GEORGETOWN
THE BARIATRIC & METABOLIC CENTER

Welcome to Georgetown Bariatrics & Metabolic Center! We are thrilled that you have chosen our program to help you get a wonderful weight loss surgery tool that will help you regain your health – and that's what it's about, right?

The paperwork in this packet is what you need to complete to start the program. It seems like a lot, but we really do need all of this information so that we know how to help you through this process. Please be accurate and thorough. **Incomplete packets will be returned.**

1. Complete the Insurance Review Form. (If you are a Medicare or Medicaid recipient, you may skip this step.) The form will lead you step-by-step.
2. If you are NOT utilizing insurance, please write "N/A" on the Insurance Review Form.
3. If you have decided to move forward based on your insurance coverage, complete the Weight Loss Surgery Application, in full. Be sure to include:
    a. Information on your healthcare providers
    b. Your height and current weight
    c. Your current medications
    d. Your previous medical history
    e. If a section does not apply to you, write "N/A" on that section.
4. Incomplete forms will not be considered for our program.
5. Make a copy of your insurance card(s) and include with your paperwork when you turn it in. You may MAIL, FAX, SCAN & EMAIL or DROP IT OFF AT OUR OFFICE.
6. **We will contact you within 15-20 business days, once your packet has been entered and reviewed.**

Our Address:	Georgetown Bariatrics & Metabolic Center 1140 Lexington Road, Ste. 230 Georgetown, KY 40324
Fax #:	502-570-3719
E-Mail Address:	Darla.Schreiber@lpnt.net

Patient Name:_____ Date of Birth:_____

GEORGETOWN
THE BARIATRIC & METABOLIC CENTER

GeorgetownBariatrics.com
502-570-3717

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare or Medicaid, however it does need to be completed for Medicare Replacement, Medicare HMO and any policy that is secondary to Medicare.**

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. **Do not leave any fields blank.**
5. **Sign the form on the back. Failure to do so will result in the form being returned.**
6. Once complete, return this form, along with a copy of your insurance card(s), to our office.
7. Please also make sure that you submit your patient profile packet via fax, mail or Internet.
8. If you have more than 1 insurance policy, a form must be filled out for each. Therefore, make as many copies as needed before writing on this form.
    a. Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. If Medicaid is secondary, this form does not need to be completed.
    b. You must complete this form if you have a Medicare Replacement policy or Medicare HMO.

Fill in this information before you call the insurance company. Please write clearly.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	☐ **Yes** (Continue with this form.) ☐ **No** (Complete #s 2, 26, 27 & 28 then end the call.) **See explanation below

****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**

Patient Name:_____ Date of Birth:_____

2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3.	Do I have a Bariatric Lifetime Maximum?	
4	Is Georgetown Community Hospital in my network? Tax ID #: 62-1757921	
6	Is Georgetown Bariatric & Advanced Surgical Services (Eric F. Smith, D.O.) in my network? Tax ID #62-1763638	
7	What is the effective date of my policy?	
8	What is the calendar year renewal date?	
9	Am I subject to a pre-existing clause?	
10	If yes, what is the end date of the pre-existing clause?	
11	Is a referral required?	
12	What is the deductible per calendar year?	
13	How much have I met towards my deductible?	
14	What is the maximum out of pocket per calendar year?	
15	How much have I met towards my max out of pocket?	
16	Is the deductible applied to the max out of pocket?	
17	What is the co-insurance percent for my policy?	
18	What are my financial obligations to the doctor for Inpatient surgery?	
19	What are my financial obligations to the doctor for Outpatient surgery?	
20	What are my financial obligations to the hospital for Inpatient surgery?	
21	What are my financial obligations to the hospital for Outpatient surgery?	
22	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
23	What is my co-pay for a primary care office visit?	
24	What is my co-pay for a specialist office visit?	
25	What is the fax number for pre-determination?	
26	Name of the representative	
27	Date you spoke to representative	
28	**If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.**	**□ Yes** **□ No**

Disclaimer:

- The Bariatric & Metabolic Center at Georgetown is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by The Bariatric & Metabolic Center at GCH.

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**
- **I have read and understand the disclaimer which includes that I am not approved for surgery.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

Patient Signature: _____ Date: _____

Patient Demographic and Medical History Questionnaire

Date Form Completed: _____ Date of Seminar Attended:_____

How did you hear about us? ❍ Family/Friend ❍ Doctor ❍ Internet ❍ TV ❍ Magazine ❍ Other _____

Have you ever started the process to have weight loss surgery in the past? YES ❍ NO ❍

If yes, what year? _____ If yes, what program/city? _____

(if here at Georgetown, we will pull your chart and update your information)

If yes, did you undergo weight loss surgery? YES* ❍ NO ❍

*(*please provide further information when entering your surgical history in the applicable section)*

If yes, but you did not proceed to surgery, for what reason(s) did you stop the process? _____

Are you able to read, write and communicate in the English Language? YES ❍ NO ❍

If not, what is your primary language?_____

Please check any other barriers to communication applicable:

❍ Hearing impaired (deafness or other) ❍ Vision impaired (blindness or other) ❍ Cannot read and/or write

We will discuss with you accommodations to ensure you receive all of the information you need!

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age:_____ Gender: Female ❍ Male ❍

Marital Status: Single ❍ Married ❍ Divorced ❍ Separated ❍ Partnered ❍ Widowed ❍

How many children do you have (include biologic and adopted/fostered and as blended family; please also list ages)?

