Houston Bariatric Surgery
Bariatric New Patient Information

Name: _____ DOB: _____

SSN: _____-_____-_____ Marital Status: Married Single

Address: _____
Street name City State Zip Code

Mailing Address (if different): _____
Street name City State Zip Code

Email Address:_____

Phone: Home: _____ Mobile: _____ Work: _____

May we leave confidential messages on these voice mails? Yes or No

Indicate if you would like mailed correspondence from our office sent in a sealed envelope marked "confidential"? Yes or Not necessary

_____
Primary Care Physician Phone # Address

_____
Referring Physician Phone # Address

Employer: _____

Employer's Address: _____ Phone: _____

Emergency Contact Name: _____Relationship: _____

Emergency Contact Phone: _____

Referral Source: _____ Phone: _____

Health Insurance Information: Name of Insurance Company: _____

ID Number: _____ Group Number: _____

Policyholder: _____Policyholder's DOB: _____SSN:_____

Relationship: _____ Policyholder's Phone #: _____

Secondary Insurance:_____

Policyholder: _____ Policyholder's DOB: _____ SSN: _____

Relationship: _____ ID Number: _____ Group Number: _____

Please list family members or other persons with whom we may leave information about your medical condition/diagnosis (including treatment/payment/health care options):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Insurance Authorization and Medical Release Form

I hereby authorize Jason M. Balette, MD, FACS, Drew Howard, MD, FACS, &/or Bradley Waggoner, MD, FACS, to furnish or obtain medical records concerning my illness and treatment to insurance carrier or medical facilities. I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for all charges regardless of insurance coverage. Co-payment is to be paid at the time of office visit, as well as any payments towards deductibles.

Signature: _____ Date: _____

Consent for Use of Email Address

- For appointment reminders.
- To inform you of benefits and services related to your health.
- Keep you updated on the approval process for Bariatric/General Surgery.
- Get your questions/concerns answered in a timely manner.
- Through the use of online surveys emailed to you by SGOTW physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received.
- As required by law and for certain law enforcement activities.
- As otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) SGOTW physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation. Declaration: I have read and understand the about agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

Signature: _____ Date: _____

Patient Name: _____

Occupation: _____

Pharmacy: _____ **Phone:** _____

Medication List: (only list names, not dosages. Include vitamins & over the counter meds)

_____

_____

_____

Medical History: (currently being treated for, or history of. Please write N/A in "other")

Hypertension	High Cholesterol	Blood Clots
Anemia	Sleep Apnea	Lung Disease/Asthma
Diabetes	Renal (Kidney) Insufficiency	Arthritis
Bladder problems	Stroke	Cancer
Seizures	Stomach Ulcers	GERD
CHF/Heart Disease	Alcoholism/Addiction	Depression/Anxiety
Abuse	Thyroid disorder	PCOS
HIV/AIDS	Liver problems/Hepatitis	Tuberculosis
Chronic Pain	Other: _____	

Allergies: _____

Surgical History (with dates):

Appendectomy: _____ Gallbladder: _____

Hernia Repair: _____ Weight loss surgery: _____

Hysterectomy: _____ Heart/Cardiac: _____

Orthopedic: _____ Other: _____

PHARMACY INFORMATION

Patient Name:_____ DOB:_____

Preferred Pharmacy:_____

Phone #:_____

Address or Cross Street:_____

**If your preferred pharmacy is a home delivery service, please list an in-person pharmacy for urgent prescriptions:

In-person Pharmacy:_____

Phone #:_____

Address or Cross Street:_____

SIGNATURE_____ DATE_____

****NOTICE: Accurate pharmacy information is required in order to receive any pre or post-operative medication as prescriptions will only be sent to your pharmacy electronically. Once medications have been sent we will not be able to transfer them to another pharmacy.**

Family History: please check conditions that apply

Blood Relatives	Obesity	Diabetes	Hypertension	Sleep apnea	High Cholesterol
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Siblings					
Children					

Review of Systems (circle any symptoms you are currently experiencing)

Gastrointestinal: Nausea Vomiting Abdominal Pain Diarrhea Constipation Heartburn

Cardiovascular: Palpitations Chest Pain Rapid Heart Rate Edema

Respiratory: Shortness of Breath Cough Sleep Apnea/Snoring Wheezing Congestion

Musculoskeletal: Joint Pain/Swelling Decreased range of motion Exercise intolerance Muscle Pain

Neurological: Dizziness Memory loss Numbness/tingling Weakness Seizures Depression

Tobacco Use: Never Current Quit (year): _____

Type used: Cigarettes Cigars Pipe Smokeless

Amount Used per day: _____ Number of Years: _____

Alcohol Use: Never Current Quit (year): _____

Type Used: Beer Wine Liquor Amount per week: _____

Illegal Drugs: Never Current Quit (year): _____

Type Used: Cocaine IV drugs Pain Pills Other: _____ Amount/week: _____

Weight History:

Birth Weight: _____ Start of High School: _____

High School Graduation: _____ Marriage: _____

Lowest weight in past 5 years: _____ Highest weight in past 5 years: _____

Exercise Habits:

Type of exercise: _____ Number of times/week & duration: _____

Diet History: (please list any diets or weight loss plans attempted in the past)

_____

_____

_____

Eating Habits: (circle those that apply)

