LIVE BY LOSING

Advanced Laparoscopic General and Bariatric Surgery
Michael L. Green, Jr., M.D., FACS & Kristin E. Kamprath, MPAS, PA-C
Fort Worth • Colleyville • Dallas
817-720-9552 • Fax 817-921-1830

Welcome to the Live By Losing Center for Treatment of Morbid Obesity!

Thank you for considering us as your partner in what is sure to be an exciting step toward a new lifestyle. In order to accommodate you and to provide the best healthcare possible, please follow the steps below to ensure a smooth transition into the program.

1. A letter of medical necessity from your primary care physician with mention of failed attempts at weight loss, weight history and any health conditions related to obesity may be required. Please bring this with you to your first consultation if at all possible. (Example letter attached)

2. Complete the new patient packet in its entirety. Be sure to bring a copy of your insurance card(s) and photo ID to your appointment.

3. It is highly recommended you attend at least one support group meeting and one information seminar. You are welcome to bring family and friends with you as they will be a source of support in this life changing decision. A schedule of these meetings is enclosed.

4. It is very important that you communicate your desire for bariatric surgery to your insurance company before your first visit. Some insurance companies have pre-surgical programs in which you must enroll before you are seen by a bariatric surgeon. Our office will verify your insurance benefits for bariatric coverage beforehand, and will go over them with you at your pre-operative appointment. At this time we will go over your out of pocket cost for the procedure you have chosen.

5. Surgical fees must be paid in full prior to surgery. Please keep in mind we only quote Dr. Green's fees, not the hospital or anesthesiologist. Patients are responsible for contacting the facility for those costs.

After your initial consultation with Dr. Green we will mail you a letter of your pre-operative appointments including provider contact information. We are here to guide you through this process, so please contact us with any questions or concerns you might have. Thank you again for choosing Live by Losing.

Live By Losing

Fort Worth· Colleyville · Dallas
817-912-9775· Fax 817-922-1108

Minimally Invasive Advanced Laparoscopic
General and Bariatric Surgery

Example: Letter of Medical Necessity

DO NOT COPY

Date:

Dear Dr. Green:

My patient, _________________ is interested in undergoing gastric bypass surgery in an effort to lose weight. She/he has been under my care for 10 years and during this time she/he has tried several weight loss programs which include **Slim Fast, Jenny Craig,** and **Weight Watchers**. She/he has also attended an exercise program at a local gym, which has been unsuccessful. As these attempts have unfortunately failed to produce the desired results, Ms./ Mr. Smith has decided to undergo surgical intervention and participate in your comprehensive weight loss program. Due to her BMI of greater than 35 with co-morbidities (hypertension, diabetes, and hypercholesterolemia), **I feel that she/he is an appropriate candidate to undergo Bariatric Surgery**.

Sincerely,

Dr. XXXXXXXXXXXX

LIVE BY LOSING

Fort Worth • Dallas

Minimally Invasive Advanced Laparoscopic
General and Bariatric Surgery

PERSONAL HISTORY

HISTORY OF PRESENT ILLNESS

____
____
____
____

ALLERGIES

____
____
____
____

MEDICAL HISTORY

Diabetes	Yes	No	____________
High Blood Pressure	Yes	No	____________
Cancer	Yes	No	____________
Stroke	Yes	No	____________
Heart Trouble	Yes	No	____________
Arthritis / Gout	Yes	No	____________
Lung Problems	Yes	No	____________
Bleeding Tendency	Yes	No	____________
Acute Infection	Yes	No	____________
Venereal Disease	Yes	No	____________
Other	Yes	No	____________
LMP	Yes	No	

SOCIAL HISTORY

Married ☐ Single ☐ Widowed ☐

Divorced ☐ Separated ☐

Tobacco Use:

Never ☐ Yes ☐ Packs/Day_________

Year Started ________ Quit/Year________

Alcohol Use:

Never ☐ Rarely ☐ Moderate ☐

Daily ☐ Quit ☐

PRIOR SURGERY OR TRAUMA HISTORY

Year	
________	______________________________
________	______________________________
________	______________________________
________	______________________________
________	______________________________

