Saint Francis Hospital - Memphis
Center for Surgical Weight Loss

Saint Francis Center for Surgical Weight Loss
6005 Park Avenue Ste. 1011B,
Memphis Tn. 38119

*****PLEASE NOTE This is our office, not our seminar address. Please see directions to our seminar location at the bottom of this page (in red)*****

Phone: (901) 881-0600
Fax: (901) 765-3585

Thank you for contacting the Saint Francis Center for Surgical Weight Loss.

Please follow the instructions provided in order to process your application.

- Complete the attached Program Application in its entirety.
- A copy of the front & back of your insurance card(s) is required to process your application. If you cannot bring a copy put all policy information on your application
- Bring the completed Program Application and copy of your insurance card(s) to the Bariatric Seminar you have been scheduled to attend. You may also fax or scan your application to Leslie.albers@tenethealth.com

If you have questions, please call Leslie Albers at (901) 881-0602

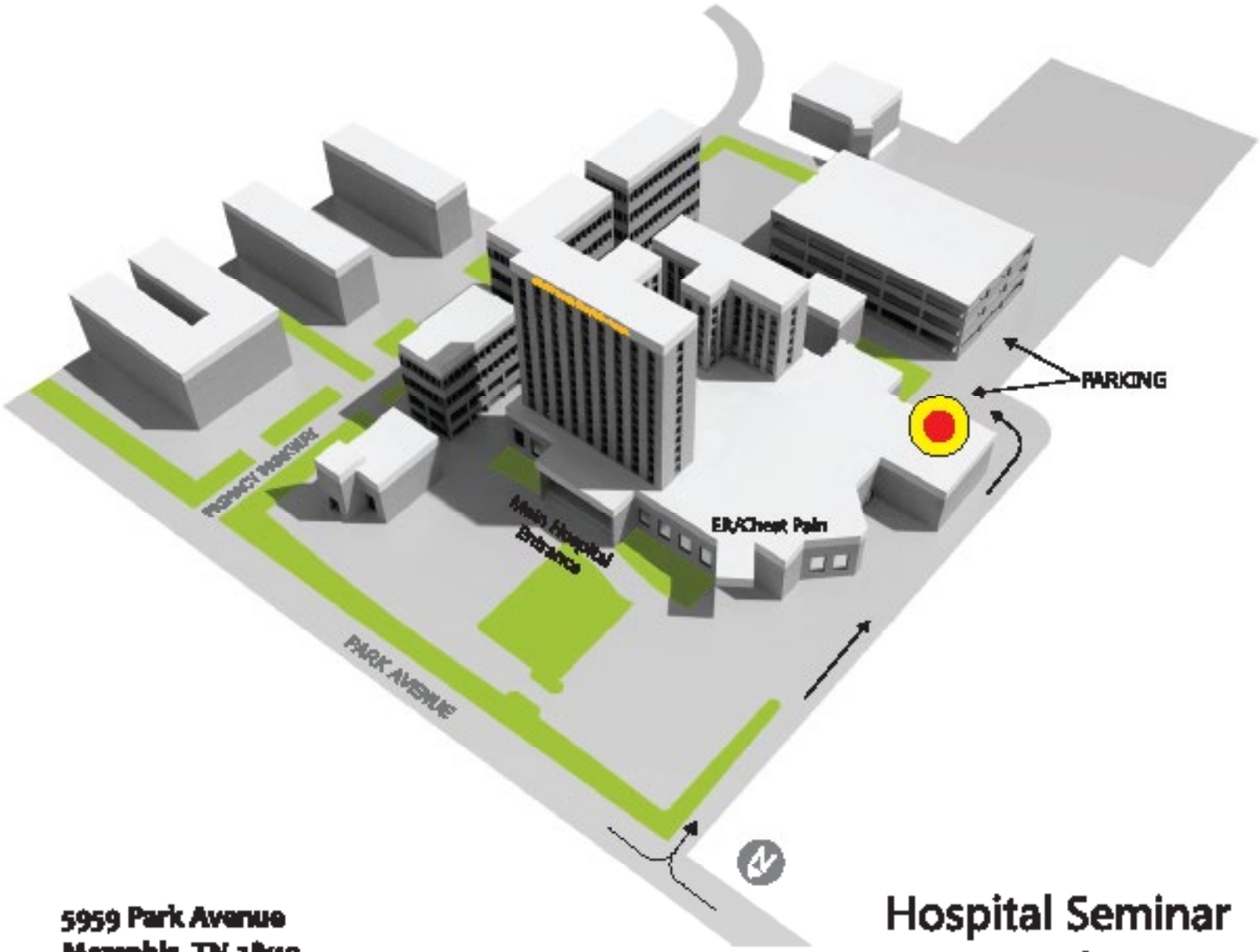
Directions To Our Seminar

Saint Francis Hospital
5959 Park Avenue
Memphis, Tn. 38119.

From Park Avenue, take the driveway leading to the Emergency Room. Continue around to the back (Nurses Row) and park in the small parking lot. Look for the door to the auditorium; this is where you will enter. The room is the second door on the right.

"Open the Door to your New Life"
www.memphisweightlosssurgery.com

Saint Francis Hospital - Memphis



5959 Park Avenue
Memphis, TN 38119
901-765-1811

Saint Francis Hospital-Memphis is located at the southwest corner of Park Avenue and Primacy Parkway.

Hospital Seminar Location

ST. CATHERINE HALL

Come in the Longinotti Auditorium Entrance

Saint Francis Hospital - Memphis
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Seminar Type: ☐ ONLINE ☐ IN-PERSON
Seminar Date: _____

Patient Information

PATIENT'S LAST NAME, FIRST, MIDDLE		RACE	☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH
STREET ADDRESS	CITY		STATE		ZIP CODE
SOCIAL SECURITY #	HOME / CELL PHONE	WORK PHONE	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED		
PATIENT'S OCCUPATION		EMPLOYER'S NAME			

***Primary Care Physician**	**How did you hear about us?**

***** Email Address:**

RESPONSIBLE PARTY INFORMATION				
LAST NAME, FIRST, MIDDLE			SOCIAL SECURITY #	DATE OF BIRTH
RELATIONSHIP TO PATIENT	STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	EMPLOYER		

INSURANCE INFORMATION - A COPY OF YOUR INSURANCE CARD(S) - FRONT AND BACK - IS REQUIRED				
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)	
NAME (ADDRESS IF POSSIBLE)	PHONE

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR MY ENTIRE MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF A DEFAULT OF PAYMENT OF MY CHARGES.

I AUTHORIZE TREATMENT BY SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS PHYSICIANS AND PERSONNEL.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR.

PATIENT'S SIGNATURE _____ GUARDIAN SIGNATURE (IF MINOR) _____ DATE _____ Revised 9 27 2011

Name: _____ **DOB:** _____

Previous Hospitalizations/Surgeries/Serious Illnesses **Date**

_____ _____

_____ _____

_____ _____

Have you had a previous weight loss surgery? _____

Do you have an abdominal mesh?: _____

_____

Have you or any of your family members had any type of problem with anesthesia? _____

_____

Patient Social History

Marital Status	Single:____	Married:____	Separated:____	Divorced:____	Widowed:____
Patient Lives	Alone:____	With Family:____	Other:____		
Use of Alcohol	Never:____	Rarely:____	Moderate:____	Daily:____	
Use of tobacco	Never:____	Previously, but quit:____	Current packs per day:____		
Use of Drugs	Never:____	Type/Frequency:_____			

Adaptive Self-Care Aids: None____ Cane____ Walker____ Wheelchair____ Oxygen____ Other:_____

Family Support:

How does your support person (family) feel about you having this type of surgery?

_____

_____

Family medical history: (parents, grandparents, brothers, sisters) Please indicate who has or has had these health problems:

Obesity:_____

Lung Disease, Asthma or Emphysema:_____

Diabetes:_____

Bleeding Tendency or Blood Disorder:_____

Blood Clots: _____

Heart Disease (Indicate what type):_____

Cancer:_____

Weight History:

Current Height: _____Ft. _____ In.

Current Weight:_____ Pounds

Please list all diets. diet pills and diet programs that you have attempted: _____

_____

_____

What are your expectations of bariatric surgery? _____

_____

_____

How much weight do you expect to lose? _____

Which procedure do you prefer? Roux-en-Y Gastric Bypass: ____ Sleeve Gastrectomy: ____ Converting from Band: ____

Name: _____ **DOB:** _____

Review of Symptoms: Please indicate any personal medical history below:

Genitourinary ☐ None
___ Frequent Urination
___ Kidney Stones
___ Bladder Stones
___ Kidney Failure
___ Nephritis
___ Urinary Tract Infections
Last UTI: _____
___ Incontinence or Dribbling
___ Pain with Urination
___ Leakage of urine with coughing laughing or sneezing
___ On Dialysis
Comments: _____
_____

Psychological ☐ None
___ Nervousness
___ Anxiety
___ Depression
Medication: _____
___ Hospitalization for emotional problem. When/Where?
_____
_____
Name of Dr. treating/has treated you
_____
Is he/she aware that you are interested in having bariatric surgery? _____
Comments: _____
_____

Neurological ☐ None
___ Stroke
___ Sleeping Difficulty (what kind?)
_____
___ Dizziness, vertigo
___ Numbness, tingling feelings, weakness. Where? _____
___ Tremors
___ Convulsions / Seizures
When and what caused it?_____
_____
___ Loss of consciousness (when & why?) _____
___ Pseudotumor Cerebri
Comments: _____

Respiratory ☐ None
___ Cough / wheezing
___ Shortness of breath
__ frequent __on exertion
If you walk at a fairly good pace how far can you walk before being out of breath? _____
___Asthma?
Ever hospitalized for asthma?____
On Oxygen? _____
___ Pulmonary embolus
(blood clot in lung)
___ COPD
___ Emphysema
___ Bronchitis: When _____
___ Sleep Apnea __CPAP __BIPAP
__Snore __Stop Breathing
When and where was the sleep study done? _____
_____
Comments:_____
_____

Cardiovascular ☐ None
___ Angina
___ Palpitations
___ Can you lie flat on your back?
If no, what happens when you lie down?
_____
___ Pain in neck, chest, arms
___ Heart attack
___ Abnormal Electrocardiogram
___ Irregular Heartbeat
___ High blood Pressure
How long _____
Medication _____
___ Congestive heart failure
___ High cholesterol / tryglicerides
How long? _____
___ Blood clots in legs
___ Recent ECG
___ Pacemaker
___ Heart Cath
Comments: _____
_____

Gastrointestinal ☐ None
___ Indigestion
___ Nausea/Vomiting
___ Diarrhea
___ Constipation
___ GERD
___ Pain with bowel movement
___ Blood in stools
___ Hemorrhoids
___ Irritable colon
___ Colitis
___ Gallbladder Disease
___ Gallbladder Removal
___ Recent colonoscopy
___ Recent EGD or "Scope"
___ Ulcers
___ History of H.pylori
___ Liver Problems
___ Hepatitis
Comments: _____
_____
_____

Endocrine ☐ None
___ Thyroid Disease
When diagnosed _____
Medication: _____
___ Diabetes
__ Insulin / __ Oral Agent
Date of onset
___ Diabetic Diet Instruction
Calorie Level: _____
___ Adrenal Gland Tumor
___PCOS
Comments:_____
_____
_____

Musculoskeletal ☐ None
___ Pain/Swelling in Joints
___ Degenerative Joint Disease
___ Arthritis
___ Low back pain / back injury
___ Ankle and foot pain
___ Joint Replacements
Which Ones? _____
___ Ankle and foot pain
___ Fibromyalgia
___ Multiple Sclerosis
___Gout
Comments:_____
_____

Other Conditions ☐ None
___ HIV / AIDS
___ Bleeding disorder
___ Blood clotting disorder
___ Are you on blood thinners /steroids?

