WEIGHT LOSS HISTORY

(Incomplete information may delay or cause denial of insurance coverage)

How long have you been at your current weight? _____

At what age did you become obese? _____ What is your goal weight? _____

What is your lowest adult weight? _____ What year? _____

What is your highest adult weight? _____ What year? _____

What type of eating style do you have:

big eater_____ sweets_____ snacker_____

grazer _____ combination of all _____

How many times do you eat out per week? _____ _____

Do you exercise? How often? _____ _____

_____

_____

Type of *previous* weight loss surgery

☐ Vertical banding ☐ Gastric Band ☐ Roux-en-Y Gastric Bypass ☐ Stapling ☐ Other

Present complications due to previous weight loss surgery: _____

Weight prior to *previous* weight loss surgery: _____

Reason you are in need of a revision weight loss surgery:

If you have prior weight loss surgery you must obtain your operative records from the surgeon or the hospital where the procedure was performed and submit them with your screening paperwork.

MEDICALLY SUPERVISED TREATMENT REGIMENTS:

Please list all diets and medications for weight loss you have used and the treating physician(s):

Did you take Fen-Phen? ☐ Yes ☐ No Year: _____ Physician: _____

Type/Name: _____ Year: _____ Physician: _____

Type/Name: _____ Year: _____ Physician: _____

OTHER WEIGHT LOSS ATTEMPTS:

Program:	Month(s) / Year(s):	Length of participation:	Amount of weight loss:
☐ Weight Watcher			
☐ Exercise			
☐ Calorie Control/Counting Calories			
☐ Slim Fast			
☐ Medifast			
☐ Nutrisystems			
☐ Sugar Busters			
☐ Jenny Craig			
☐ Metabolife			
☐ Optifast			
☐ Xenical			
☐ Adkins/South Beach			
☐ Dexatrim			
☐ Meridia			
☐ Overeaters Anonymous			
☐ LA Weight Loss			
☐ Hydroxycut			
☐ Alli			
☐ Other			

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

Physicians and Specialists

Please list your physicians and specialists below:

If you have no physicians or specialists, please check this box: ☐

***Please complete an **Authorization For Release Of Information (Non-Baylor)** form for **EVERY** physician/specialist listed below.

Specialty	Name	Phone	Fax	Address
Primary Care Provider				
Psychologist				
Psychiatrist				
Weight Loss Physicians/ Programs				
Cardiologist				
Endocrinologist				
Gastroenterologist				
Oncologist/ Hematologist				
Nephrologist				
Obstetrics/ Gynecology				
Dietitian				
If you have completed any labs (blood work) recently, who was the provider? PLEASE REMEMBER TO BRING COPIES OF YOUR RECORDS.				
Labs				
Please list all other specialists or physicians below.				
1.				
2.				
3.				
4.				
5.				

Medications

☐ Not currently taking any medications

Medication (including strength)	How many times per day?	How long taken?
Example: Lipitor 40mg	1x per day	4 years
Non-Prescription/Over-The-Counter	**How many times a day?**	**How long taken?**
(Example: Vitamins, Herbs, Home Remedies, etc.)		

Patient History

Name:_____ Birth date:_____ Sex:_____ Date:_____

Medical Problems:

☐ Diabetes type I ___ type II___
☐ High Blood Pressure
☐ High Cholesterol/Triglycerides
☐ Liver problems/Fatty liver
☐ DVT/history blood clots
☐ Anxiety
☐ Asthma
☐ Emphysema
☐ Renal Failure
☐ Heart Disease
☐ Sleep Apnea
☐ Depression
☐ History of Cancer, Type:_____
☐ Stroke/TIA
☐ Heartburn/GERD/Ulcers
☐ Thyroid problems
☐ CPAP/BIPAP
☐ Bipolar

Other:_____
_____

Prior Surgical History:

☐ Appendectomy Year:_____
☐ Breast Biopsy/Mastectomy Year_____
☐ Open Heart Surgery Year_____
☐ C-section: How many? _____
☐ Gallbladder (Open/Closed) Year_____
☐ Hernia: Type:_____ Year_____
☐ Hysterectomy (Vaginal/Stomach) Year_____
☐ Knee/Hip replacement (circle which one) Year _____
☐ Previous Bariatric surgery type _____ Year _____

