergies** to medications you may have to your History & Physical appointment. **Continue to bring a list to your office visits** to make sure our office is aware of your CURRENT medications.
5. A **medical record release form needs to be filled out** and given to your family physician and other specialists that we need records from. Feel free to run copies of the release if needed for more than one doctor. They can mail, fax us the records or you can bring them into our office yourself. Some physician offices can take several weeks or longer to get us the medical records. This is the responsibility of the patient to obtain these records. Delays in receiving these records can delay us from sending to your insurance carrier for approval.
6. **Full clearances from physicians caring for you** (i.e. cardiac, pulmonary, etc) are required prior to surgery approval. This is a requirement and NO exceptions will be made in order to avoid any potential health problems.
7. A **psychological evaluation from a licensed psychologist or licensed psychiatrist is required**. A letter on their office letterhead must be supplied stating their clearance for you from a psychological standpoint. It must be an up to date evaluation. This will need to be completed before paperwork can be submitted to insurance for approval.
8. **Nutritional consultations are required.** It must be performed by a licensed dietician/nutritionist and this is usually done at a local hospital. You can schedule this appointment or someone from our office can help you to schedule your appointment. Most insurance companies require nutritional consultations. If your insurance company does not pay for your consultation, it will be your responsibility to pay for the charges incurred.
9. Dietary weight loss attempts are to be documented to show that non-surgical attempts have been made before seeking a surgical weight loss alternative. Please provide a **2 year diet history (or longer if your insurance requires it)**, so that we can provide your insurance carrier with all efforts you have made for non-surgical weight loss.
10. Please bring your **current insurance cards and a photo ID** with you to your appointment. Co-payments are required at the time of your visit. If your insurance requires a referral from your primary care doctor, be sure to bring this with you at the time of your appointment with the doctor
11. If after reviewing all patient information the doctor feels that there is a medical necessity for the procedure, the patient information is **submitted to the insurance company for approval**. Depending upon the different requirements by insurance carriers, the approval process may vary and may take a longer period of time. We will not be able to send your paperwork to the insurance company unless ALL requirements for the carrier are met.
12. **Your insurance carrier has requirements to gain approval for weight loss surgery**. We are unable to change their requirements. This is an agreement between you and your insurance carrier. We will be glad to assist you in understanding the requirements made by your carrier. Approval cannot be obtained until all of the requirements have been made for weight loss surgery.
13. **Attendance at support group session is recommended for success.** Patients that regularly attend the support meetings generally have greater success with their surgical weight loss.
14. After insurance approval, the patient is **scheduled for surgery and pre-admission testing (P.A.T.)** This will include all necessary testing for this procedure. If a clearance is determined to be needed by the hospital, this will be required to be completed and reviewed before surgery can proceed.
15. You will be scheduled for attendance at a **LIVE CLASS or completion of an ONLINE education** prior to surgery. This is a REQUIREMENT. Surgery will not proceed until this is completed
16. A **packet of information for the patients to prepare for the procedure is provided prior to surgery**. You will be working with our office or the hospital to schedule your follow-up appointments. We will try to schedule a convenient time as long as it works with the available schedules. Keep in mind you may be scheduled for multiple appointments that may or may not be made on the same day.

