



BAPTIST HEALTH[®]

PADUCAH



Dear Patient,

Thank you for your interest in our program. Our program would like to personalize your care. Please register in our patient portal before you come to your first appointment. Our patient portal can help keep you on track throughout your process in preparing for surgery and will allow you to access the REQUIRED online seminar. This portal is separate from MyChart.

Link for website: www.baptisthealthweightloss.com

- Click on Information Seminars
- On the next page click on the link for Paducah in-person and online weight loss seminars
- Watch Paducah Bariatric seminar
- Before the video will load you will have to create an account and then the video will load automatically once this is complete.
- You will need to activate your account through email before you can complete the next step
- At the top of the page it says to complete Patient Information Survey, click where it says Click Here
- **Please fill in general information, size information, weight history, food preferences and beverage frequency only. DO NOT FILL OUT MEDICAL HISTORY IN BARITRAX.**

This is REQUIRED before your first appointment.

We look forward to seeing you. Please contact our office with any questions or concerns 270-575-8462.

Thank you again!

300047

BAPTIST HEALTH MGW Bar Surg Pad
Department/Practice:

BH VERBAL RELEASE AUTHORIZATION [Authorization to Verbally Disclose Protected Health Information with Family Member(s) or Other Designated Person(s)]

I _____ DOB _____ hereby authorize MGW Bar Surg Pad
(Patient's Name – please print) (Department/Practice)

to verbally share the following information:

- Appointments
- Payments/Billing
- Prescription refills
- Test Results
- Plan of Care/Progress

with the individuals listed below who may be involved with my health care or payment for my health care:

Name:	Relationship to Patient:	Telephone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

- I authorize my provider or other staff in his/her practice/department to leave detailed messages regarding the above medical information on my answering machine/voicemail at:
- Home Cell/mobile
 - All phone numbers listed

I understand that I have the right to revoke this authorization at any time by written notification to the Department/Practice listed above; however, the revocation will not apply to information that already has been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to advise the Department/Practice listed above of changes to my telephone numbers or my preferences regarding Individuals involved in my care and telephone messages. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand and acknowledge that the confidential health care information disclosed to the above-named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations. The provider expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

Patient's Signature (parent/guardian if patient is a minor)

Date



BAPTIST HEALTH[®]

MEDICAL GROUP

Patient Information Packet

Baptist Health Bariatrics and Weight Loss-Paducah

2601 Kentucky Ave Suite #102

Paducah, KY 42003

270-575-8462

Fax 270-443-0235

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

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

Asian Caucasian Native Hawaiian / Other Pacific Islander Other: _____

Religious affiliation: _____ Are you a veteran? Yes No

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: _____

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

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

YES NO If yes, who? _____ Relationship to you? _____

Spouse Information

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

Insurance Information – (You must bring your insurance card with you to your appointment)

Emergency Contact

First Name: _____ Last Name: _____

Relation to you: _____ Phone: _____

Activity Level: Check all that apply:

Can you walk unassisted? Yes No Can you walk indoors around the house without stopping? Yes No

Can you walk at a BRISK pace for 5 minutes without stopping? Yes No

Can you do light housework (dusting, dishes) without stopping? Yes No

What is the most demanding physical activity you participate in? _____

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)

What limits your activity (joint/back pain, chest pain, shortness of breath, balance, vision

Exercise: NONE Walking or Running Stationary cycle or treadmill Swimming

Weight Training Team Sports Other: _____

Unsupervised Diet Attempts: NONE

- High Protein Low Fat Mayo Clinic Fasting Herbal Life Calorie Counting
 Richard Simmons Atkin's Diet Slim Fast Noom Living the Life Cabbage Soup Diet
 South Beach Low Carbohydrate/KETO

Supervised Diet Attempts: NONE

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

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

- Acutrim Dexatrim Wellbutrin Xenical Diuretics Phentermine
 Other: _____

Behavioral Treatments for Weight Loss: NONE Hypnosis Psychological Therapy

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 Over Consumption Inactivity Emotional Well being

Review of Symptoms: (Check all that apply)

General:

NONE

- Fevers Weight Gain Tired / No Energy Appetite Change Night Sweats
 Insomnia Hair Loss Other: _____

Psychiatric

NONE

Are you currently under the care of a mental health provider? Yes No

- Alcoholism/Substance Abuse Anxiety Depression Been hospitalized for psychiatric problems
 Been in a chemical dependency program Bipolar Disorder Attempted suicide
 Currently taking medications for psychiatric problems or for depression Victim of Mental/Emotional/Sexual/Physical Abuse
 Other: _____

HENT (OPHTHALMIC/ENT)

NONE

- Wear contact /glasses Vision Problems Hearing Problems Sinus Drainage Nose Bleeds
 Hoarseness Dentures, Partial/Full Allergies Regular Ear Infections Other: _____

Hematological & Lymphatic (Blood/Lymphatic)

NONE

- Bruise Easily Swollen Lymph Nodes Bleeding/Clotting Disorder Blood thinning medicine use
 Prior blood Transfusion Other: _____

Endocrine **NONE**
 Low Blood Sugar Excessive Thirst Abnormal Facial Hair Excessive Urination Cold Intolerance
 Warm/Heat Intolerance • Fatigue Pre-Diabetes Other: _____

Respiratory **NONE**
 Chronic Cough Shortness of Breath at Rest Wheezing Coughing up blood Use of Oxygen
 Snoring Asthma COPD/Emphysema Other: _____

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

Gastrointestinal **NONE**
 Diarrhea Blood in Stool Constipation Abdominal Pain Difficulty Swallowing
 Rectal Bleeding Black, Tarry Stool Nausea / Vomiting Other: _____
 IBS Barrett's Esophagus

Kidney/Bladder **NONE**
 Blood in Urine Leaking urine w/ cough/laugh/sneezing Trouble starting urine Burning/Pain on urination
 Urinary Urgency/Frequency Overall Loss of Bladder Control Other: _____

Gynecologic/Breast **NONE**
How many pregnancies have you had: _____ Problems Conceiving/Infertility Currently Pregnant Menstrual Irregularity
 Menstrual Pain Excessively Heavy Periods Plan to have more children Breast Nipple Discharge
 Breast Lumps Polycystic Ovaries (PCOS) Breast Pain Other: _____

Musculoskeletal **NONE**
 Back Pain Broken Bones Muscle Pain / Spasm Joint Pain: (which) _____
 Other: _____

Neurologic **NONE**
 Balance Disturbance Dizziness Seizures or convulsions Weakness Numbness / Tingling
 Migraines Other: _____

Dermatological (Skin) **NONE**
 Frequent Skin Infections Keloids (Raised Scars) Poor Wound Healing Rashes under Breasts/Skin Folds
 Hair or Nail Changes History of boils Other: _____

Please check to make sure that you have completed all the following before bringing in your packet:

- Filled out this form as completely as possible
- Called your insurance and completely fill out the

PATIENT INSURANCE REVIEW FORM

This form is to help you determine if your insurance policy has benefits for weight loss surgery and/or nutritional counseling. Please follow the instructions below. **This form does not need to be completed for Medicare or Medicaid but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**

Instructions:

1. Call the member services 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. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as need before writing on this form.
 - a. **Medicare or Medicaid 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.**

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 Date of Birth	

#	Question for Representative	Answer from Representative
1	Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	<input type="checkbox"/> Yes (Continue with this form.) <input type="checkbox"/> No (Complete #s 2, 9 & 10 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. If they inform you that it is not a covered service this also means it will not be covered even if medically necessary.		
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	Am I required to have Weight Loss Surgery at a Blue Distinction Center? (we are not BDC)	

5	Is Baptist Health Medical Group-Bariatric (Dr. Anthony Davis) in my network? Tax ID#: 205497203	
6	Is the Baptist Health facility in my network? Tax ID# 610444707	
7	Is a referral required for specialist office visits?	
8	What are the preoperative requirements for surgery approval?	
9	Is nutrition counseling for obesity covered? What %?	
10	Which procedures are covered? At what %? Sleeve Gastrectomy (43775)? Gastric Bypass (43664)?	
11	What is the deductible per calendar year?	
12	What is the maximum out of pocket per calendar year?	
13	Is the deductible applied to the maximum out of pocket?	
14	Name of the representative	
15	Date you spoke to representative	
16	Reference number for call	

Disclaimer:

- o Baptist Health Medical Group- Bariatric is not responsible for incorrect information the insurance company may provide to you.
- o 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.
- o Completion of this form does not mean that you are approved for weight loss surgery. **A surgical pre-approval can only be obtained once all necessary medical testing is completed and reports are able to be sent to the insurance company.**

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: _____