BAPTIST HEALTH®
MEDICAL GROUP

Dear Valued Patient,

My name is Samantha Sanders and I am the Practice Manager with Baptist Health Medical Group Floyd Bariatrics. On behalf of the entire team, I would like to welcome you and thank you for your interest in our program. BHMG Floyd Bariatrics started in 2016 and has been a growing program every year since. It is because of patients like you that we continue to grow and are committed to providing you the best care possible. If there is anything you need throughout your journey, please reach out to me directly at, 812-949-7151.

Congratulations! You have completed the first step in your weight loss journey by receiving this packet. Once you have returned your completed packet our Bariatric Team will guide you throughout the surgical process and work diligently to help you succeed before and after surgery.

We look forward to serving you in your quest for better health. Thank you again for choosing Baptist Health Medical Group Floyd Bariatrics.

Sincerely,

Samantha Sanders
Practice Manager

Baptist Health Medical Group Floyd Bariatrics
2125 State Street, Suite 1
New Albany, IN 47150

812.949.7151 office
812.989.7191 fax
BHMGBariatrics@bhsi.com

AETNA INSTITUTES OF QUALITY® aetna™

AMERICAN COLLEGE OF SURGEONS · MBSAQIP® ACCREDITED CENTER · QUALITY PROGRAM · AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY

Blue Distinction® Center Bariatric

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Patient Information Packet

Preferred Procedure:

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ Laparoscopic Sleeve Gastrectomy

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

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require: _____

Patient Information

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

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

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

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify

❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

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

What is your height?_____ft. _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student

❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ☐ Yes ☐ No If Yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ☐ Yes ☐ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ☐ Cane ☐ Walker ☐ Crutches ☐ Other:_____

Are you wheelchair bound and unable to stand at all? ☐ Yes ☐ No How long in wheelchair?_____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney, healthcare companion/caretaker, or anyone who makes your medical decisions?

☐ YES ☐ NO If yes, who?_____Relationship to you?_____

Do you have a living will? ☐ YES ☐ NO

Please provide the office with a copy of any legal documentation pertaining to the above questions.

Spouse Information

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ☐ Insurance ☐ Self Pay

Primary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____Phone:_____

"I hereby authorize Baptist Health Medical Group to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician

First Name:_____ Last Name:_____

Street Address:_____

City:_____State:_____ Zip Code:_____Phone:_____

Have you discussed Weight Loss Surgery with your physician? ☐ Yes ☐ No Is your physician supportive? ☐ Yes ☐ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Other:_____

Please list any specialists/ providers that you currently see: ☐ NONE

Name	Specialty	Address/phone

Blood Consent

You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (*☐ If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Weight Loss History

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ☐ Yes ☐ No

(If yes, please provide this information when entering in your previous surgical history)

What is the most weight you have ever lost on a single diet?_____Lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ☐ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ☐ NONE

☐ Body for Life/Bill Phillips	☐ High Protein	☐ Low Fat	☐ Cabbage Soup
☐ Pritikin	☐ Stillman Diet	☐ Mayo Clinic	☐ Fasting
☐ Gloria Marshall	☐ Herbal Life	☐ Calorie Counting	☐ Scarsdale
☐ Richard Simmons	☐ Sugar Busters	☐ Atkin's Diet	☐ Slim Fast
☐ Health Spa	☐ Low Carbohydrate	☐ South Beach	☐ Other:_____

Supervised Diet Attempts: ☐ NONE

☐ Nutri-System	☐ Overeaters Anonymous	☐ Weight Watchers	☐ Jenny Craig
☐ TOPS	☐ Optifast	☐ HMR	☐ DASH
☐ LA Weight Loss	☐ Diet Center	☐ Other:_____	

Over-the-Counter or Prescribed Medications for Weight Loss: ☐ NONE

☐ Acutrim	☐ Dexatrim	☐ Ionamin/Adipex	☐ Phendiet	☐ Prozac
☐ Wellbutrin	☐ Amphetamines	☐ Didrex	☐ Tenuate	☐ Phentrol
☐ Redux	☐ Byetta	☐ Plegine	☐ Sanorex	☐ Meridia
☐ Xenical	☐ Diuretics	☐ Pondimin	☐ Phenteramine	
☐ Fen-Phen,				

# of months:_____ ☐ Other:_____

Behavioral Treatments for Weight Loss: ☐ NONE

☐ Hospitalization	☐ Hypnosis
☐ Physical Therapy	☐ Psychological Therapy
☐ Residential Programs	☐ Other:_____

Exercise: ☐ NONE

☐ Walking/Running	☐ Stationary cycle or treadmill
☐ Swimming	☐ Weight Training
☐ Team Sports	☐ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ☐ Yes ☐ No

- If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages/soda? ❍ Yes ❍ No

- If yes, how many cans/bottles per day?_____

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

☐ Binging and Purging ☐ Binging followed by food restriction ☐ Vomiting

☐ Excessive Exercise ☐ Excessive Calorie Restriction/Fasting

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

Do you currently force yourself to vomit after eating? ☐ Yes ☐ No

Why do you feel you eat? ☐ Physical Hunger ☐ Loneliness ☐ Anxiousness ☐ Makes me happy ☐ Bored

What reasons do you feel contribute to your weight? ☐ Over Consumption ☐ Inactivity ☐ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how/why you have been unable to lose weight and/or maintain?

_____

_____

_____

Please tell us how your weight is interfering with your health and life?

_____

_____

_____

Why are you seeking weight loss surgery?

_____

_____

_____

Please tell us why you feel you can be successful with weight loss surgery?

_____

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?

_____

_____

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

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:_____	

Head and Neck	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:_____

Cardiovascular	☐ **NONE**	
☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Shortness of Breath on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:_____

Respiratory	☐ **NONE**	
☐ Asthma	☐ Emphysema / COPD	☐ Bronchitis
☐ Pneumonia	☐ Chronic Cough	☐ Shortness of Breath at Rest
☐ Use of CPAP / BiPAP	☐ Use of Oxygen	☐ Snoring
☐ Pulmonary Embolism	☐ Sleep Apnea	☐ Had a sleep study; when:_____
☐ Other:_____		

Gastrointestinal	☐ **NONE**	
☐ Heartburn	☐ Hiatal Hernia	☐ Ulcers
☐ Diarrhea	☐ Blood in Stool	☐ History of elevated Liver Enzymes
☐ Constipation	☐ IBS (irritable bowel syndrome)	☐ Umbilical Hernia
☐ Difficulty Swallowing	☐ Hemorrhoids	☐ Fissure / Polyps
☐ Rectal Bleeding	☐ Black, Tarry Stool	☐ Ventral Hernia
☐ Abdominal Pain	☐ Enlarged Liver	☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems	☐ Jaundice	☐ Pancreatic Disease
☐ Nausea / Vomiting	☐ GERD	☐ Incisional Hernia
☐ Barrett's Esophagus	☐ N A F L D / N A S H	☐ Other: _____

Bladder/Kidney ☐ **NONE**

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

☐ Overall Loss of Bladder Control ☐ Urinary Urgency/Frequency/Pain/Burning ☐ Other: _____

Gynecologic (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post-Menopausal

Current method of birth control: _____

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram: _____

Musculoskeletal ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Osteoarthritis ☐ Other: _____

Neurologic ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**
If yes, please provide name & phone number: _____

☐ Depression/Anxiety ☐ Hospitalized for psychiatric problems When:_____

☐ Bipolar Disorder ("manic-depression") ☐ Attempted suicide When: _____

☐ Alcoholism / Substance Abuse ___ Past? ___ Present? ☐ Experience Suicidal Ideation When: _____

☐ Been in a chemical dependency program When: _____ ☐ Inflicted self-harm When: _____

☐ Schizoaffective disorder ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Borderline Personality Disorder ☐ Other:_____

Endocrine ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ PCOS ☐ Other: _____

Blood/Lymphatic ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Other:_____

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		

Current Pharmacy:	**Address:**	**Phone #**

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 ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

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

_____

Foods (List foods and the reaction):_____

Surgical Procedure(s):	☐ **NONE**	**Year**		**Year**
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	☐ Ovaries Removed	_____	Pacemaker	_____
Hernia: ☐ Hiatal	☐ Inguinal	☐ Incisional	☐ Umbilical	
Tubal Ligation		_____	Knee: ☐ Right ☐ Left	_____
Cesarean Section		_____	Breast Biopsy: ☐ Right ☐ Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Hemorrhoidectomy		_____	Kidney Surgery:_____	_____
Colon Resection		_____	Back:_____	_____
Endoscopy/EGD		_____	Other:_____	_____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation 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

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ☐ **NONE**

☐ Nausea ☐ Heart Stopped ☐ Woke up during procedure

☐ Vomiting ☐ Stopped Breathing ☐ Other:_____

☐ Difficulty Waking Up ☐ Difficulty Urinating

Social History

Do you smoke now? ☐ Yes ☐ No If yes, how many packs per day?_____

Have you smoked in the past? ☐ Yes ☐ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ☐ Yes ☐ No If yes, how frequently do you use?_____

Do you consume alcohol now? ☐ Yes ☐ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years have/had you drank alcohol? _____Years

Is anyone concerned about the amount you drink? ☐ Yes ☐ No If you have quit, how many years since?_____

Do you use street drugs now? ☐ Yes ☐ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

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?_____

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 Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Name of person completing packet: _____

Relationship to patient: _____

Signature of person completing packet: _____

Signature of patient: _____

Thank you for taking the time to complete the Patient Information Packet.
Please return this packet, a copy of your insurance card(s) front and back, a copy of your photo ID, and your current insurance plan's certificate of insurance to Baptist Health Medical Group Floyd Bariatrics. The office will start processing your information once received and will contact you within the next 30 business days.

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Welcome to Baptist Health Medical Group. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are several steps leading up to bariatric surgery, so we have developed a multidisciplinary team to help you. It is very important that you take an active role during this process. Your efforts will ensure the process moves as efficiently as possible.

In order to provide you with the best possible service, we must have the following information on file before scheduling your initial intake appointment in our Weight Management and Bariatric Center. You may use this sheet as a checklist for your items.

Send or bring to Baptist Health Medical Group Floyd Bariatrics

- **New Patient Paperwork Packet**
- **Certificate of insurance for your current plan**: this can be obtained by calling your insurance and requesting it or logging into your insurance patient portal
    - If you have a Medicaid or original Medicare policy you may skip this step
- **Insurance and Prescription Cards**: Include copies of all cards, front and back
- **Photo ID**: front and back

Baptist Health Medical Group Floyd Bariatrics
2125 State Street Suite 1
New Albany, IN 47150

Fax: 812-949-7191
Email: BHMGBariatrics@bhsi.com

Determining Your Insurance Benefits

- The amount insurance pays depend upon specific coverage of the individual policy.
- If you have a lifetime limit or max for bariatric surgery, once that is met, you will be responsible for any remaining charges.

You may get started on the following items, but they are not necessary to complete before your first visit.

- Insurance companies may require participation in a medical weight management program before surgery is approved. In order to best prepare patients for a new post-surgery lifestyle, Baptist Health Medical Group Floyd Bariatrics can provide this service to our patients.
    - However; you may see your primary care physician monthly to fulfill the requirement specified by your insurance plan. Our office can provide the forms that include the insurance requirements. Each monthly visit must include; height, weight and goals for a diet and exercise plan.
      **Diet programs (Weight Watchers®, Jenny Craig®, etc.) typically do not meet this requirement.
- Many insurance companies require daily food and exercise logs. You may consider beginning these as soon as possible.
- Please note that preauthorization is not a guarantee of payment. Medical necessity of the services will be determined by insurance before they are provided.

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Additional Fees: Billed to Your Insurance and Subject to Co-pays and Deductibles

- Psychiatric evaluation
- Lab workup
- Additional tests (if needed): sleep study, cardiac stress test, EGD, EKG, etc.
- Surgeon consult
- Follow-up visits to surgeon

Additional Out of Pocket Fees

- Fusion Shakes for liver reduction diet $45.00-$95.00. These can be purchased in our office at your pre-operative appointment
- Bariatric vitamin supplementation, prices vary depending on type and quantity, but range $29.00- $52.00. These can be purchased in our office at your 1st post-operative appointment.

Some insurance policies have contract exclusions which mean that weight loss surgery will not be paid for even if it is medically necessary. Self-pay information is available by request. If you have questions regarding your insurance, please contact our office at, (812) 949-7151.

I give Baptist Health Medical Group Floyd Bariatrics permission to contact my insurance company for information regarding my coverage.

By signing below, I certify that I have read and understand the above instructions provided to me.

Sign: _____ **Date: _____**

Patient Name: _____ **Date of Birth: _____**

PLEASE KEEP THIS FOR YOUR RECORDS

Bariatric Surgery Patient Process

1. Attend zoom seminar or watch pre-recorded seminar

2. Return completed new patient paperwork packet, certificate of insurance for your current policy, copy of insurance card(s) (front & back), copy of prescription card (if applicable), and photo ID for benefits and clinical review
    - You may return your packet via mail, email, fax or in person
    - If you have a Medicaid or original Medicare insurance policy, you do not need to submit a copy of your certificate of insurance

3. Our office will then call you to discuss insurance benefits and clinical review findings
    - **This can take up to 30 business days**

4. Initial intake appointment will include:
    - Nutrition Education Group Class
    - Exam and medical education with APRN
    - Psychiatric exam
    - Nutrition Evaluation with Registered Dietitian
    - Meeting with surgery coordinator to discuss insurance requirements and surgical clearances

**This is an extremely important appointment that we ask you be committed to having surgery before you schedule.

5. Submit necessary documentation to the office
    - Insurance required document (i.e., Supervised Weight Loss Visits, Food and Exercise logs, medical testing and clearances)

6. Our office will submit your file to insurance for prior-authorization.
   Prior authorization is not a guarantee of payment. Medical necessity of the services will be determined by insurance before they are provided.
    - **It can take up to 60 days to have surgery once you have completed everything.**

7. Pre-Op Appointment will include:
    - Pre-op group education class with Registered Dietitian
    - Surgical consent, education, and meeting with Dr. Gore

If you choose to purchase protein shakes in our office for the Liver Reduction Diet it is approx. $45.00-$95.00 (Not covered by insurance)

8. Receive a Surgery Date
   All surgery dates are subject to change

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PLEASE KEEP THIS FOR YOUR RECORDS

Bariatric Surgery Patient Process

- We offer a Bariatric Support Group via Zoom the 2nd Thursday of the Month with our Registered Dietitian.

Return completed paperwork to:

Email: BHMGBariatrics@bhsi.com

Address: 2125 State St, Suite 1
New Albany, IN 47150

Fax: 812-949-7191

We appreciate your business and take pride in helping our patients succeed. Please be advised that our office has a no show and cancellation policy. If you fail to make your scheduled appointments, you may be dismissed from the bariatric program.

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