_____

Patient Ethnicity: African American ❍ Asian ❍ Caucasian ❍ Hispanic ❍ Native American or Alaska Native ❍

Native Hawaiian or Other Pacific Islander ❍ Choose not to specify ❍ Other: _____

Patient's level of Education: _____ Religious Preference:_____

Address Information:

Mailing Address: _____

City: _____State: _____Zip Code: _____

E-mail: _____(We utilize e-mail addresses for contact when phone messages are not possible. We will also sign you up for our e-mail patient notices and newsletters. If you wish to be excluded from the patient notices, check here: ❑

Home Phone #: _____(OK to leave msg: Y or N) Work Phone#: _____(OK to leave msg: Y or N)

Mobile Phone #:_____(OK to leave msg: Y or N)

Preferred Procedure: Undecided ❍ Roux-en-Y Gastric Bypass ❍ Adjustable Gastric Band ❍ Gastric Sleeve ❍

Adjustable Gastric Band with Plication ❍ Laparoscopic Greater Curvature Plication (LGCP) ***(investigational; currently not covered by insurance)*** **Revision ❍** ***(Revision/conversion procedure of prior weight loss surgery; will discuss further with Bariatric Surgeon)***

What is your height? _____ft _____in How much do you weigh? _____lbs. BMI (if known) _____

Transportation:

Reliable and punctual transportation is needed to all weight loss surgery center appointments as we must maintain a timely schedule in the center to ensure patients are seen by the providers. We apologize in advance for any inconvenience, but please be aware that late arrival will likely cause you to have to reschedule your appointment. If you rely on others for transportation, please tell us who provides that transportation.

Name:_____ Phone Number:_____

Patient Employment/Mobility Information:

Employment status: **Full Time ❍** **Part Time ❍** **Student ❍** **Retired ❍** **Disabled ❍** **Homemaker ❍** **Unemployed ❍** **Leave of Absence ❍**

Patient's present or former occupation: _____

Patient's Current Employer: _____ Years Employed: _____

Patient's Employer's address: _____State:_____Zip:_____Phone #: _____

Disabled? Yes ❍ No ❍ *If Yes, specify the year and cause(s):* Year: _____ Cause(s):_____

Can you walk at least 15 feet unassisted? Yes ❍ No ❍

If you need assistance walking, what device(s) do you use *(circle all that apply)*?

Cane Walker Crutches Other: _____

Are you confined to a wheelchair and unable to stand at all? Yes ❍ No ❍ If yes, how long confined to wheelchair? _____ (months/years)

Spouse/Significant Other Employment Information:

Name: _____Date of birth: _____Phone #: _____

Employment status: Full Time ❍ Part Time ❍ Student ❍ Retired ❍ Disabled ❍ Homemaker ❍ Unemployed ❍ Leave of Absence ❍

Occupation: _____ SSN: _____

Employer: _____Years employed: _____

Employer's address: _____

Insurance Information: *This section must be filled out in addition to enclosing a copy of your insurance card!*

Payment Type: Insurance ❍ Self Pay ❍

Primary Insurance:

Insurance Company: _____ Customer Service Number:_____

Policy Number: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____Subscriber Social Security #_____

Secondary Insurance (if applicable):

Insurance Company: _____ Customer Service Number:_____

Policy Number: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____Subscriber Social Security #_____

Emergency Contact:

First Name: _____ Last Name: _____

Relation to you: _____ Phone:_____

Do you have a designated Medical Surrogate, Health Care Power of Attorney or anyone who can legally make medical decisions for you? YES ❍ NO ❍ If yes, who is that person(s)? _____ Relationship to you? _____

Authorization to discuss/review medical care plan:

"I hereby authorize the staff of the Bariatric Center at Georgetown Community Hospital to discuss my condition/treatment/plan of care, diagnostic test results and any scheduled appointments with the following named person(s), **and/or** further consent to the staff leaving messages for me on voicemail/answering machine":

Name: _____ Relation to you: _____

Name: _____ Relation to you: _____

Patient Signature: _____ Date: _____

Healthcare Provider Information:

Please complete the following information on all of your healthcare providers. We will share information about your process and completion of our weight loss surgery program with the healthcare providers for the purposes of continuity of care. If you do not have a specialty provider, write "N/A" in that area. **Note: You MUST have a Primary Care Provider to start our program.** If you need help finding a PCP in your area, please call us at 502-570-3720.

Primary Care Provider			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:
Cardiologist			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:
Nephrologist			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:
Oncologist			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:
Psychological Services			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:
Other Specialist			
First Name:	Last Name:		❍ MD ❍ DO ❍ APRN ❍ PA
Street Address:			
City:	State:	Zip:	Phone:

Patient Name:_____ Date of Birth:_____

Do you have a physician who can document your weight loss attempts for at least 6 months if required? Yes ❍ No ❍

Can your long-term (>5 years) weight and health history be documented by a medical provider if required? Yes ❍ No ❍

Blood Consent:
"I consent to accept blood or blood products during or after surgery if my condition is such that the physician deems it necessary"

Patient Signature: _____ Date: _____

Blood Products Refusal*: ❍ I wish to complete the Blood/Blood Products Advance Directive form

(**if Jehovah's witness please also check here: ❍)*

Weight Loss History:

At what periods of your life have you been overweight? *(may check more than one response)*

❍ Childhood ❍ Adolescence ❍ Young Adulthood (age < 30) ❍ Middle Adulthood (age < 60) ❍ Pregnancy ❍ Illness/Injury

If applicable, how long have you been 100 pounds or more overweight? _____Years

At what age did you start dieting? _____Age *Check if no prior diet attempts of any kind ❍*

What dieting method(s) were most successful in helping you lose weight? _____

What is the most weight you lost on a single attempt? _____ lbs. How long did you maintain the weight loss? _____ (months/years)

Please check all applicable weight loss methods you have previously tried from the list below:

Unsupervised Diet Attempts:

❍ Calorie Counting/Restriction
❍ High protein / Low Carbohydrate
(ex: South Beach, Atkins, Body for Life)
❍ Low Fat
❍ Heart Healthy / DASH
❍ Diabetic Diet
❍ Supplements (ex: Herbal Life)
❍ Meal replacements (ex: Slim Fast)
❍ Other: _____

Supervised Diet Attempts/Organized Group Support:

❍ Nutri-System / LA Weight Loss
❍ Diet Center / Jenny Craig
❍ Optifast / HMR
❍ Weight Watchers
❍ TOPS / Overeaters Anonymous
❍ Nutritionist / Dietitian supervised
❍ Physician supervised
❍ Other: _____

Over-the-Counter or Prescribed Medications for Weight Loss:

❍ Dexedrine (dextroamphetamine)
❍ Didrex (benzphetamine)
❍ Accutrim / Dexatrim
❍ Phentermine
❍ Ionamin/Adipex
❍ Fastin/Pro-Fast
❍ Redux (dexfenfluramine)
❍ Pondimin (fenfluramine)
❍ Fen-Phen: # Months_____
❍ Tenuate (diethylproprion)
❍ Meridia (sibutramine)
❍ Xenical/Alli (orlistat)
❍ Antidepressants
❍ Diuretics ('fluid pills')
❍ Laxatives
❍ Byetta / Januvia
❍ Other: _____

Behavioral Treatments for Weight Loss:
❍ Hospitalization
❍ Psychological Therapy
❍ Hypnosis
❍ Physical Therapy
❍ Residential Programs
❍ Other: _____

Exercise:
❍ Walking / Treadmill
❍ Running
❍ Stationary cycle
❍ Weight Training
❍ Swimming / Water fitness
❍ Team Sports
❍ Other: _____

Have you used any of the following behaviors in the past to control your weight? *(Check all that apply)*

❍ Bingeing and then Vomiting
❍ Bingeing followed by food restriction
❍ Vomiting purposefully after eating ('bulimia')
❍ Excessive/Obsessive Calorie Restriction/Fasting ('anorexia')
❍ Excessive/Obsessive Exercise

If so, when and how long was this period of behavior? _____

Do you currently use any of these methods for weight control? Yes ❍ No ❍ Please specify: _____

Current Eating:

Do you eat large meals in one sitting? Yes ❍ No ❍

Do you frequently skip meals, or eat only 1-2 times per day? Yes ❍ No ❍

Do you "graze" or snack frequently throughout the day/evening? Yes ❍ No ❍

Do you eat or snack late in the evening or at night? Yes ❍ No ❍

Taking into account your current lifestyle and schedule, please tell us if you prepare more meals at home or do eat more meals from take-out, fast-food and sit-down restaurants.

❍ More meals prepared at home
❍ More meals from restaurants

What is your preferred beverage of choice? (Please check all that apply.)

❍ Regular Soda ❍ Diet Soda ❍ Regular Coffee ❍ Decaf Coffee ❍ Sweet Tea
❍ Unsweetened Tea ❍ Fruit Juice ❍ Milk ❍ Water ❍ Other_____

Please check any triggers for overeating that impact you: Physical Hunger ❍ Anxiousness ❍ Boredom ❍
Makes me happy ❍ Loneliness ❍ Helps me handle stress ❍

What other factors do you feel contribute to your obesity disease? *(Check all that apply)*

Food choices:

❍ Poor food and beverage choices/lack of nutritional knowledge
❍ Poor environmental control (surrounded by temptations)
❍ Lack of time for healthy food preparation
❍ Cost of healthy foods
❍ Dislike of healthy foods

Physical Activity:

❍ Lack of knowledge or access to physical activity options
❍ Physical condition(s) that limit physical activity
❍ Lack of time for physical activity
❍ Cost of physical activity options
❍ Dislike of physical activity

Please explain in more detail any other issues that you feel contribute to your difficulty in losing weight and/or maintaining weight loss?

_____

_____

Why have you chosen to pursue weight loss surgery at this point in your life?

_____

_____

_____

_____

Patient Name:_____ Date of Birth:_____

Knowing your eating patterns and food choices must change; what, if any, lifestyle changes have you begun to make in preparation?

What support / accountability tools have you considered or begun to use to help achieve and maintain your weight loss success?

Medical History/Review of Symptoms: (Check all that apply)

General / Head and Neck: ❑ **I have no medical conditions listed in this section.**

☐ Cancer: (list year of diagnosis, area of body affected and treatment received):

☐	Glaucoma / Eye disease	☐	Cataracts	☐	Hearing problem / Hearing aide
☐	Blindness				

Other symptoms (General):

☐	Fevers	☐	Hair loss	☐	Insomnia
☐	Chills / Night sweats	☐	Appetite change / Loss	☐	Fatigue / Tired / No energy
☐	Hot flashes	☐	Unexplained weight gain / loss	☐	Other_____

Other symptoms (Head and Neck):

☐	Wear contacts / glasses	☐	Sinus drainage	☐	Hoarseness
☐	Blurred / Double vision	☐	Seasonal allergies / Hay fever	☐	Sore throat
☐	Tinnitus (ringing in ears)	☐	Dentures / Partials	☐	Other_____
☐	Vertigo (room spinning)	☐	Gum problems / bleeding		
☐	Nose bleeds	☐	Dry mouth		
☐	Repeated ear infections	☐	Altered taste		

Cardiovascular: ❑ **I have no medical conditions listed in this section.**

☐ High Blood Pressure: ❍ Borderline/No medication ❍ Single medication ❍ Multiple medications ❍ Poorly controlled

☐ Poor circulation in legs/Peripheral vascular disease (PVD): ❍ Medication ❍ Surgery/revascularization

☐ Deep blood clot in leg (DVT): ❍ resolved with anticoagulation ❍ recurrent

☐ Blood clot in lungs (pulmonary embolism): ❍ resolved with anticoagulation ❍ recurrent ❍ vena cava (Greenfield) filter placed

☐	Heart disease/Prior heart attack	☐	Pacemaker / Defibrillator	☐	Varicose veins
☐	Congestive heart failure (CHF)	☐	Atrial Fibrillation / Arrhythmia	☐	Venous insufficiency
☐	Heart murmur / 'leaky' valve	☐	Rheumatic Fever / Valve damage	☐	Prior stroke or TIA

Other symptoms:

☐	Ankle swelling / Edema: ❍ Diuretic ('fluid pill')				
☐	Chest pain with activity	☐	Irregular heartbeat / Skipped beats	☐	Leg infections ('cellulitis')
☐	Shortness of breath with exercise	☐	Rapid heart rate	☐	Skin changes of legs ('stasis')
☐	Difficulty breathing when lying flat	☐	Very slow heart rate	☐	Cramping in legs when walking
		☐	Ankle / Leg ulcers	☐	Other_____

Patient Name:_____ Date of Birth:_____

Endocrine: ❑ **I have no medical conditions listed in this section.**

☐ Diabetes: ❍ oral medication only ❍ Insulin only ❍ oral medication and insulin ❍ complications (neuropathy/organ damage)