Snacking/Grazing 3 meals/day 2 meals/day Skip Breakfast Skip Lunch Skip Dinner

Average weight lost with each diet attempt: _____

Most successful diet or weight loss plan: _____

Weight loss medications taken in past/currently: _____

Other weight loss methods attempted: _____

Why do you want to lose weight? _____

_____

_____

Are you or could you be pregnant? _____

Would you like your doctor to pray with you? _____

How did you hear of us/who referred you? _____

Houston Bariatric Surgery

Written agreement to comply with therapy

I have reviewed all of the information, including reading the bariatric manual and viewing the bariatric seminar, which has been provided to me by Dr. Jason Balette, Dr. Drew Howard and/or Dr. Bradley Waggoner. Information has been provided regarding obesity, options for surgical weight loss including the vertical sleeve gastrectomy, Roux-en-Y gastric bypass, and/or adjustable gastric banding. It is imperative that I follow the strict post-operative dietary program with lifestyle modifications which include increased exercise. I also understand that follow-up clinic visits are an important aspect of care to avoid potential complications and for optimal weight loss. I have been given an opportunity to ask questions regarding management of my obesity, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks involved. I believe that I have sufficient information concerning the procedures named above. I agree to comply, to the best of my ability with all therapy and recommendations made by my physician and healthcare providers, including: (please initial)

____ I will take a bariatric-specific multivitamin and calcium supplement for the rest of my life.

____ I will follow the guidelines of the pre- and post-operative diet.

____ I will exercise on a regular basis after surgery.

____ I will not get pregnant for at least 2 years after my surgery.

____ I will quit smoking 2 months before surgery and remain smoke-free for the rest of my life.

____ I will follow up in clinic after surgery at 2 weeks, 3 months, 6 months, 12 months, & annually.

_____ _____

Signature of patient Date

_____ _____

Signature of provider Date

Jason Balette, M.D., F.A.C.S.,
Drew D. Howard, M.D., F.A.C.S.,
Bradley Waggoner, M.D., F.A.C.S.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we **require** you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE**
- **WE ACCEPT Cash, Checks, Visa, or MasterCard**

Regarding Insurance
We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. **Your insurance policy is a contract between you and your insurance company**. **We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not be considered reasonable and necessary under the Medicare Program and/or other medical insurance, see attached ABN. Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Disclosure of Ownership:
Houston Bariatric Surgery is a physician owned facility and your physician may have a financial interest in a surgery center, laboratory or other entity where you may be scheduled for treatment. You have the right to choose where you receive medical and surgical services including an entity in which your physician may have a financial relationship.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Surgery
Deductible, co-insurance and co-payments are due prior to surgery date, unless other arrangements have been made.

SIGNATURE _____ Date _____

HOUSTON BARIATRIC SURGERY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ D.O.B._____

SECTION B: TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment, and health care operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your health information. A copy of our Notice is available upon request. It is also posted in our office.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

The Surgical Group of the Woodlands
9200 Pinecroft Suite 250
The Woodlands, TX 77380
Ph. (281)419-8400
Fax (281)292-1972

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION
At The Surgical Group of the Woodlands we are committed to treating and using protected health information about you responsibly. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY
Law Requires Us to:
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.
3. Follow the terms of the current notice.

We have the right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including
information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed.
However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your
medical information for any purpose not listed below, without your specific written authorization.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: you name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. We will share information about your location , general condition, or death. If you are present, will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decision in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for nation's security and intelligence activities, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defector problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug
Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share
medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigation or proceedings, inspections, license or disciplinary actions or other similar programs.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspects of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives

SURGICAL GROUP OF THE WOODLANDS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

JASON BALETTE, MD, FACS - DREW HOWARD, MD, FACS - BRADLEY WAGGONER, MD, FACS

9200 PINECROFT DR, STE 250
THE WOODLANDS, TX. 77380
PHONE (281) 419-8400 FAX (281) 292-1972 ALT FAX (713) 389-5625

Patient Name _____ Date Of Birth _____

Phone Number _____ Last 4 Of SSN _____

Above listed patient authorizes Surgical Group of the Woodlands to make records disclosure to and receive records from the following healthcare providers or facilities:

PLEASE LIST ANY DOCTORS YOU'VE SEEN IN THE LAST 5 YEARS:

Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number

DATES AND TYPE OF INFORMATION TO DISCLOSE:

- ✓ Please send all progress notes from 2018 to present
- ○ Other:_____

THE PURPOSE OF DISCLOSURE:

- ✓ Consideration For Bariatric Surgery

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I authorize this information to be disclosed to/from Surgical Group of The Woodlands

_____ I do not authorize this information to be disclosed to/from Surgical Group of The Woodlands

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire on the date:_____. If no expiration date is specified, this authorization will expire 1 year from the date signed.

Signature of Patient/Parent/Guardian or Authorized Representative Date

Printed Name of Authorized Representative Relationship to Patient

Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name:	**Provider Plan ID Number:**
Provider Address:	
Description of services that may be appealed:	**Date(s) services were provided:**

I agree to allow this health care provider file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name:	**Patient Date of Birth:**	**Health Insurance Company**:
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature:	**Signature Date:**	

The above name enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date**:

Print Witness Name:	**Witness Signature:**	**Signature Date:**

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Health System. Exhange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Health System Providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFOMRATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEATH RECORDS, AND Y OUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Memvers of the MHiE are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this consent will also have no effect on your person health information made available to Exchange Members during the time frame in which your Consent was active.

INDIVIDUALS'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Patient / Guardian Signature	Print Name	Relationship to patient	Date

Patient unable to sign due to: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include this Consent in the individual's records.

Official Use Only:

MEMORIAL HERMANN
Information Exchange Patient Consent For The Use And Disclosure