17. The **hospital selection** is determined by insurance coverage, surgeon/hospital time availability and procedure type. In the event that the doctor feels that it would be in the patients' best interest to have surgery at a different hospital, the patient will need to be compliant to this request by the doctor. The time of your surgery may change from what is originally scheduled. Arrival time for your surgery will be earlier than your surgery time to allow for you to be prepped for surgery. The office will only be able to provide a "tentative time" for your surgery. After the schedules have been reviewed, you will be called by hospital the night before surgery to give you a "firm arrival time."
18. **If surgery is denied by the insurance company**, our office may or may not appeal to the insurance carrier. Patients may appeal the denial on their own. Keep in mind that there is a limited number of appeals allowed by insurance carriers.
19. **Patients without insurance may pay up-front for the surgery & hospital charges**. Surgery charges are paid directly to our office in the form of money order, cashiers check, or credit card. This is separate from the charges incurred by the hospital, anesthesia, etc. See self-pay instructions in packet. Payment arrangements for any hospital charges must be arranged directly with the hospital before surgery will be performed. It is the responsibility of the patient to be aware of what their insurance will cover.
20. **Your office co-pays for the surgical weight loss procedure are included for the first 90 days**. After 90 days you are required by your insurance carrier to resume co-payments as set out in your insurance contract or pay any out-of-pocket charges. Any charges other than for the routine post-op care will be billed separately and patients will be responsible for balances not paid by their insurance carrier.
21. **Adjustable gastric band patients may need to have their band adjustments under fluoroscopy at the hospital** if the adjustment is unable to be done at a regular office visit. Any charges incurred for this service will be the responsibility of the patient or responsible party for the patient.
22. **Adjustable gastric band patients may experience complications that require the band to be removed, repositioned, revised or replaced by additional surgeries being performed.** Charges for additional surgeries or services may not be covered by the insurance carrier. Any charges not paid by insurance are the responsibility of the patient or the responsible party of the patient.
23. **Any surgical weight loss patient may experience complications that require additional surgeries.** Charges for additional surgeries or services may not be covered by the insurance carrier. Any charges not paid by insurance are the responsibility of the patient or the responsible party of the patient.
24. All patients are expected to **follow-up annually in addition to their routine post-operative care such as lab work**, as directed by the doctor. Charges for these services are the responsibility of the patient or the responsible party for the patient.
25. All patients are to **follow dietary & exercise guidelines** given unless otherwise instructed by their doctor. **Patient must be financially capable of supplying vitamin supplements and office visit charges** based upon physician guidelines. **Patient must be able to obtain transportation** to/from all doctor appointments, support group meetings, testing facilities, and hospital for scheduled surgery.
26. **All patients are to be in compliance** with recommendations given by our doctor and/or office staff. Any patient that is found to be non-compliant with the office and/or doctor recommendations and is found to ignore, berate, harass or any other way cause disruption in the normal procedures for proper patient care, risks the possibility of being released from the practice of Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network)
27. **If you have a primary insurance and Medicare as secondary insurance** and your primary insurance denies surgical weight loss, our office requires payment for the procedure before scheduling you for surgery. If we receive a payment at a later time from one of your insurance companies, you will be reimbursed for the amount that the insurance allows payment for or for an open credit on your account.

Dayton Bariatric & General Surgery Center and its staff are dedicated to the care and well being of their patients. Understand that we do our best to accommodate your needs and the needs of other patients. Care will be administered with the patient's best interest in view and as necessary will be performed in conjunction with the care given by the hospitals and health facilities within the surrounding communities**. I have read the above items and understand the program guidelines above** and understand that at anytime there may be changes in the process due to regulations or changes within the health or insurance industries. I also understand that the process for approval is a detailed and time-consuming process. I will work with the doctor(s) as requested. I understand that if I do not work with the doctor and/or staff I risk the possibility of being released from the practice of Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network)

PATIENT NAME (PRINTED)	PATIENT SIGNATURE	DATE

DAYTON BARIATRIC & GENERAL SURGERY CENTER
INFORMED CONSENT FOR SURGICAL WEIGHT LOSS

I, _____ have viewed a presentation by **Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network)** I have been educated about the Surgical Weight loss surgeries performed by **David E. Bruce, D.O. and/or Stephen R. Fleischer, D.O.** understand and accept the risks/complications associated with surgical weight loss procedures (listed below non-inclusive list).