☐ Elevated Cholesterol / Triglycerides: ❍ diet modification ❍ single medication ❍ multiple medications

☐ Gout: ❍ no active symptoms ❍ medication ❍ joint destruction/disability

☐ Under / Overactive thyroid	☐ Pre-diabetes / "Insulin Resistance" with elevated blood sugars	☐ Gestational diabetes (during pregnancy)
☐ Parathyroid/ High calcium		
☐ Endocrine gland tumor		

Other symptoms:

☐ Goiter	☐ Heat or cold intolerance	☐ Excessive sweating
☐ Excessive thirst	☐ Low blood sugar	☐ Other_____
☐ Excessive urination	☐ Abnormal facial hair growth	

Respiratory: ❑ **I have no medical conditions listed in this section.**

☐ Asthma: ❍ inhaler(s) ❍ oral meds ❍ not controlled ❍ multiple hospitalizations required

☐ Obstructive Sleep Apnea: ❍ symptoms but negative or no formal sleep study ❍ diagnosed but no appliance ❍ CPAP or BiPAP

☐ COPD/Emphysema: ❍ supplemental oxygen	☐ Recurrent Bronchitis / Pneumonia ☐ Prior Tb	☐ Pulmonary hypertension/ right heart failure

Other symptoms:

☐ Chronic cough	☐ Snoring	☐ Other_____
☐ Shortness of breath at rest	☐ Abnormal breathing pattern	
☐ Coughing up blood	☐ Wheezing	

Gastrointestinal: ❑ **I have no medical conditions listed in this section.**

Date of last colonoscopy, if done: _____

☐ GERD/Heartburn**:** ❍ no medication ❍ intermittent medication ❍ daily medication ❍ prior surgery

☐ Gallbladder Problems/Gallstones: ❍ intermittent symptoms ❍ prior gallbladder removal ❍ ongoing/unresolved complications

☐ Abnormal Liver findings / Elevated Liver Enzymes: ❍ enlarged liver ❍ elevated enzymes ❍ NASH ❍ Liver failure

☐ Barrett's esophagus	☐ Bile duct disease/blockage	☐ Polyps
☐ Achalasia / motility disorder	☐ Cirrhosis / Hepatitis	☐ Diverticulosis
☐ Hiatal hernia	☐ Ulcerative Colitis / Crohn's Disease	☐ Hemorrhoids / Anal fissure
☐ Stomach ulcer / +H. pylori		☐ Pilonidal cyst
☐ Pancreatic disease	☐ Irritable bowel syndrome (IBS)	☐ Incisional / Abdominal hernia

Other symptoms:

☐ Difficulty swallowing	☐ Excessive gas or bloating	☐ Rectal bleeding/Blood in stool
☐ Belching / regurgitation	☐ Diarrhea	☐ Frothy/mucousy stools
☐ Nausea / Vomiting	☐ Constipation	☐ Incontinence of stool
☐ Abdominal pain	☐ Change in bowel habit	☐ Other_____
☐ Jaundice	☐ Black, tarry stools	

Bladder/Kidney: ❑ **I have no medical conditions listed in this section.**

☐ Leaking urine with cough/laugh/sneezing: ❍ intermittent ❍ daily; requires sanitary pad ❍ disabling or prior surgery

☐ Kidney Stones: *Treatment including (if applicable):* ❍ medication ❍ prior surgical procedure or lithotripsy (ESWL)

☐ Kidney Failure / Renal Insufficiency

Other symptoms:

☐	Blood in urine	☐	Trouble starting urine	☐	Terminal dribbling
☐	Burning / Pain on urination	☐	Urinary urgency/Frequency	☐	Other_____
☐	Overall Loss of bladder control (global leakage)	☐	Decreased force of stream		
		☐	Incomplete emptying		

Musculoskeletal / Autoimmune: ❑ **I have no medical conditions listed in this section.**

☐ Back Pain: ❍ intermittent ❍ non-narcotic treatment ❍ narcotic medication ❍ prior or recommended surgery ❍ failed surgery

☐ Other Joint pain: ❍ non-narcotic treatment ❍ pain with walking ❍ prior surgery ❍ past or recommended surgery

☐ Fibromyalgia: ❍ exercise ❍ non-narcotic treatment ❍ narcotic medication ❍ surgery ❍ disabling; treatment ineffective

☐	Degenerative arthritis / Degenerative disk disease	☐	Rheumatoid Arthritis	☐	Carpal tunnel syndrome
		☐	Lupus / Scleroderma	☐	Plantar fasciitis

Other symptoms:

☐	Neck pain	☐	Hand/Finger(s) pain	☐	Foot/Heel pain
☐	Shoulder pain	☐	Hip pain	☐	Ball of foot/Toe pain
☐	Elbow pain	☐	Knee pain	☐	Muscle pain/Spasm
☐	Wrist pain	☐	Ankle pain	☐	Other_____

Neurologic: ❑ **I have no medical conditions listed in this section.**

☐	Headaches	☐	Pseudotumor Cerebri (severe headaches with nausea, and possible loss of vision from high pressure in the brain)	☐	Sciatica
☐	Migraines			☐	Restless legs syndrome (RLS)
☐	Seizures or convulsions				
☐	Multiple sclerosis				
		☐	Neuropathy/Nerve damage		

Other symptoms:

☐	Frequent or recurrent headaches	☐	Memory loss		
		☐	Dizziness / Vertigo	☐	Numbness/Tingling
☐	Balance disturbance	☐	Head Injury/Knocked unconscious	☐	Other_____
☐	Weakness				

Blood/Lymphatic: ❑ **I have no medical conditions listed in this section.**

☐	Anemia (iron deficient)	☐	Lymphoma / Leukemia	☐	Prior blood transfusion
☐	Anemia (vitamin B12 deficient)	☐	Superficial blood clot in leg / 'phlebitis'	☐	Blood thinning medicine use
☐	HIV / AIDS				
☐	Low platelets (thrombocytopenia)	☐	Bleeding/Clotting Disorder		

Other symptoms:

☐	Swollen lymph nodes	☐	Bruise easily	☐	Other_____

Testicular/Prostate (for men only): ❑ **I have no medical conditions listed in this section.**

Date of last prostate exam: _____

☐	BPH (benign prostate hypertrophy)	☐	Erectile dysfunction (ED)	☐	Testicular masses/asymmetry

Gynecologic (for women only): ❑ **I have no medical conditions listed in this section.**

Date of last PAP smear: _____ Date of last bone density scan, if done: _____

☐ Polycystic ovarian syndrome (PCOS): ❍ no treatment ❍ birth control pills ❍ diabetic medication ❍ combination therapy

Patient Name:_____ Date of Birth:_____

How many pregnancies have you had? _____ Live births? _____ Miscarriages or abortions? _____

Are you currently pregnant? Yes ❍ No ❍ Do you plan to have more children? Yes ❍ No ❍

History of problems conceiving? Yes ❍ No ❍ History of pregnancy or delivery complications? Yes ❍ No ❍

Are you post menopausal? Yes ❍ No ❍ *If so, age at Menopause onset:* _____

Date of last menstrual period if premenopausal: _____ *Current method of birth control if premenopausal:* _____

☐	Menstrual irregularity / Abnormal periods	☐	No menses	☐	Cervical dysplasia
		☐	Menstrual pain	☐	Endometriosis
☐	Excessively heavy periods / Passage of clots	☐	Postmenopausal vaginal bleeding	☐	Other_____

Psychiatric:

Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential.

☐	Alcoholism / Substance abuse	☐	Post Traumatic Stress Disorder (PTSD)	☐	Mental/Emotional abuse
☐	Anxiety	☐	Schizophrenia/Schizoaffective Disorder	☐	Physical abuse
☐	Attempted suicide	☐	Sexual abuse	☐	Other psychiatric illness or condition? Please describe here: _____
☐	Attention deficit disorder (ADD/ADHD)				
☐	Bipolar disorder ('manic-depression')				
☐	Depression				

Have you ever had outpatient psychiatric counseling?

Yes ❍ No ❍

If yes, for what condition(s)?_____

Have you ever been in a chemical dependency program?

Yes ❍ No ❍

If yes, when?_____

Have you ever been hospitalized for psychiatric problems?

Yes ❍ No ❍

If yes, when? _____

Are you currently taking medications for anxiety ('nerves') or other mental health problems? Yes ❍ No ❍

If yes, who is your prescriber?

_____
Provider Name

_____
Address

_____
Phone

Are you currently seeing a counselor/psychiatric professional?

Yes ❍ No ❍

If yes, for what condition(s)?_____

Breast: ❑ **I have no medical conditions listed in this section.**

Date of last Mammogram: _____

☐	Breast skin changes	☐	Pain	☐	Other_____
☐	Lumps / Fibrocystic disease	☐	Nipple discharge		

Patient Name:_____ Date of Birth:_____

Skin: ❑ **I have no medical conditions listed in this section.**

☐	Keloids (raised scars)	☐	Rosacea	☐	Psoriasis
☐	Chronic abscesses or boils (hydradenitis suppurativa)	☐	Eczema	☐	Prior MRSA infection or positive MRSA test

Other symptoms:

☐	Recurrent/chronic rashes/chafing ('heat rash' or 'galding') under skin folds	☐	Poor wound healing	☐	Hair or Nail Changes / Fungus
		☐	Frequent skin infections	☐	Other_____
		☐	Skin ulcers		

Surgical Procedure(s):

	Year		Year
Gallbladder: open laparoscopic	_____	Peripheral Vascular Procedure	_____
Anti-reflux procedure/Nissen fundoplication	_____	Heart surgery: CABG/Other: _____	_____
Appendectomy: open laparoscopic	_____	Breast Biopsy: diagnosis: _____	_____
Hysterectomy: abdominal vaginal	_____	Breast: lumpectomy mastectomy	_____
❍ Laparoscopic approach		Breast Cancer Radiation	_____
❍ Ovaries also removed		Wisdom Teeth	_____
Other Ovary Surgery *Describe:* _____	_____	Tonsillectomy	_____
Vasectomy	_____	Hernia: *Type:* _____	_____
Cesarean Section (*if multiple, list all dates*)	_____	Tubal Ligation ('tubes tied')	_____
Neck: *Describe:* _____	_____	Bowel resection	_____
Back: *Describe:* _____	_____	Vagotomy	_____
Hip: replacement fixation	_____	Other:_____	_____
Knee: replacement arthroscopy	_____	Other:_____	_____

Anesthesia: ❍ **No Problems**

Please tell us about any problems that you have had with anesthesia:

☐ Nausea	☐ Woke up during procedure	☐ Difficulty Urinating
☐ Vomiting	☐ Heart Stopped	☐ Other:_____
☐ Difficulty Waking Up	☐ Stopped Breathing	

Previous Weight Loss Surgery (WLS) procedure: _____

(We will need a copy of the Operative Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ ☐ Estimated ☐ Actual Lowest Weight Achieved: _____ ☐ Estimated ☐ Actual

Patient Name:_____ Date of Birth:_____

List Prescribed Medications*:	**Taken for what condition:**	**Dosage/How Often:**

Also include prescription medications taken/used only 'as needed' or occasionally

❑ **I am currently not taking any medications**

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	**Taken for what purpose:**	**Dosage/How Often:**

Allergies:

Please **circle if allergic** and list your **Reaction**

Substance/Medication

❍ **No history of allergies to these products**

Latex	Reaction:_____	Iodine	Reaction:_____
Tape (adhesives)	Reaction:_____	IV Contrast Dye	Reaction:_____

Medications: List any medications that you are allergic to and your reaction

❍ **No Medication Allergies**

Foods: List any foods that you are allergic to and your reaction

❍ **No Food Allergies**

Social History:
***Please note: you must be tobacco- and nicotine-free up to six (6) months prior to surgery depending on procedure; this includes cigarettes, cigars and pipe tobacco; snuff/smokeless tobacco and chewing tobacco; and nicotine replacement/step-down products**