MEDICATIONS

____
____
____
____
____

FAMILY HISTORY

Diabetes	Yes	No	____________
High Blood Pressure	Yes	No	____________
Cancer	Yes	No	____________
Stroke	Yes	No	____________
Heart Trouble	Yes	No	____________
Arthritis/Gout	Yes	No	____________

HERBS

____
____
____
____
____
____

Print Patient Name ______________________________ *Date* ____________

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING: please check or circle all that apply			
	CONSTITUTIONAL SYMPTOMS		
	Headaches		Change in force or strain when urinating
	Hereditary defects		Urinary incontinence
	Fever		Kidney stones
	Fatigue		Nocturia
	Weight Change		Female – Number of pregnancies -
	EYES		Female – Number of miscarriages -
	Eye disease or injury		**MUSCULOSKELATAL**
	Wear glasses or contacts		Joint pain
	Blurred vision		Joint swelling
	Double Vision		Muscle weakness
	Glaucoma		Muscle pain/cramps
	EAR/NOSE/MOUTH/THROAT		Cold extremities
	Hearing loss or ringing		Difficulty walking
	Earaches or drainage		**INTEGUMENTARY**
	Chronic sinus problems/rhinitis		Rash
	Nose bleeds		Itching
	Mouth sores		Change in skin color
	Bleeding gums		Change in hair or nails
	Bad breath/bad taste in mouth		Varicose veins
	Sore throat		Breast pain
	Voice change		Breast lump
	Swollen glands in neck		Nipple discharge
	CARDIOVASCULAR		Light headed or dizzy
	Heart trouble		**NEUROLOGICAL**
	Chest pain		Headache
	Palpations		Dizziness
	Swelling of feet		Convulsions
	Swelling of ankles		Extremity numbness
	Swelling of hands		Tremors
	RESPIRATORY		Paralysis
	Chronic cough		Stroke
	Spitting up blood		Head Injury
	Shortness of breath		**PSYCHIATRIC**
	Wheezing		Memory Loss
	GASTROINTESTINAL		Confusion
	Loss of appetite		Anxiety
	Change in bowel movement		Depression
	Nausea		Insomnia
	Vomiting		Psychosis
	Diarrhea		**ENDOCRINE**
	Painful bowel movement		Glandular problems
	Constipation		Hormone problems
	Rectal bleeding/blood in stool		Polydipsia
	Abdominal pain		Tired/Sluggish
	Heartburn		Diabetes
	Peptic ulcer		**HEMATOLOGIC/LYMPHATIC**
	GENITOURINARY		Bleeding tendency
	Venereal disease		Slow to heal
	Urinary frequency		Anemia
	Hematuria		Phlebitis
	Dysuria		Past blood transfusion
			Swollen glands

Print Patient Name ______________________________ *Date* ____________

Nutrition Profile

Patient Name______________________________________ Date of Birth__________________________

DIET HISTORY

Describe your past diets. (Include diet pills and/or laxatives, fad diets, liquids, etc.)

Type of Diet	Time Frame (i.e., month & year)	Total Weight Lost

Family History of Obesity? (Specify)

____

____

DIETARY HABITS: PLEASE (√) ANY OF THE FOLLOWING THAT DESCRIBES YOUR EATING PATTERNS:

☐ Eat 3 meals each day	☐ Eat a normal amount of food	☐ Eat 3 meals with snacks
☐ Restrict intake of food	☐ Binge without purging	☐ Binge followed by vomiting
☐ Binge followed by restricting food intake	☐ Binge followed by laxatives	☐ Restrict followed by diuretics
☐ Binge followed by exercise	☐ Vomit without binging	☐ Restrict food intake w/o binging
☐ Use of laxatives without binging	☐ Use of diuretics without binging	☐ Exercise excessively w/o binging

Exercise/Activity: ☐Not Currently Exercising ☐Activity_____________ Times/Week ________ Duration_______

Highest Adult Weight: ___________________Last time you were at your desired weight:_____

_______________ ______________________

Describe what hunger feels like to you:____

Describe what fullness feels like to you:____

How do you know when to quit eating?:____

BEHAVIORAL: PLEASE (√) ANY OF THE FOLLOWING THAT DESCRIBES YOUR EATING PATTERNS:

☐ Use of food as a reward/to pamper	☐ Eating on the run – fast food/convenience food
☐ Emotional Eating – stress, boredom, depression	☐ Eating too fast - rushing
☐ Skip meals – inconsistent meal pattern	☐ Binge eating - compulsive
☐ Portion Control	☐ Purging, vomiting, laxatives
☐ Inappropriate eating – watching TV, driving, while cooking	☐ Avoidance of major food groups
☐ Eating alone	☐ Fear of weight loss or gain
☐ Frequent traveling/eating out	☐ Salty foods
☐ Sweets-sugar, candy, chocolate, cookies, etc.	☐ Fats – butter, margarine, dressings, oils, etc.
☐ Food intolerance or allergies	

YOUR TYPICAL DAILY INTAKE:

Breakfast Time:	Snack	Lunch Time:	Snack	Dinner Time:	Snack

What are your personal nutritional goals? ____

____

____

____

Patient Signature

Date

Epworth Sleepiness Scale

Name:_______________________________________ ○ Male ● Female DOB:________________

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
1. Sitting and reading	________
2. Watching TV	________
3. Sitting inactive in a public place	________
4. Being a passenger in a motor vehicle for an hour or more	________
5. Lying down in the afternoon	________
6. Sitting and talking to someone	________
7. Sitting quietly after lunch (no alcohol)	________
8. Stopped for a few minutes in traffic while driving	________
TOTAL SCORE (This is your Epworth score)	________

Please check the box if you experience any of the following symptoms on a regular basis:

- ☐ I snore or have been told I snore.
- ☐ I've been told I stop breathing when I sleep or suddenly wake gasping for breath.
- ☐ I have high blood pressure.
- ☐ I tend to sweat excessively during the night.
- ☐ I frequently wake with headaches in the morning.
- ☐ I have been told that I sleep restlessly.
- ☐ I tend to fall asleep during inappropriate times.
- ☐ I am overweight or have recently gained weight.

____ ________________________

Patient Signature Today's Date

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)

Provider's Name:	**Recipient's Name:** Michael L. Green, Jr., M.D., FACS		
Provider's Address:	**Address 1:** 900 Jerome St.		
	Address 2: ***Suite 204***	**Recipient's Phone:** 817-720-9552	
	City: *Ft. Worth*	**State:** TX	**Zip:** 76104

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email** ☐ **FAX 817-921-1830**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: Medical Care

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Office Visit Notes:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _______________ (Initial)

I understand that:
- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes **X** No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes **X** No
If yes, describe: N/A
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes **X** No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ROI

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, LIVE BY LOSING may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge LIVE BY LOSING may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to LIVE BY LOSING any insurance or other third-party benefits available for health care services provided to me. I understand LIVE BY LOSING has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to LIVE BY LOSING, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to LIVE BY LOSING by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for LIVE BY LOSING, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that LIVE BY LOSING or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or LIVE BY LOSING or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: ______________________________ **Date**: ________________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Guarantor
- ☐ Healthcare Power of Attorney
- ☐ Other (please specify) ______________________________

Live by Losing Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes

*This Form to be used in Conjunction with Form entitled "Consent for Use and Disclosure of Image, Voice and/or Written Testimonials"

Patient Identification

Printed Name: ___________________________________ Date of Birth: ____________________

Address: ____

____

Telephone: __________________________________

Information to Be Released – Covering the Periods of Health Care

From (date) ___________________________________ to (date) _All - ongoing due to the nature of the internet

Type of information to be released: Video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials and statements, including biographical information, of the individual identified above.

Purpose of Request To videotape, photograph and record audio of patients for the facility's marketing purposes, including but not limited to production of recordings, brochures, advertisements, videos and similar image and sound capture for purposes of publication and/or distribution via all types of media.

Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to the facility for this use of protected health information. Check One: ☐ **Yes** ☐ **No** _________ **Initials**

Persons Authorized to Receive Information

I agree that the publication and distribution of the protected health information described herein may and likely will include distribution of such information to the general public via various methods, including all types of media outlets (e.g., TV, radio, newspaper, Internet) for the facility's marketing purposes. I also understand that the facility may hire third parties to capture the image and/or voice of the individual identified above, and that my information will be used and disclosed by these third parties as instructed by the facility.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if any videotape, photograph or audiotape references drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐ **Yes** ☐ **No** _________ **Initials**

Expiration & Right to Revoke Authorization Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at _________________________________. Unless revoked, this authorization will expire on the following date or event: ____.

In the event that facility has relied on this authorization to create marketing and/or other promotional materials featuring my likeness (e.g., photographs or video), audiotapes of my voice, my name, my testimonial or recommendation and/or other information released pursuant to this authorization, I understand and agree that facility shall retain the right to use my likeness, voice, name, testimonial and/or other information until such time as all such marketing and/or promotional materials then in existence at the time of any revocation of this authorization are distributed, disseminated or expire. Any revocation of this authorization will become effective only after all marketing and/or promotional materials are distributed, disseminated or expire.

Re-disclosure I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure I understand that facility may not condition treatment for the individual identified above on whether I sign this authorization form. I may inspect or copy the protected health information to be used or disclosed. I authorize the facility to use and disclose the protected health information specified above for the purposes set forth above.

Signature: _________________________________ Print Name: _____________________________ Date: _____________

Authority to Sign if not patient (e.g., parent, guardian): ____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify _______________________________

Verified by Facility Employee (Signature): ____

Live by Losing Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes

***This Form to be used in Conjunction with Form entitled "Consent for Use and Disclosure of Image, Voice and/or Written Testimonials"**

CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS

For good and valuable consideration, receipt of which is hereby acknowledged, I authorize HCA Management Services, L.P., and its affiliates (collectively, "HCA") and its respective parents, affiliates, subsidiaries, licensees, successors, and assigns to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish any verbal or written statements, testimonials or biographical information I may provide regarding HCA and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s) (collectively, the "Materials"). I understand that for purposes of this consent, the terms "image," "voice" and "photograph" encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

HCA shall be the owner of the results and proceeds of such taping, photography, and recording with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet, all or any portion thereof or of a reproduction thereof, free of any payment, royalty, or other compensation of any kind to me. I expressly understand and agree that the Materials and all results and proceeds derived therefrom, shall be the sole and absolute property of HCA for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf. I further represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby represent and warrant that I have not given any other person, entity or firm the exclusive right to use by name, likeness, voice or photograph, and that by signing this document I am not in breach of any other agreement to which I am a party.

I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of HCA and that HCA is under no obligation to use the Materials. I acknowledge that HCA will rely on this permission potentially at substantial cost to HCA and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby acknowledge that I am solely responsible for any statements made by me during the recording of my voice and/or likeness as described above, which statements shall consist solely of my opinions and do not necessarily represent those of HCA, which is not responsible for the content of such statements. I hereby forever release and discharge HCA, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither HCA nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above or in the execution of this Consent for Use and Disclosure of Image, Voice and/or Written Testimonials (the "Consent").

I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the "Authorization"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: ___________________________________

Print Name: ______________________________________ Date: _________________

Relationship of Legal Representative to Patient (e.g., parent, guardian):

____

CIRCLE OF CARE

Patient Name: ____ **Patient DOB:** ______________________________

Pharmacy Name/Location: ____ **Pharmacy Phone:** ______________________

List all physicians you see:

Provider Name: ____ Specialty: _________________________

Address: ____ Phone/Fax: __________________________

Provider Name: ____ Specialty: _________________________

Address: ____ Phone/Fax: __________________________

Provider Name: ____ Specialty: _________________________

Address: ____ Phone/Fax: __________________________

Provider Name: ____ Specialty: _________________________

Address: ____ Phone/Fax: __________________________