All patients must sign an informed consent form, acknowledging that you have been informed about various complications that can result from surgery. The complications and information are as follows:

I understand and accept the risks/complications associated with the surgical weight loss as listed below (non-inclusive list) **PLEASE INITIAL ON EACH LINE YOUR ACKNOWLEDGEMENT OF THE RISKS AND SIGN BELOW**

A. _____The potential risks, complications and benefits of surgical weight loss.
B. _____Alternatives available including non-surgical options
C. _____Dietary changes are needed and a development of an exercise plan and the possible need for counseling.
D. _____Nutrition is very important, eating a balanced diet and the necessity of taking vitamin and mineral supplements for the remainder of your life
E. _____Surgical weight loss is no guarantee of weight loss. There is a need for long term weight management as a result of getting the surgery
F. _____Follow-up medical care is required
G. _____Lab work is required annually or more often as directed by the physician
H. _____Potentially serious complications from the surgery could result in; death, further surgery, or prolonged hospital stays for the patient.

I. **Surgical complications that may arise, but not limited to**.

1. _____Bleeding, this may require a transfusion of blood or blood products
2. _____Infection, at the surgical site, either superficial or deep to include port sites for laparoscopic access. These could lead to wound breakdowns and hernia formation.
3. _____Perforations (leaks) of the stomach or intestine causing peritonitis, subphrenic abscess or enteroenteric or enterocutaneous fistulas.
4. _____Sepsis
5. _____Systemic Inflammatory Response Syndrome (SIRS)
6. _____Adult Respiratory Distress Syndrome (ARDS)
7. _____Myocardial infarction (heart attack)
8. _____Cardiac rhythm disturbances
9. _____Congestive heart failure
10. _____Atelectasis
11. _____Pneumonia
12. _____Pulmonary edema (fluid in the lungs)
13. _____Pleural effusions (fluid around the lungs)
14. _____Injury to adjacent structures, including the spleen, liver, diaphragm, pancreas and colon.
15. _____Possible removal of the spleen
16. _____Stroke
17. _____Kidney failure
18. _____Pressure sores

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

19. _____Deep vein thrombosis (blood clot in the legs or arms)
20. _____Pulmonary embolism (clots migrating to the heart and lungs) –can be fatal
21. _____Staple line disruption
22. _____Ulcer formation (Marginal ulcer or in the distal stomach)
23. _____Small bowel obstructions
24. _____Internal hernias
25. _____Incisional hernias, this includes port sites for laparoscopic access
26. _____Dehiscence or evisceration
27. _____Inadequate or excessive weight loss
28. _____Kidney stones
29. _____Gout
30. _____Encephalopathy
31. _____Stomal stenosis (outlet narrowing obstruction, which may require dilatation(s) or surgeries or EGD
32. _____Urinary tract infections
33. _____Esophageal, pouch or small bowel motility disorders
34. _____Wound seromas/hematomas

J. Nutritional complications to include, but not limited to:

1. _____Protein malnutrition
2. _____Vitamin deficiencies, including B12, B1, B6, Folate and fat soluble vitamins A, D, E and K
3. _____Mineral deficiencies including calcium, magnesium, iron, zinc, copper and other trace minerals.
4. _____Uncorrected deficiencies can lead to anemia, neuro-psychiatric disorders and nerve damage
5. _____Hair thinning and/or hair loss

K. **Psychiatric complications to include, but not limited to**:

1. _____Depression
2. _____Bulimia
3. _____Anorexia
4. _____Dysfunctional social problem

L. Other complications to include, but not limited to:

1. _____Adverse outcomes may be precipitated by smoking
2. _____Constipation
3. _____Diarrhea
4. _____Bloating
5. _____Cramping
6. _____Development of gallstones
7. _____Intolerance of refined or simple sugars, dumping, with nausea, sweating and weakness
8. _____Low blood sugar, especially with improper eating habits
9. _____Vomiting, the inability to eat certain foods, especially with improper eating habits or poor dentition
10. _____Loose skin
11. _____Intertriginous dermatitis due to loose skin
12. _____Malodorous gas, especially with improper food habits
13. _____Hair loss (alopecia)
14. _____Anemia
15. _____Bone disease
16. _____Stretching of the pouch or the stoma

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

INFORMED CONSENT – PAGE 2 of 3

17. _____Low blood pressure
18. _____Cold intolerance
19. _____Fatty liver disease or non alcoholic liver disease (NALF)
20. _____Progression of existing/preexisting NALF or cirrhosis
21. _____Vitamin deficiencies may already exist before surgery
22. _____Diminished alcohol tolerance

M. Complications more specific for adjustable band patients (applicable to adjustable band patients only)

1. _____Band slippage can cause pain and or obstruction. Removal or replacement can occur due to these conditions.
2. _____Erosion of band which would need removal
3. _____Infection of the port, may need removed.
4. _____Infection of the band, may need removed.
5. _____Device failure – leak in system – would have to be remove and/or replace
6. _____Obstruction of intestine
7. _____Inadequate weight loss.
8. _____Inability to do band adjustments in the office setting. Adjustments will need to be scheduled in the hospital setting under fluoroscopy to make adjustments

N. Complications more specific for Gastric Sleeve patients

1. _____Stricture
2. _____Obstruction
3. _____Dilitation of Sleeve
4. _____Long term – possible weight regain

O. Pregnancy complications should be explained as follows (applicable to women only)

1. _____Pregnancy should be deferred for 12-18 months after surgery, or until after the weight loss is stabilized
2. _____Vitamin supplementation during the pregnancy should be continued
3. _____Extra folic acid should be taken if the pregnancy is planned
4. _____Obese mothers have children with a higher incidence of neural tube defects and congenital heart defects
5. _____Pregnancy should be discussed with the obstetrician
6. _____Special nutritional needs may be indicated or necessary
7. _____Secure forms of birth control should be used in the first 18 months after surgery.
8. _____Fertility improves with weight loss

I understand the risks and complications, both foreseen and unseen, including the risk of death with any surgical weight loss procedure performed. Some or all of the complications listed may exist in a patient.

NOTE: Any questions I may have as a patient regarding the risks or hazards of this proposed treatment or other possible treatments, I understand that it is my responsibility as a patient to discuss with my surgeon prior to surgery.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

INFORMED CONSENT – PAGE 3 of 3

DAYTON BARIATRIC & GENERAL SURGERY CENTER
SURGICAL WEIGHT LOSS PROGRAM
PATIENT CONTRACT

I, _____ authorize David E. Bruce, D. O. and/or Stephen R. Fleischer, D. O. and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, and instruction in behavior modification techniques. Other treatment options may include a very low calorie diet, or a protein supplemented diet.

I understand that any medical/surgical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I understand that surgical treatment for obesity is the beginning. In order to be a successful patient, I must come for regular check-ups, for the greatest success I understand I must attend support group meetings and I should call the office whenever I have a problem. For the first year following the surgery, I should be seen at seven to ten days post-op, six weeks, post op, three months post-op, six months and one year post-op. After one year, I should have an annual check up. I understand that following the surgery there is need for lab studies at six months, one year and more frequently if determined by the doctor.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

NOTE: Any questions I may have as a patient regarding the risks or hazards of this proposed treatment or other possible treatments, I understand that it is my responsibility as a patient to discuss with my surgeon prior to surgery.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

PATIENT CONTRACT

Dayton Bariatric & General Surgery Center

A Member of Kettering Physicians Network

Patient Financial Information

- All insurance company co-pays are due at the time of service. Following surgery, patients are not required to pay a co-pay or office visit charge for the 1st 90 days, or according to individual insurance mandates. Our office is considered a *specialist.* We will collect co-pays accordingly. Co-payments are due at the time of service. Our office accepts cash, check, credit card, money order or cashier check.
- All patients will be required to update their personal information 'in writing' on a yearly basis. This will verify that your personal information has not changed.
- If a new bariatric patient is <u>not covered by insurance</u> there will be a charge for the 1st visit. This charge will be due at the time of service. If not covered by insurance <u>Lap Band adjustment</u> charges will be due the same day as service.
- $35 fee will be assessed on your account for any returned checks. Our office now processes check payments electronically. If you do not have sufficient funds in your account, please have an alternate payment (credit card, cashier check or cash) available at the time of your visit.
- Patients are responsible to notify Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network), of any personal information changes (i.e.: phone, insurance, address, marital status, etc). Failure to do so can cause delays in billing, scheduling or other problems. If the patient fails to provide information any unpaid balance will be the patient's responsibility.
- Patients that are unable to keep appointments must call to cancel appointments prior to their appointment. Any no shows for appointments, without notifying our office, beforehand, may be charged $20. Excessive cancellations risk being released from the practice of Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network),
- The responsible party for a patient account is responsible for any balance due after insurance reimbursement(s) are made.
- If a payment is not received on an account within 90 days, then a ten-day notice will be sent on the patient's statement. If payment is not made within 10 days of receipt of that statement, your account may be forwarded to our collections agency and all inquiries thereafter will be referred to them.
- As the patient it is your responsibility to know your insurance company's policies. Be sure to contact your insurance carrier to verify that requested tests or services are a covered benefit. Many procedures or services are not covered by insurance carriers. It is understood that your doctor may order services or testing that may or may not be paid by your insurance carrier. If the insurance carrier does not cover the charges for any reason, it is the patient's responsibility to pay for the balance. Benefits and coverage rules and policies differ among insurers and even between different plans of the same insurer. Whether you have insurance coverage or not, any services rendered are the responsibility of the patient for payment. Unpaid charges that are not paid
- Cash pay surgery patients may make payment by credit card, money order or cashier check. (Cash will not be accepted for pre-payment on surgeries, personal check payments will be processed immediately for verification of availability of funds. If your check payment is denied payment will be required by credit card, money order or cashier check only. Pre-payment must be made prior to being scheduled for surgery. **There are no payment arrangements and no surgery dates given without full payment being received. Any charges incurred in excess of the original self-pay fee are the responsibility of the patient.**
- Monthly payment plans are NOT available for any of our surgeries.
- Copies of medical records can be made, as needed. There is a charge for copies of records in accord with guidelines set out in OH revised code 3701.741. Please allow time for your files to be located and to run the copies needed.
- Disability paperwork and miscellaneous paperwork that needs filled out by our office is done at a $5 charge per form This fee must be paid prior to the forms being filled out There is a 5 business day time period to fill out these forms. For forms needed in less than 5 business days, there is an additional $5 charge per form. Forms can be mailed, faxed or dropped off in our office. It is preferred that forms be dropped off at our Centerville office. For forms mailed or faxed, there is no guarantee that they will be received in our office.
- After surgery many bariatric patients are prescribed Lovenox®. This medicine may not be covered by your insurance. It is recommended that you contact your insurance to see if it will be covered. Otherwise, the payment for the meds will be collected by you the patient.
- Charges billed by the hospital are to be handled through the hospital billing department. Dayton Bariatric & General Surgery Center maintains accounts for office visits and surgeon fees incurred.

I have read the above and understand that I am financially responsible for all charges whether or not paid by insurance. I understand that charges listed above are subject to change. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney fees and court costs. I have read and understand all of the above and have agreed to these statements. I understand that Dayton Bariatric & General Surgery Center (A Member of Kettering Physicians Network) may change the above requirements at any time.

Patient Signature:_____ Date:_____

PATIENT FINANCIAL INFORMATION

Dayton Bariatric & General Surgery Center

A Member of Alliance Physicians
7740 Washington Village Drive, Suite 110, Dayton OH 45459
165 Edwin C. Moses Blvd. Dayton OH 45407 (VJC Health Center)
Dayton OH 45459
937-439-4145 phone 937-439-4371 fax

HIPAA Compliancy

Providers and health insurers are required to comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission for specific purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes

What information is protected?

- Information your healthcare providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your physicians office

Please list any person(s) that you agree that your information may be released to: ex. doctor, spouse, parent, etc.

NAME	***RELATIONSHIP TO PATIENT***	***ADDRESS***	***PHONE***

_____ **YES,** It is *okay to leave messages with detail* on my home voice mail in reference to my surgery or follow-up

_____ **NO**, do **not** leave messages with detail on my home voice mail just a general name and number

By signing below I agree that any names listed above may have access to my medical records at Dayton Bariatric & General Surgery Center. This includes, but is not exclusive to: calling to make appointments, requesting medical information, picking up any medical information in the office, etc. I understand that if I do not want the above contacts to have any further access to my medical information at Dayton Bariatric & General Surgery Center that it is my responsibility to keep this document up to date with any changes.

Patient Signature:_____ Date:_____

HIPAA Compliancy

Dayton Bariatric & General Surgery Center

A Member of Kettering Physicians Network

ONLINE EDUCATION

To assist our patients with their busy schedules, at times we are able to offer ONLINE classes instead of LIVE classes. Online education can be beneficial to allow you the ability to choose the time you are available. Completion of the online education is a requirement if not attending live education classes. Online classes will be offered when they are available.

Failure to complete ALL STEPS or all modules for the ONLINE classes may require additional education. This may need to be completed online or at a live educational class. This will be at the discretion of the surgeon. Surgery cannot be scheduled until this has been completed.

If you are interested in utilizing the ONLINE education classes when available, please complete the information below:

☐ No, I do NOT want to participate in any ONLINE education

If you do NOT want ONLINE education, please sign here _____

Please fill in the information below

Last Name	
First Name	
Home Phone	
Cell Phone	
Date of Birth	

Email address (required to use online education)	

☐ NO EMAIL AVAILABLE FOR PATIENT

By signing below, I agree to the statements above. In addition, I am acknowledging that I agree to receive information via email and/or a website link for my education. I am certifying that any online education will be done by myself only and not by another person. I agree that I will not misrepresent my identity or arrange for someone other than myself to represent me for my education. I understand that any and all trademarks, copyrights or proprietary notices cannot be removed or altered in any way. I also understand that by signing this it is my responsibility to contact my surgeon about any and all questions I have about the procedure, the hospital, the program guidelines and/or the risks and benefits associated with my personal healthcare. I understand that the information I receive was as accurate as possible at the time of posting. Every attempt is made to assure the accuracy and reliability of the information contained on the educational training whether provided directly or indirectly to our patients. I agree to complete any required information whether it is in the form of a quiz, questionnaires or module for learning. Compliance with the program guidelines are a requirement. Any omission or variation from the program requirements without approval risks immediate dismissal from Dayton Bariatric Center weight loss program.

I have read the above and agree as stated:

Patient name: _____

Patient Signature:_____ Date:_____

ONLINE EDUCATION

MEDICAL RECORDS RELEASE

FAX COMPLETED FORM TO:

☐ **Commercial insurance** patients fax this form to Dayton Bariatric Center 937-439-4371
☐ **Medicaid, Caresource or Molina** patients fax this form to Victor Cassano Center 937-558-0158

Patient Name: _____Date:_____

Address _____City/State/Zip:_____

Name at time of service _____

Date of Birth _____Social Security #:_____

REQUESTED FROM:

Physician Name _____Specialty:_____

Address _____City/State/Zip:_____

Phone # _____ Fax # _____

I hereby authorize you to release my records to:

Dayton Bariatric & General Surgery Center

A Member of Kettering Physicians Network

Main office: 7740 Washington Village Drive, Suite 110, Dayton OH 45459
937-439-4145 phone 937-439-4371 fax
Victor Cassano Center: 165 S. Edwin C. Moses Blvd., Dayton OH 45402
937-558-0156 phone 937-558-0158 fax

This information is being requesting for insurance predetermination for weight loss surgery only, this patient is NOT requesting to terminate care from your facility.

Please supply last __2__ years of Medical Records also any record, testing(ex: EKG,CXR,UGI, Cardiac or Pulmonary, Thyroid), progress notes pertaining to Obesity or medical problems relating to obesity (ex: diabetes, hypertension, sleep apnea) Your assistance is *greatly appreciated!*

Patient Signature:_____ Date:_____

MEDICAL RECORD RELEASE