Do you smoke now?* **Yes ❍ No❍**

If yes, how many packs per day? Less than 1 pack/day ❍ 1 to 2 ❍ 2 to 3 ❍ More than 3 ❍

Have you smoked in the past? Yes ❍ No❍

If yes, how many packs per day did you smoke? Less than 1 pack/day ❍ 1 to 2 ❍ 2 to 3 ❍ More than 3 ❍

For how many years did you smoke? ___Years If you have quit, how long ago? _____ weeks / months / years

Do you use snuff or chew?* Yes ❍ No❍

If yes, how frequently do you use snuff/chew? Less than once per week ❍ Once per week ❍ Several per week ❍
Less than once per day ❍ Once per day ❍ Several per day ❍

For how many years have you/did you use smokeless tobacco? _____Years If you have quit, how long ago? _____ weeks/months /years

Do you consume alcohol now? Yes ❍ No❍

If yes, how many times per week? _____ How many drinks (on average) each time? _____

If yes, is anyone concerned about the amount you drink? Yes ❍ No❍

For how many years have you/did you drink alcohol? _____Years If you have quit, how long ago? _____ weeks / months / years

Do you use street drugs now? Yes ❍ No❍

If yes, what drugs?_____

If yes, how frequently do you use these drugs? Less than once per month ❍ Once per month ❍ Several per month ❍
Less than once per week ❍ Once per week ❍ Several per week ❍
Less than once per day ❍ Once per day ❍ Several per day ❍

For how many years have you/did you use street drugs? _____Years If you have quit, how long ago? _____ weeks / months / years

How many hours a day do you watch TV? Never ❍ Rarely ❍ 3-5 hours ❍ 5+ hours ❍

What hobbies do you have that are important to you? _____

Do you routinely engage in planned physical activity or exercise now? Yes ❍ No ❍

If yes, how frequently: daily ❍ several times per week ❍ weekly ❍ Less than weekly ❍

Please list the types of planned physical activity you currently do: _____

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life:

Married Life/Romantic Partner? 1 ❍ 2 ❍ 3❍ 4❍ 5❍

Present job/activities? 1 ❍ 2 ❍ 3❍ 4❍ 5❍

Overall satisfaction with yourself? 1 ❍ 2 ❍ 3❍ 4❍ 5❍

Describe your present life stressors*(Check all that apply)*: Finances ❍ Family ❍ Illness ❍ Work ❍ Friends ❍
Other: _____

Describe your present support(s) *(Check all that apply)*: Spouse ❍ Family ❍ Friends ❍ Church ❍ Co-Workers ❍ Others ❍

Could someone help care for you if you were seriously ill? Yes ❍ No ❍ Who? _____

Are there people for whom you are the primary care giver? Yes ❍ No ❍ Who? _____

Have you required home health/nursing support, or formal PT/OT, in the past following hospitalizations or surgery? Yes ❍ No ❍

Have you required special medical equipment at home in the past following hospitalizations or surgery? Yes ❍ No ❍

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes (age of onset)							
High Blood Pressure							
Heart/ Cardiovascular Disease							
Heart Attack (age)							
Stroke (age)							
Cancer: List type and age of onset							
Elevated Lipids/ Cholesterol							
Gallstones / Gallbladder problems							
Sleep Apnea							
Asthma							
COPD/ Emphysema							
Schizophrenia							
Other (please list/describe):							
Death: List age and cause							
If still living, what age are they now?							

Reviewing Medical Provider Signature _____ **Date** _____

Thank you for taking the time to fill out our Patient Demographic and Medical History Questionnaire. Please also complete the attached Sleep Questionnaire and expanded Eating Questionnaire. ***Also, don't forget to include a copy of the front and back of your insurance card(s) and your Insurance Review Form when mailing this information back to us!***

Patient Name:_____ Date of Birth:_____

Sleep History Questionnaire

Ronald Shashy, MD

Date of prior sleep study if done:_____ **Diagnosis:** _____

Machine used, if applicable (please circle): **C- Pap** **Bi-Pap** **Other:**_____

Symptoms During Sleep -

Check all that apply:

- ☐ Loud Snoring
- ☐ Gasping
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Awaken Too Early
- ☐ "I worry that I won't be able to fall asleep"
- ☐ Fatigue
- ☐ Morning Headaches
- ☐ Irritability/Depression
- ☐ Inability to Concentrate
- ☐ Sinus symptoms interfere with sleep
- ☐ Heartburn, Indigestion, Sour Taste
- ☐ Inability to move while going to sleep or waking up
- ☐ Vivid or life-like visions (people in room, etc.) while going to sleep or waking up
- ☐ Sudden weakness or feel your body go limp when angry or excited
- ☐ Irresistible urge to move arms or legs
- ☐ Creeping or crawling sensation in legs before falling asleep
- ☐ Legs or arms jerking during sleep
- ☐ Frequent urination disrupting sleep
- ☐ Sleep Walking or Sleep Talking

Current Sleep Habits

1. At what time do you usually get to bed?
   _____
2. How long does it take to fall asleep after lights out?
   _____
3. How often do you awaken at night?
   _____
4. Total time spent awake in bed?
   _____
5. I usually wake up at?
   _____
6. Total length of naps daily?
   _____
7. Do you work a rotating shift?
   _____
8. Do you have an unusual work schedule?
   _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these things, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never dose
1 = slight chance
2 = moderate chance of dosing
3 = high chance of dosing

Sitting and Reading _____

Watching TV _____

Sitting, inactive, in a public place (movie theater or a meeting) _____

As a passenger in a care for an hour without a break _____

Lying down to rest in the afternoon _____

Sitting & talking with someone _____

Sitting quietly after lunch with alcohol _____

In a car, whole stopped for a few minutes in traffic _____

Total Points: _____

Patient Name:_____ Date of Birth:_____

Questionnaire on Eating and Weight Patterns Revised
Reprinted from Yanovski S.Z. (1991) Obesity Research, 1, 306-324.

1. **During the past 6 months**, did you often eat an unusually large amount of food within a two-hour period (an amount that most people would agree in unusually large)?

_____Yes _____No

2. During the times when you at an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating?

_____Yes _____No

IF NO, SKIP TO QUESTION 11 IN THIS SECTION. DO NOT COMPLETE QUESTIONS 3-10.