Other Conditions we should be aware of?
_____
_____
_____
_____
_____
_____
_____

Name: _____ **DOB:** _____

Allergies to Medications: _____

_____

Allergies to Food: _____

Latex or Other Allergies: _____

MEDICATION LOG

Date RX	Medication	Dosage	Frequency

☐ Medication List Added Separately

Your pharmacy's name, location and phone number: _____

_____

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Authorization to Release Medical Information

I, _____, hereby authorize the following organization or person:

_____ at _____

to disclose the following information by mail, fax, electronically, or orally to:

Robert W. Wegner, M.D.
6005 Park Avenue, Suite 1010B, Memphis, TN 38119
Tel: (901) 881-0600, FAX: (901) 765-3585

From the health records of: _____
(Name of person whose record will be disclosed) (DOB)

For the purpose of: **Medical Review for Bariatric Surgery**

My authorization extends only to those data elements/documents marked below:

☐Complete medical records ☐Progress Notes ☐Statements of charges or payments
☐Records of all visits ☐Consultation Reports ☐Discharge Summary
☐AIDS or HIV information ☐Hepatitis information ☐History and Physical Examination
☐Photographs, videotapes, digital, or other images
☐Record of visit for a specific date(s): _____
☐Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

☐**Other (must be specific):**_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law,

2. A photocopy or fax of this authorization is as valid as this original,

3. I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form to the clinic. The clinic will act upon my revocation within two (2) working days of receipt. This authorization is valid for a one year period from the date it is signed, or sooner if noted below,

4. Saint Francis Medical Partners, Saint Francis Center for Surgical Weight Loss, 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,

5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule,

6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization

7. The patient will be provided with a copy of this authorization.

_____ _____
Patient/Legal Representative Signature Signature Date

_____ _____
Printed Name of Signatory Relationship to Patient

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CONSENT TO CONTACT

In order to contact you to provide program details or reminders, it might be necessary to leave messages on your voicemail or with a family member. If you would like to give the Center for Surgical Weight Loss staff permission to leave these messages please initial and sign below. If you **DO NOT** want to provide permission please **DO NOT** sign this sheet. Your decision to provide permission for us to leave messages will in no way affect your acceptance or standing in the program, but will simply facilitate communication of program details to you.

I give permission for any member of the Saint Francis Center for Surgical Weight Loss staff to leave messages regarding program specifics, insurance information, medical details, appointment dates and times, or other program information:

On my home voice mail or answering machine _____ (initial if you accept)

On my work voice mail or answering machine _____ (initial if you accept)

On my cell phone voice mail _____ (initial if you accept)

With persons who answer my home phone _____ (initial if you accept)

By E-mail: Email Address: _____ _____ (initial if you accept)

I authorize any member of the Center for Surgical Weight Loss staff to release any and all of my medical information to the Medical Director for the Surgical Weight Loss Program, Dr. Robert Wegner. _____ (initial if you accept)

I understand that personal information that is volunteered during group discussions in class and/or seminars will be kept within the group, and will not be repeated. _____ (initial if you accept)

I acknowledge receipt of NOTICE OF PRIVACY PRACTICES. _____ (initial if you accept)

Name (please print) _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE KEEP THIS FOR YOUR RECORDS.

The policy of Saint Francis Center for Surgical Weight Loss is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Saint Francis Center for Surgical Weight Loss.

Individually identifiable health and personal information are any information obtained by Saint Francis Center for Surgical Weight Loss in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Saint Francis Center for Surgical Weight Loss receives from you as our patient.

Saint Francis Center for Surgical Weight Loss collects personal infonnatiol1 in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your medical chart. Saint Francis Center for Surgical Weight Loss limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

NOTICE OF PRIVACY PRACTICES

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Saint Francis Center for Surgical Weight Loss Privacy Officer.

- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Saint Francis Center for Surgical Weight Loss will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. Saint Francis Center for Surgical Weight Loss is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact Leslie Albers at (901) 881-0600. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

Other uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study.

- We may leave a message on your answering or voice mail to contact you about appointments or to have you call our office.