Other:_____
_____

Food or Medication Allergies: please list and type of reaction

_____
_____
_____

Social History (mark if answer is yes):

☐ Have you ever smoked? Age started:_____ Age quit:_____ Packs/day:_____
☐ Alcohol Use: Drinks per week:_____
☐ Other drug use: Type:_____ Last used:_____
☐ Caffeine: Type:_____ How much per day:_____
☐ Married ☐ Single ☐ Widowed ☐ Divorced
☐ Exercise: How many times a week_____ ☐ Use a walker/wheel chair

Family History:

☐ Diabetes: Who_____
☐ High blood pressure: Who_____
☐ High Cholesterol/triglycerides: Who_____
☐ Cancer: Type_____ Who_____
☐ Heart disease: Who_____
☐ Stroke: Who _____

☐ I am ready to pursue surgery as an option for treatment for my obesity.

☐ I agree to follow the program as prescribed and actively participate in my follow up care.

☐ I understand that I am primarily responsible for obtaining insurance approval for this procedure. I will furnish all records requested by the program in a timely manner. I will make and complete all necessary appointments to fulfill necessary requirements.

☐ I understand I am responsible for any charges not covered by my insurance.

_____ _____
Patient Signature Date

Patient Review of Symptoms (Current)

Name:_____ Birth date:_____ Sex:_____ Date:_____

Constitutional:

- ☐ Fatigue
- ☐ Persistent Fevers
- ☐ Thyroid problems
- ☐ Weakness
- ☐ Sensitive to heat/cold
- ☐ Received blood transfusion
- ☐ Night sweats
- ☐ Marked weight loss/gain
- ☐ Daytime sleepiness

Eyes:

- ☐ Temporary vision loss
- ☐ Cataracts
- ☐ Glasses/Contacts

Ears/Nose/Mouth/Throat:

- ☐ Loss of hearing/wear hearing aides
- ☐ Bleeding gums
- ☐ Sinus/Allergy problems
- ☐ Hoarseness/sore throat
- ☐ Dentures
- ☐ Frequent ear infections
- ☐ Ringing in ears
- ☐ Snoring
- ☐ Loss of smell

Breasts:

- ☐ Breast lumps/fibrocystic disease
- ☐ Mammogram: Year:_____
- ☐ Breast tenderness
- ☐ Nipple discharge

Heart:

- ☐ Chest Pain
- ☐ Stress test/echo Year: _____
- ☐ Palpitations/rapid heartbeat
- ☐ Leg swelling
- ☐ Rheumatic fever
- ☐ Leg pain with walking

Lungs:

- ☐ Persistent cough/productive cough
- ☐ Pneumonia: Year: _____
- ☐ Chest X-ray: Year: _____
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Blood in sputum
- ☐ Wheezing

Musculoskeletal:

- ☐ Back/neck pain
- ☐ Muscle cramps
- ☐ Knee pain
- ☐ Joint swelling
- ☐ Shoulder
- ☐ Disc/Joint Disease

Gastrointestinal:

- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Blood in stools
- ☐ UGI/Barium Swallow: Year:_____
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Vomiting blood/ulcers
- ☐ Endoscopy: Year:_____
- ☐ GERD
- ☐ IBS
- ☐ Difficulty swallowing
- ☐ Colonoscopy: Year:___

Genitourinary:

- ☐ Leakage of urine
- ☐ Frequent urination at night
- ☐ Frequent urination
- ☐ Erectile dysfunction
- ☐ Kidney failure
- ☐ Blood in urine

Gynecologic:

- ☐ Irregular periods
- ☐ PCOS
- ☐ Heavy periods
- ☐ Post menopausal/no periods
- ☐ Fibroids
- ☐ Infertility

Dermatology:

- ☐ Chronic skin condition: Type_____
- ☐ Hair loss
- ☐ Cancer: Type:_____

Neurologic:

- ☐ Headaches/Migraines
- ☐ Numbness: Where_____
- ☐ Seizures
- ☐ Balance issues/Falls
- ☐ Memory loss

Mental Health:

- ☐ Axiety
- ☐ Depression
- ☐ Biplar

GERD-Health Related Quality of Life Questionnaire (GERD-HRQL)

Patient Name:_____ Date _____

□ On PPIs □ Off PPIs If off, for how long? _____ days / months

Scale:
0 = No symptom
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activity
5 = Symptoms are incapacitating to do daily activities

*Please check the box to the right of each question which best describes your experience over the past **2 weeks***

1.	How bad is the heartburn?	□0 □1 □2 □3 □4 □5
2.	Heartburn when lying down?	□0 □1 □2 □3 □4 □5
3.	Heartburn when standing up?	□0 □1 □2 □3 □4 □5
4.	Heartburn after meals?	□0 □1 □2 □3 □4 □5
5.	Does heartburn change your diet?	□0 □1 □2 □3 □4 □5
6.	Does heartburn wake you from sleep?	□0 □1 □2 □3 □4 □5
7.	Do you have difficulty swallowing?	□0 □1 □2 □3 □4 □5
8.	Do you have pain with swallowing?	□0 □1 □2 □3 □4 □5
9.	If you take medication, does this affect your daily life?	□0 □1 □2 □3 □4 □5
10.	How bad is the regurgitation?	□0 □1 □2 □3 □4 □5
11.	Regurgitation when lying down?	□0 □1 □2 □3 □4 □5
12.	Regurgitation when standing up?	□0 □1 □2 □3 □4 □5
13.	Regurgitation after meals?	□0 □1 □2 □3 □4 □5
14.	Does regurgitation change your diet?	□0 □1 □2 □3 □4 □5
15.	Does regurgitation wake you from sleep?	□0 □1 □2 □3 □4 □5
16.	How satisfied are you with your present condition? □ Satisfied □ Neutral □ Dissatisfied	

Administered by

Monitored by

Date (mm/dd/yy)

Date (mm/dd/yy)

The Reflux Symptom Index

Reflux Symptom Index Scale Test: Rate the following items on a scale of 1-5. The composite of these scores should be 10 or below. If it is more than 10, you should consider an evaluation to check for "Silent Gastroesophageal Reflux Disease," or GERD.

The Reflux Symptom Index

Within the past month, how did the following affect you?

0 = No problem
5= Severe problem

	0	1	2	3	4	5
Hoarseness or a problem with your voice?	•					
Clearing your throat?	•					
Excess throat mucus or postnasal drip?	•					
Difficulty swallowing food, liquids or pills?	•					
Coughing after you ate or lie down?	•					
Breathing difficulties or choking episodes?	•					
Troublesome or annoying cough?	•					
Sensations of something sticking in your throat or a lump in your throat?	•					
Heartburn, chest pain, indigestion, or stomach acid coming up?	•					

SLEEPINESS SCALE

EPWORTH SLEEPINESS SCALE

Name: _____ **DOB:** _____ **Date:** _____

This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness.

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0 Would ***never*** doze

1 ***Slight*** chance of dozing

2 ***Moderate*** chance of dozing

3 ***High*** chance of dozing

	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
			Total Score:	

Interpreting Epworth Sleepiness Scale Scores[1,2]		
Normal	EDS*	High Levels of EDS*
0-10	>10	>16

Sources: **1.** Johns M, Hocking B. Excessive daytime sleepiness: daytime sleepiness and sleep habits of Australian workers. *Sleep*. 1997;20(10):844-849. **2.** Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. *Sleep*. 1991;14(6): 540-545.

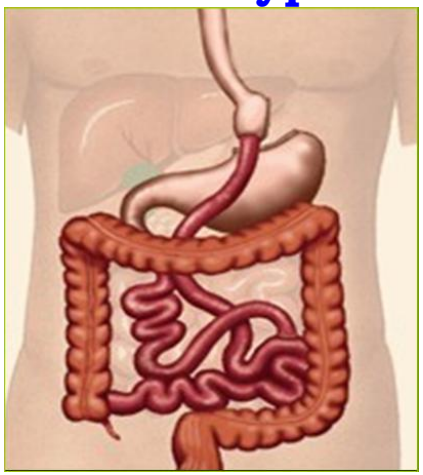
*Excessive daytime sleepiness.

ES&OSA

CHOICES

Which weight loss surgery procedure do I choose? This is the second most important decision t
you have to make. The first decision was to have surgery at Baylor University Medical Center at Dallas. T
surgeons are available to assist you in this process.

Gastric Bypass



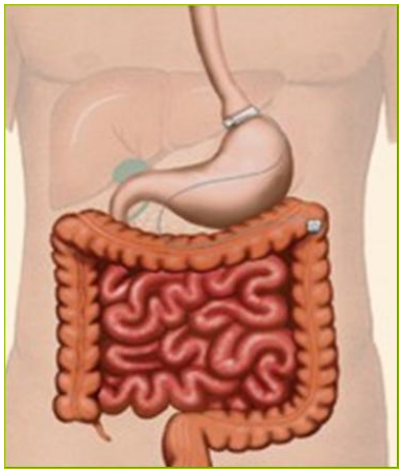
Advantages

Rapid weight loss
No need for adjustment
Restrictive and malabsorptive

Disadvantages

Higher risk
Non-adjustable
Lifetime need for supplements

Adjustable Gastric Band



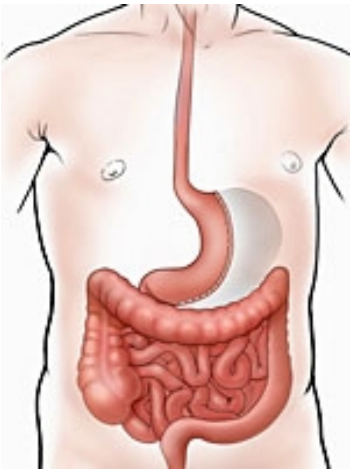
Advantages

Gradual weight loss
Adjustable
No malabsorption
Lower risk

Disadvantages

Slow weight loss
Frequent clinic visits for fills
Foreign body

Gastric Sleeve



Advantages

Moderate weight loss
No malabsorption
Moderate risk
No foreign body

Disadvantages

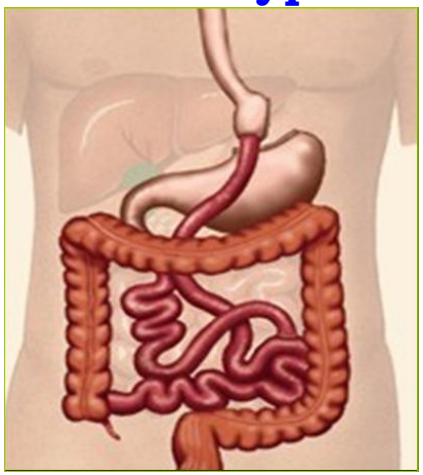
Slower weight loss than the Gastric Bypass
Non-adjustable
No long term results available

What are the risks for weight loss surgery? All surgeries, especially in the obese, carry risks. Common to all types of surgery are:

- Pulmonary complications such as blood clots, pneumonia, and shortness of breath
- Infections such as wound breakdown or abscess
- Heart, kidney, spleen, or other organ injury

WE TAKE PRECAUTIONS AGAINST ALL OF THESE AND MONITOR PATIENTS CLOSELY.

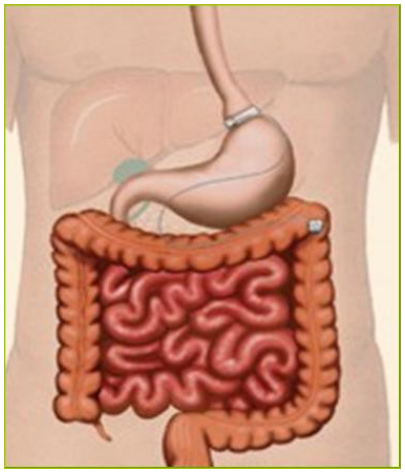
Gastric Bypass



Risks

Leakage from staple lines
Bleeding
Strictures
Too much weight loss
Too much malabsorption
Longer surgery

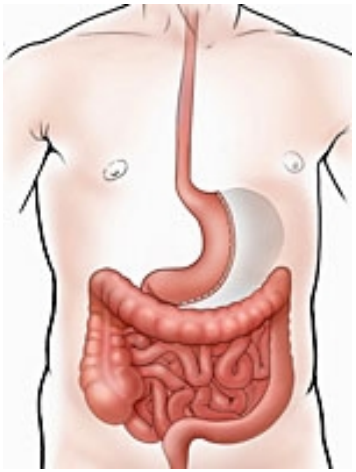
Adjustable Gastric Band



Risks

Band slippage
Band erosion
Inadequate weight loss

Gastric Sleeve

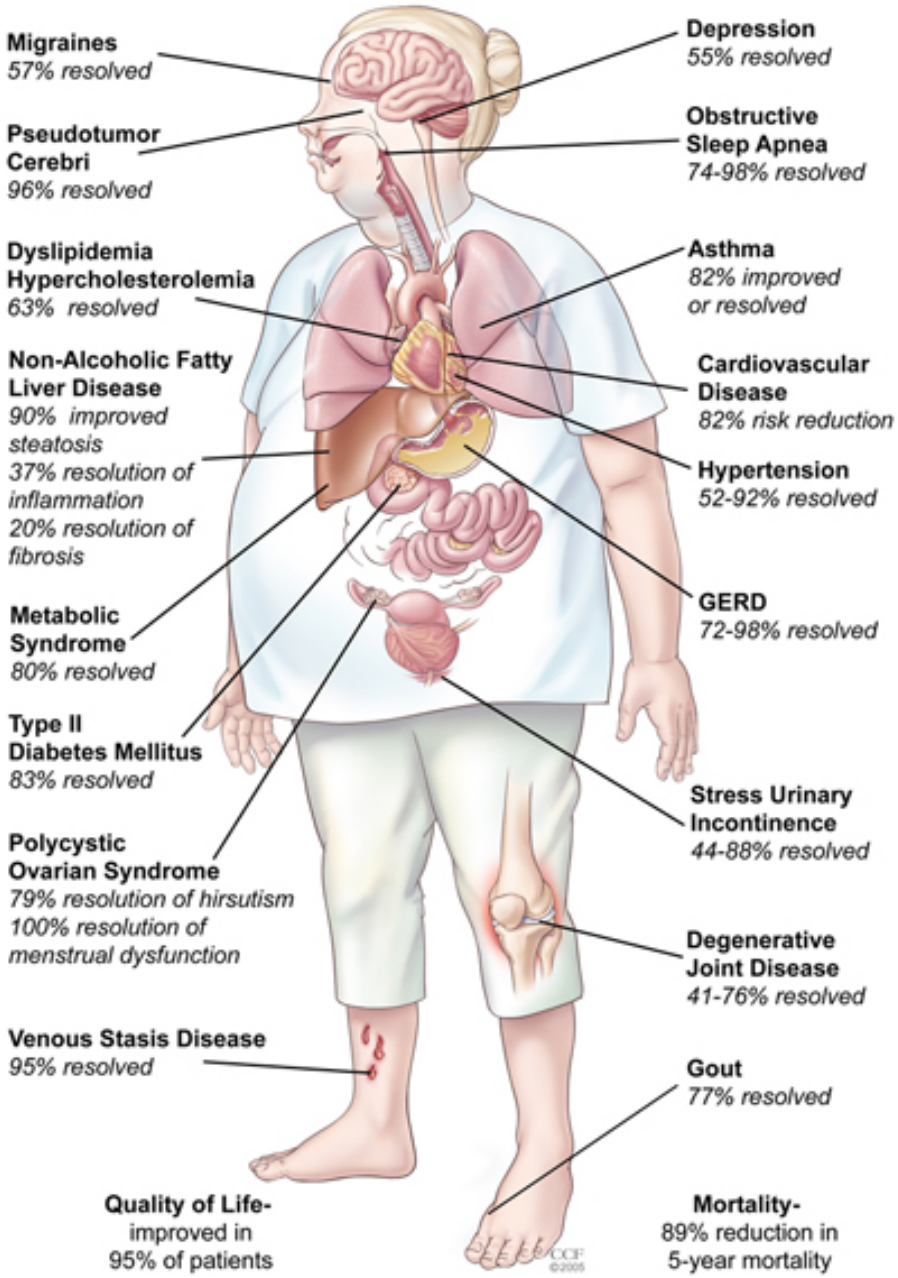


Risks

Leakage from staple lines
Inadequate weight loss

(214) 820-8220 • 9101 North Central Expressway, Suite 370• Dallas, Texas 75231

Bariatric Surgery is known to be the most effective and long lasting treatment for morbid obesity



Mounting evidence suggests it is among the most effective treatments for metabolic diseases and conditions including:
Type 2 Diabetes,
High blood pressure,
High cholesterol,
Non-alcoholic fatty liver disease and
Obstructive sleep apnea.

Baylor Scott & White
CENTER FOR MEDICAL & SURGICAL
WEIGHT LOSS MANAGEMENT

Bariatric Care Financial Acknowledgement & Agreement

As your prospective bariatric care provider, we want to ensure that you are aware and understand your bariatric benefits with your insurance company. Our office strives to assist in this process as much as possible, but we strongly encourage that you become familiar with the bariatric portion of your insurance policy by contacting your insurance company.

General Knowledge

If your insurance policy includes bariatric benefits, most will first require that you have a certain body mass index (BMI) in addition to having another qualifying comorbidity to be eligible for bariatric surgery. Additionally, if you do meet the minimum requirements, most insurance policies will also require a minimum of certain types of visits and testing prior to any surgical procedure. Lastly, even if you were referred from another physician due to medical necessity, that does not qualify you for bariatric benefits.

Lifetime Maximum

Most insurance companies have a lifetime maximum policy in place for bariatric benefits. What does that mean? If you have had a previous gastric procedure that is considered as a weight loss procedure, this will not be covered even if you have bariatric benefits as you have previously had this type of procedure.

What does that mean for the patient?

Our office strongly encourages that you become familiar with your specific policy while our office also coordinates with your insurance company to determine what type of bariatric benefits you may have.

Although you may have and qualify for bariatric benefits, you may be responsible for a portion of your care out of pocket until your policy comes into effect. Our office will notify you of any out of pocket expenses you may have, but we strongly encourage that you do the same to plan for payments that may be due at the time of service.

What if I do not have or qualify for bariatric benefits?

If your insurance policy does not include bariatric benefits or if you have used your lifetime maximum, our office offers a cash pay option that may be an option for you. If you do not qualify for bariatric benefits per your insurance policy, we will not submit to your insurance company.

We understand that insurance policies and coverage can be confusing and burdensome. As your prospective provider, we want to encourage you to understand the specifics of your plan and be aware of potential charges that may take place at the time of your visits. With this in mind, we strongly encourage you to contact your insurance company for any questions that you may have in regards to your bariatric benefits and your financial responsibility.

Sincerely,

Baylor Scott & White Center for Metabolic and Weight Loss Surgery

By signing below, I understand and acknowledge the above notice.

_____ _____

Name (Print) Date of Birth

_____ _____

Signature Date

24-Hour Cancellation and No Show Acknowledgement

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, BSW Center for Metabolic and Weight Loss Surgery reserves the right to consider patients a No Show that have not given proper 24-hour notice of cancelling or rescheduling their appointment.

Additionally, patients that do not show or are tardy 15 or more minutes for their scheduled appointment time will also be considered a No Show. Due to our high clinic volume, we allow (3) reschedules and/or (2) No Shows per patients. In the event you exceed our specified guidelines, it will result in a dismissal from our practice.

We do understand that circumstances may arise where this cannot be avoided. These circumstances will be addressed by the provider as they arise.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, I acknowledge that I have received this notice and understand the above policy.

_____ _____

Name (Print) Date of Birth

_____ _____

Signature Date

Center for Medical and Surgical Weight Loss Management
9101 N. Central Expressway, Suite 370
Dallas, TX 75231 214-820-8220

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **procedure** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **procedure** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Initial Consult 99203	May not be deemed medically necessary May deny for medical frequency May be deemed experimental	Up to $196.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. procedure** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

o **OPTION 1.** I want the **procedure** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

o **OPTION 2.** I want the **procedure** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

o **OPTION 3.** I don't want the **procedure** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

Center for Medical and Surgical Weight Loss Management
9101 N. Central Expressway, Suite 370
Dallas, TX 75231 214-820-8220

- **Patient Name:** **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **procedure** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **procedure** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Initial Nutrition Consult 97802	May not be deemed medically necessary May deny for medical frequency May be deemed experimental	Up to * $89 each 15 minutes * Possible total of $356

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. procedure** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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