3. During the past 6 months, how often, on average, did you have times when you ate unusually large amounts of food and felt that your eating was out of control? (There may have been some weeks when it was not present – just average those in.) Circle one.

a. less than one day a week.
b. One day a week
c. Two or three days a week
d. Four or five days a week
e. Nearly every day

4. Did you have any of the following experiences during these occasions? (Complete all items.)

a. Eating much more rapidly than usual. _____Yes _____No
b. Eating until you felt uncomfortably full. _____Yes _____No
c. Eating large amounts of food when you didn't feel physically hungry? _____Yes _____No
d. Eating alone because you were embarrassed by how much you were eating? _____Yes _____No
e. Feeling disgusted with yourself, depressed or feeling very guilty after overeating? _____Yes _____No
f. Eating large amounts of food throughout the day with no planned mealtimes? _____Yes _____No

5. Think about a typical time when you ate this way (that is, large amounts of food and feeling that your eating was out of control). What time of day did this episode start? (Circle one.)

a. Morning (8 am t0 12 Noon)
b. Early afternoon (12 Noon to 4 PM)
c. Late afternoon (4PM to 7 PM)
d. Evening (7 PM to 10 PM)
e. Night (After 10 PM)

6. Approximately how long did this episode of eating last, from the time you started to eat until when you stopped and did not eat again for at least two hours? _____ hours _____ minutes

Name:_____ Date of Birth:_____

7. As best as you can remember, please list everything you might have eaten or drunk during that episode. If you ate for more than two hours, describe the food eaten and liquids drunk that you ate the most. Be specific – include amounts and brand names (when possible). Estimate as best as you can.

For example: 7 ounces Ruffles potato chips; 1 cup Breyer's chocolate Ice Cream with 2 teaspoons hot fudge; two 8-ounce glasses of Coca-Cola and 1 ½ ham and cheese sandwiches with mustard.

Food	Amount	Brand (if possible)

8. At the time this episode started, how long had it been since you had previously finished eating a meal or snack?

_____hours _____minutes

9. In general, **during the past 6 months**, how upset were you by overeating episodes in which you ate unusually large amounts of food? Circle one.)

a. Not at all
b. Slightly
c. Moderately
d. Greatly
e. Extremely

10. In general, **during the past 6 months**, how upset were you by feeling that you could not stop eating or could not control what or how you were eating? (Circle one.)

a. Not at all
b. Slightly
c. Moderately
d. Greatly
e. Extremely

11. In general, **during the past 6 months**, how important has your weight or shape been in how you feel about or evaluate yourself as a person – compared to other aspects of your life (i.e. how you do at work, as a parent, or how you get along with other people)?

Weight and shape...

a. were not very important
b. played a part in how I felt about myself
c. were among the main things that affected how I felt about myself
d. were the most important things that affected how I felt about myself

12. **During the past 3 months**, did you ever make yourself vomit in order to avoid gaining weight after binge eating?

_____Yes _____No

If yes: How often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

13. **During the past 3 months**, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating? _____Yes _____No

If Yes; how often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

14. **During the past 3 months**, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating? _____Yes _____No

If Yes; how often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

15. **During the past 3 months**, did you ever fast (not eat anything at all for at least 24 hours) in order to avoid gaining weight after binge eating? _____Yes _____No

If Yes; how often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

16. **During the past 3 months**, did you ever exercise for more than one hour specifically to avoid weight after eating?

_____Yes _____No

If Yes; how often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

17. During the past 3 months, did you ever take more than twice the recommended dosage of a diet pill in order to avoid gaining weight after binge eating? _____Yes _____No

If Yes; how often, on average, was that? (Circle one.)

a. Less than once a week
b. Once a week
c. Two or three times a week
d. Four or five times a week
e. More than five times a week

Eating Questionnaire © 2006 K.C. Allison & A.J. Stunkard

Directions: Please circle ONE answer for each question.

1. How hungry are you usually in the morning?

0	1	2	3	4
Not at all	A little	Somewhat	Moderately	Very

2. When do you usually eat for the first time?

0	1	2	3	4
Before 9 am	9:01 – 12 pm	12:01 – 3 pm	3:01 – 6 pm	6:01 or later

3. Do you have cravings or urges to eat snacks after supper, but before bedtime?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

4. How much control do you have over your eating between supper and bedtime?

0	1	2	3	4
Not at all	A little	Some	Very much	Complete

5. How much of your daily food intake do you consume after suppertime?

0	1	2	3	4
0% (none)	1 – 25% (up to a quarter)	26 – 50% (about half)	51-75% (more than half)	76 – 100% (almost all)

6. Are you currently feeling blue or down in the dumps?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely

7. When you are feeling blue, is your mood lower in the:

0	1	2	3	4	
Early Morning	Late Morning	Afternoon	Early Evening	Late Evening/Night	☐ Check if your mood does not change during the day.

8. How often do you have trouble getting to sleep?

0	1	2	3	4
Never	Sometimes	About ½ the time	Usually	Always

9. Other than only to use the bathroom, how often do you get up at least once in the middle of the night?

0	1	2	3	4
Never	Less than once a week	About once a week	More than once a week	Every Night

********** **IF 0 ON #9, PLEASE STOP HERE**********

Name:_____ Date of Birth:_____

10. Do you have cravings or urges to eat snacks when you wake up at night?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

11. Do you need to eat in order to get back to sleep when you awake at night?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Extremely so

12. When you got up in the middle of the night, how often do you snack?

0	1	2	3	4
Never	Sometimes	About half of the time	Usually	Always

********** **IF 0 ON #12, PLEASE STOP HERE**********

13. When you snack in the middle of the night, how aware are you of your eating?

0	1	2	3	4
Not at all	A little	Somewhat	Very much so	Completely

14. How much control do you have over your eating while you are up at night?

0	1	2	3	4
None at all	A Little	Some	Very Much	Complete

How long have your current difficulties with night eating been going on? _____ months _____ years

Name:_____ Date of Birth:_____

GEORGETOWN
THE BARIATRIC & METABOLIC CENTER

The following forms concern Release of Information (ROI). Your written permission via a signed ROI form is needed to allow us to communicate directly with your healthcare providers.

See the attached examples for instruction. If you have concerns about completing these ROI forms, you may call our office at 502-570-3717.

Please note that we are **required** to have completed ROIs before we can start your process in our weight loss surgery program.

Thank you.

Name:_____ Date of Birth:_____

GEORGETOWN
COMMUNITY HOSPITAL

RELEASE OF INFORMATION *EXAMPLE*

☐ AUTHORIZATION ☐ REQUISITION *(Check one)*

SECTION A: This section to be completed by the patient.

Name of Patient:	Medical Record Number:	Social Security Number:	Date of Birth:
Jane Doe			

Address: 123 Center St

City: Georgetown | State: Ky | Zip Code: 40324

Releasing Facility

Facility Name: PCP Name (Primary Care Provider)

Address: PCP Address

City: for PCP → | State: → | Zip: → | Telephone Number: →

Requesting Facility or Individual

Requestor Name:

Address:

City:

Georgetown Bariatrics
1138 Lexington Road, Ste. 230 B
Georgetown, KY 40324
P. 502-570-3717
F. 502-570-3719

Zip:

Telephone Number:

Date(s) of Service: _____ thru _____

List Specific Description of Information to be Released:

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other: _____
☐ UB04	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery / Progress Report	☐ Accounting of Disclosure	☐ _____

Do you want the hospital to release your psychotherapy notes (if any) to the person or facility you have listed above? ☐ Yes ☐ No

Describe the purpose / reason for this request: _____

SECTION B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read / acknowledge the following statements:

1. I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that this facility may need to have my physician agree to the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

DOB:
ADMIT:
ATT:
MR #:

HSV:
AGE: SEX:
ROOM/BED /
#:
PAT #:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

FOR OFFICE USE ONLY

Verified: ☐ Yes ☐ No By: _____

License No: _____ SS No: _____

Signature: ☐ Yes ☐ No

John Doe
_____
Signature of Patient or Legal Representative

11-7-14
_____
Date and Time

_____
If Patient Representative – please type in name

_____
Basis for which representative has the authority to act for the patient

_____
Signature of Witness

_____
Date and Time

DOB:
ADMIT:
ATT:
MR #:

HSV:
AGE: SEX:
ROOM/BED /
#:
PAT #:

GEORGETOWN
COMMUNITY HOSPITAL

RELEASE OF INFORMATION

☐ **AUTHORIZATION** ☐ **REQUISITION** *(Check one)*

SECTION A: This section to be completed by the patient.

Name of Patient:	Medical Record Number:	Social Security Number:	Date of Birth:

Address:			

City:	State:	Zip Code:

Releasing Facility	Facility Name:			
	Address:			
	City:	State:	Zip:	Telephone Number:

Requesting Facility or Individual	Requestor Name:			
	Address:	**Georgetown Bariatrics** 1138 Lexington Road, Ste. 230 B Georgetown, KY 40324		
	City:	P. 502-570-3717 F. 502-570-3719	Zip:	Telephone Number:

Date(s) of Service: _____ thru _____

List Specific Description of Information to be Released:

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other: _____
☐ UB04	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery / Progress Report	☐ Accounting of Disclosure	☐ _____

Do you want the hospital to release your psychotherapy notes (if any) to the person or facility you have listed above? ☐ Yes ☐ No

Describe the purpose / reason for this request: _____

SECTION B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read / acknowledge the following statements:

1. I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that this facility may need to have my physician agree to the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

DOB:
ADMIT:
ATT:
MR #:

HSV:
AGE: SEX:
ROOM/BED /
#:
PAT #:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

FOR OFFICE USE ONLY

Verified: ☐ Yes ☐ No By: _____

License No: _____ SS No: _____

Signature: ☐ Yes ☐ No

X _____ X _____

Signature of Patient or Legal Representative Date and Time

_____

If Patient Representative – please type in name

_____

Basis for which representative has the authority to act for the patient

_____ _____

Signature of Witness Date and Time

DOB: HSV:
ADMIT: AGE: SEX:
ATT: ROOM/BED /
MR #: #:
PAT #:

GEORGETOWN COMMUNITY HOSPITAL

RELEASE OF INFORMATION

☐ AUTHORIZATION ☐ REQUISITION *(Check one)*

SECTION A: This section to be completed by the patient.

Name of Patient:	Medical Record Number:	Social Security Number:	Date of Birth:

Address:

City:	State:	Zip Code:

Releasing Facility

Facility Name: Eric F Smith, DO
Address: 1138 Lexington Road, Ste. 140, Georgetown, KY 40324
City: P. 502-570-3727 F. 502-570-3753
Zip:
Telephone Number:

Requesting Facility or Individual

Requestor Name: Georgetown Bariatrics
Address: 1138 Lexington Road, Ste. 230 B, Georgetown, KY 40324
City: P. 502-570-3717 F. 502-570-3719
Zip:
Telephone Number:

Date(s) of Service: _____ thru _____

List Specific Description of Information to be Released:

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other: _____
☐ UB04	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery / Progress Report	☐ Accounting of Disclosure	☐ _____

Do you want the hospital to release your psychotherapy notes (if any) to the person or facility you have listed above? ☐ Yes ☐ No

Describe the purpose / reason for this request: _____

SECTION B: Must be completed by the patient for all authorizations:

The patient or the patient's representative must read / acknowledge the following statements:

1. I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that this facility may need to have my physician agree to the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

HSV:
DOB: AGE: SEX:
ADMIT: ROOM/BED /
ATT: #:
MR #: PAT #:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

FOR OFFICE USE ONLY

Verified: ☐ Yes ☐ No By: _____

License No: _____ SS No: _____

Signature: ☐ Yes ☐ No

X _____ X _____

Signature of Patient or Legal Representative Date and Time

_____

If Patient Representative – please type in name

_____

Basis for which representative has the authority to act for the patient

_____ _____

Signature of Witness Date and Time

DOB:
ADMIT:
ATT:
MR #:

HSV:
AGE: SEX:
ROOM/BED /
#:
PAT #: