Mooresville PPM, LLC

Outpatient Information / Consent to Treat

PATIENT INFORMATION	Account #:		Medical Record#:		Date:	
Patient Name:			Referring Doctor:			
Billing Address:			City	State	Zip	
Physical Address:			City	State	Zip	
(H) Phone:	(C) Phone:		Work Phone:	Other:		
Primary Doctor			Employer/School:			
Social Security #:	Date of Birth:	Age	Marital Status:	Sex:		
Emergency Contact:	Relationship:		(H) Phone:	(C) Phone:		
Responsible Party:	Relationship:		DOB:	SS#:		
Email (responsible party if minor/child)			Pharmacy/Location			
Responsible Party Address:			Pharmacy Phone #			
City:	State	Zip	(H) Phone:	(C) Phone:		
INSURANCE INFORMATION						
Primary Insurance:	Employer:		Secondary Insurance:	Employer:		
Insurance ID #:	Insurance Group #:		Insurance ID #:	Insurance Group #:		
Insured Name:			Insured Name:			
Address:			Address:			
City	State	Zip	City	State	Zip	
DOB:	Insured Social Security #:		Insured DOB:	Insured Social Security #:		

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

For Staff Use Only

❑ Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

❑ Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer.

(Check one)

Signature _____ ***Date/Time:*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

❑ Interpreter Accepted _____ ❑ Interpreter Refused

(Name/Number of Person/Services Chosen/Used

REV. 1-11

The Center for Surgical Weight Loss
MEDICAL QUESTIONNAIRE

Patient Name _____ DOB _____

Primary reason for today's visit: _____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

MEDICAL / FAMILY MEDICAL HISTORY:

List any current medications and dosage:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any medications YES ( ) NO ( ) If "yes," please list below:

_____

List any major surgical procedures and approximate dates: _____

_____
_____
_____

Have you had any of the following conditions:

	YES	NO
Diabetes	( )	( )
High Blood Pressure	( )	( )
Cancer	( )	( )
Thyroid Disease	( )	( )
Heart Attack	( )	( )
Stroke	( )	( )
Emphysema	( )	( )
Rheumatoid Arthritis	( )	( )
GI Bleeding/Colitis	( )	( )
Osteoarthritis	( )	( )
Sleep Apnea	( )	( )

Has anyone in your immediate family had any of the following conditions:

	YES	NO
Diabetes	( )	( )
High Blood Pressure	( )	( )
Cancer	( )	( )
Thyroid Disease	( )	( )
Heart Attack	( )	( )
Stroke	( )	( )
Emphysema	( )	( )
Rheumatoid Arthritis	( )	( )
GI Bleeding/Colitis	( )	( )
Osteoarthritis	( )	( )
Sleep Apnea	( )	( )

SOCIAL HISTORY:

Please list your current or most recent occupation _____

How long have you been or were you employed in this field? _____

	YES	NO	
Do you drink alcohol?	( )	( )	# of drinks per day / week_____
Do you smoke?	( )	( )	# packs per day / week _____
Do you use recreational drugs?	( )	( )	
Have you ever had a blood transfusion?	( )	( )	

The Center for Surgical Weight Loss

MEDICAL QUESTIONNAIRE (continued)

REVIEW OF SYSTEMS:

Do you currently have any of the following problems? If "yes," please explain.

	YES	NO	EXPLANATION
Weight Loss / Gain	( )	( )	_____
Fatigue	( )	( )	_____
Vision Problems	( )	( )	_____
Hoarseness	( )	( )	_____
Nose Bleeds	( )	( )	_____
Chest Pain	( )	( )	_____
Dizziness	( )	( )	_____
Shortness of breath	( )	( )	_____
Swelling, lower extremities (legs)	( )	( )	_____
Cough	( )	( )	_____
Abdominal Pain	( )	( )	_____
Constipation	( )	( )	_____
Diarrhea	( )	( )	_____
Rectal Bleeding	( )	( )	_____
Difficulty swallowing / speaking	( )	( )	_____
Blood in urine	( )	( )	_____
Vomiting with pain	( )	( )	_____
Unusual Bruising	( )	( )	_____
Prolonged Bleeding	( )	( )	_____
Weakness/Tingling in arms / legs	( )	( )	_____
Rash	( )	( )	_____
Itching	( )	( )	_____
Sleep Apnea	( )	( )	_____
Osteoarthritis	( )	( )	_____

Patient's signature _____ Date _____

The above is true and correct to the best of my knowledge.

History reviewed:

Physician Signature	Date	
_____	_____	No changes ( ) Changes as noted ( )
_____	_____	No changes ( ) Changes as noted ( )
_____	_____	No changes ( ) Changes as noted ( )
_____	_____	No changes ( ) Changes as noted ( )
_____	_____	No changes ( ) Changes as noted ( )

The Center for Surgical Weight Loss at
LAKE NORMAN

General Consent to Treat/Patient Authorization/ Acknowledgement of Benefits Release

The following are the conditions for services provided by The Center for Surgical Weight Loss for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by The Center for Surgical Weight Loss and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to, syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury), insurance and/or any third party payer, all medical information, test results and findings made during the course of this examination and/or treatment, To include information referring to psychiatric care, sexual assault or tests for infectious diseases, including AIDS/HIV, for services provided during this visit. I/we also agree to the release of medical or other information about me to government, federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and The Center for Surgical Weight Loss. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that The Center for Surgical Weight Loss can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assigned of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I/we should read it carefully. I/we am/are aware that the Notice may be changed at any time.

_____ _____

Date

Signature of Patient/Parent, Guardian or Legally Authorized Representative

MOORESVILLE PPM, LLC

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): September 23, 2013

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from: Mooresville PPM, LLC.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement form in the individual's records.

The Center for Surgical Weight Loss at
LAKE NORMAN

Patient History Forms. *Please fill out completely and bring to your consult appointment

Family Health/Weight History:

In this section, complete this chart to the best of your knowledge. If adopted and have no history of your biological family, place an X in this box ☐ **Adopted.**

	Family Member	Approximate Weight	Present Age	If Deceased, age at death	If Deceased, list the cause of death	List any Medical Problems e.g. Heart Disease, Cancer, Diabetes, Hypertension
1.	Mother					
2.	Father					
3.	Maternal Grandmother					
4.	Maternal Grandfather					
5.	Paternal Grandmother					
6.	Paternal Grandfather					
7.	Brother(s)					
8.	Sister(s)					

Has one of your relatives ever had Bariatric (weight reduction) surgery? ☐ Yes ☐ No

***(Required) Please explain *in your own words why* you want Bariatric surgery:**

_____

_____

_____

_____

_____

On average, how many hours per week do you spend watching TV/Cable/VCR?

☐ 0 to 1 hour/week
☐ 2 to 5 hours/week
☐ 6 to 10 hours/week
☐ 11 to 20 hours/week
☐ 21 to 40 hours/week
☐ 61 or more hours/week

Excluding time spent watching TV/Cable/VCR, how many hours per week do you spend sitting (e.g., working at a desk, relaxing on the couch)?

☐ 0 to 1 hour/week
☐ 2 to 5 hours/week
☐ 6 to 10 hours/week
☐ 11 to 20 hours/week
☐ 21 to 40 hours/week
☐ 61 or more hours/week

Would you say that during the past week (the week used for questions 2 – 4) you were:

☐ less active than usual ☐ more active than usual ☐ about as active as usual

Was there anything about the past week that made it especially different for you in terms of extended illness, injury or vacation?
☐ Yes ☐ No

Exercise Habits:

Were there any sports, recreational, or physical activities in which you participated during the past **week**? If so, please list each sport/activity, the number of times you participated, and the time spent engaged in the activity (please count only the time during which you were physically active).

	Sport or Recreation	Number of Times/Week	Average Time/Episode (minutes)
a.			
b.			
c.			

History of Weight Loss Attempts:

Have you been on a 3-6-month physician supervised diet within the last year? ☐ Yes ☐ No

If yes, please provide supporting documentation. (A copy of each office visit)

Please list the history of any food or liquid diets that you have tried in an attempt to lose weight over the past five years. Please be as complete as possible. ***Do not leave any blanks.**

	Name of Diet	Year	Length (days, weeks, months or years uninterrupted	Weight at Start of Diet	Number of lbs. lost
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Please list the history of any medications that you have tried in an attempt to lose weight.

	Medication/Dose	Year	Length (days, weeks, months or years uninterrupted)	Weight at Start of Diet	Number of lbs. lost
1.					
2.					
3.					
4.					

Please list the history of any behavioral treatments (e.g., hypnosis, therapy, etc.) that you have tried in an attempt to lose weight:

	Behavioral Treatment	Year	Length (days, weeks, months or years uninterrupted)	Weight at Start of Diet	Number of lbs. Lost
1.					
2.					
3.					
4.					

Please list any specific questions that you may have about your surgical procedure or the program?

_____

Health Management™
PHYSICIAN NETWORK

e-Prescribing/Medication History Download Consent Form

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in and e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – providers the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Health Management Physician Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Health Management Physician Associates to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name DOB

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient