Date: ____________

Bon Secours St. Francis Comprehensive Weight Loss Program

135 Commonwealth Dr. Suite 210 Greenville, SC 29615
Phone: 864-675-4819 Fax: 864-675-4836

Name: ___________________________________ D.O.B: _____________ Last 4 Digits of SSN: _______

Address: ___________________________________ City: _________________ State: _________

Zip Code: _____________ Contact Phone: ___________________ Contact Email: __________________

Age: _________ Gender: M F Race: ________________

Height: ____ft ____in Weight: _________lbs BMI: ___________

Have you previously participated in any other Surgical Weight Loss program? Yes No

Which program are you interested in? Please check one or both ◻ Surgical Weight Loss ◻ Obesity Medicine

If interested in surgery, which procedure: ◻ Sleeve Gastrectomy ◻ Gastric Bypass

Do you have a surgeon preference? ◻ David Anderson, MD ◻ Jessica Gonzalez, MD ◻ No Preference

Registration Information

Marital Status: ◻Married ◻Single ◻Divorced ◻Separated ◻Widowed

Education Level-Highest Degree Earned:

◻HS Diploma ◻Associates Degree ◻Bachelor's Degree ◻Master's Degree ◻Post-Graduate Degree

Employment Status: ◻Full Time ◻Part Time ◻Retired ◻Disabled ◻Not employed

If disabled, please list reason: ____________________________

Employer: ___________________________ Position/Occupation: _______________ Length: _________

Insurance

Primary Insurance Provider: ___________________________ ID#: _________________________

Policy Holder & Relationship: ______________________ Employer of Policy Holder: ___________________

Secondary Insurance Provider: ___________________________ ID#: _________________________

Policy Holder & Relationship: ______________________ Employer of Policy Holder: ___________________

Have you contacted your insurance company regarding Bariatric Surgery benefits? Yes No

Support

Who is your support person? ____________________

Relation to you: _________________

Do they support you having surgical/medical weight loss? Yes No

Prior Attempts at Weight Loss

How many attempts have you made to lose weight?

□ 1-3 □4-10 □11-15 □>15

Please note any diet programs you have attempted, along with the year(s), duration, and total weight loss:

Type	Year(s)	Duration	Weight Loss
Medication (Name: ____________________)			
Weight Watchers			
Optifast			
Jenny Craig			
Atkins			
Nutrisystem			
Herbalife			
Nutritionist/Dietitian			
Psychotherapy/Hypnotherapy			
Surgery			

Other: ____

Social History

Do you currently smoke? Yes No

Past smokers: When did you quit? _________ How many years and packs per day? ________________

Do you currently vape? Yes No If yes, level of nicotine in vape: ________________

Do you drink alcohol? Yes No If yes, how many drinks per day? ________ per week? ________

Do you use illicit/street drugs? Yes No

Past users: When did you quit? _________

Have you ever been hospitalized for substance abuse? Yes No

Describe any significant home issues: Ex: recent death of family member, incarceration, unusual stress

____

Are you bedbound? Yes No

Do you engage in physical activity? Yes No If yes, how often and what type? ______________________

Do you require someone to drive you? Yes No

Are you able to walk without assistance (cane, walker, etc.)? Yes No

Are you able to walk up 5 steps? Yes No

Are you able to dress and bathe yourself? Yes No

Do you have impaired hearing? Yes No

Have you ever seen a mental health professional? Yes No

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, when and where: ____

Check any applicable conditions, past or present:

□ Depression □ Anxiety □ Bipolar Disorder □ PTSD □ ADHD □ Diagnosed Eating Disorder

□ Schizophrenia □ Borderline Personality Disorder □ Attempted Suicide/Suicidal Thoughts

Other psychological conditions not listed: ________________________

Medical History

List names and specialties of all doctors (primary care, heart doctor, psychiatrist, therapist, etc.) that you see on a regular basis:

Physician Type/Specialty	Physician Name	Medical Condition
Primary Care Physician		

What is the name and address of your local pharmacy?

Name: ____________________________ Address: ____

Please list all hospitalizations. Please note dates and reasoning for each.

Date(s)	Reasoning

Have you had any major long-term hospital stays (>1 week) for any reason in your past? Yes No

If yes, please describe: ____

Have you ever had any problems with anesthesia or other surgical procedures in your past? Yes No

If yes, please describe: ____

Have you ever had surgery on your stomach or esophagus? (ex: Nissen, stomach stapling, etc.) Yes No

If yes, please describe: ____

Please list all surgeries you have had, including place, date, and surgeon.

Type of Surgery	Surgeon	Hospital	Date

List all prescription and over-the-counter medications you currently take. Attach additional if needed.

Medication	Dose	How often is the medication taken?	Reason for medication?

List all allergies to medication, food, or environment. Include any to latex, iodine, and/or IV contrast.

Allergy	Type of Reaction

Is there a family history (mother, father, sister, brother) of any of the following? If so, please list relationship.

□ Diabetes _________________

□ Cancer _________________

□ High Blood Pressure _________________

□ Bleeding Disorder _________________

□ Medullary Thyroid Carcinoma or Multiple Endocrine Neoplasia Syndrome _________________

□ Colon Cancer _________________

□ Other Family Disease _________________

Do you have **diabetes**? Yes No

If yes: How many years? _________ Do you use insulin? Yes No Last A1c, if known: _______

Do you have **hypertension**? Yes No

If yes: How many years? _________ How many medications do you take for hypertension? _________

Do you have a diagnosis of **hyperlipidemia/hypercholesterolemia** (high lipids or cholesterol)? Yes No

If yes, do you take medication? Yes No

Do you have a diagnosis of **hypothyroidism**? Yes No

If yes, do you take medication for it? Yes No What is the name of the medication? __________

Do you take any **Immunosuppressant Medications**? Ex: Prednisone, Methotrexate, Remicade Yes No

If yes, what is the name of the medication? ____________________________

Do you take any **Monoamine oxidase inhibitors** (MAOIs)? Ex: Marplan, Nardil, Emsam, Parnate Yes No

If yes, what is the name of the medication? ____________________________

Do you take **Aspirin**? Yes No

Do you take any medications for **chronic pain** (ex: opioids)? Yes No

If yes, what is the name of the medication? ____________________________

Have you ever seen a Pulmonologist/sleep doctor? Yes No

Do you have a diagnosis of Sleep Apnea? Yes No If yes, do you use CPAP/BiPAP? Yes No

Do you use oxygen? Yes No If yes, how much? __________________

Do you snore loudly? Yes No

Do you often feel tired, fatigued, or sleepy during the daytime? Yes No

Has anyone observed you stop breathing or choking/gasping during your sleep? Yes No

Do you have, or are you being treated, for High Blood Pressure? Yes No

Have you ever seen a Gastroenterologist? Yes No

Do you have GERD (reflux)? Yes No If yes, do you take medication? _____________________

Have you ever had an EGD (upper endoscopy)? Yes No

Have you ever had a colonoscopy? Yes No

Do you have difficulty chewing or swallowing medication or food? Yes No

Do you have any missing or broken teeth? Yes No

Do you wear dentures? Yes No

Have you ever seen a Cardiologist? Yes No

If yes, why? ____

Have you ever seen a Hematologist or Oncologist? Yes No

Have you ever received blood or blood products? Yes No

Do you have a blood clotting disorder? Yes No

Do you take any blood thinners (ex: Coumadin, Plavix, Eliquis,etc.)? Yes No

If yes, what is the name of the medication? _____________________________

For Females:

Have you gone through menopause? Yes No If not, date of last menstrual cycle: _____________

Have you ever had a mammogram? Yes No If yes, date of last exam: _____________________

Date of last Pap smear: ______________________

Carolina Surgical Associates (864) 675-4815:
Monday – Thursday 8:00 am – 5:00pm
Friday 8:00 am -12:00 pm

St Francis Surgical Weight Loss (864) 675-4819:
Monday – Thursday 8:00 am – 5:00pm
Friday 8:00 am -12:00 pm

Please check if you currently experience, or have a past or present diagnosis of, any of the following:

□ Barrett's Esophagus
□ COPD
□ Congestive Heart Failure
□ Venous Stasis
□ Heart attack, year: ___________
□ Heart catheterization, year: ___________
□ Blood clot (DVT)
□ Chronic abdominal pain
□ Nausea or Vomiting
□ Dark/black stool
□ Diarrhea or constipation
□ Bright red blood in stool
□ Stomach Ulcers (past or present)
□ Gallstones (past or present)
□ Pancreatitis (past or present)
□ Gastroparesis
□ Malabsorption
□ Severe or chronic headache/migraine
□ Chest pain with exertion
□ Chest pressure
□ Irregular heartbeat
□ Palpitations
□ COVID-19
□ Multiple Endocrine Neoplasia Syndrome
□ Medullary Thyroid Carcinoma
□ Seizures/Epilepsy

□ Asthma
□ Coronary Artery Disease
□ Osteoarthritis
□ Stroke, year: ___________
□ Pacemaker
□ Heart surgery, year: ___________
□ Pulmonary Embolism
□ Cancer
□ HIV
□ Liver Disease
□ Hepatitis A, B, or C
□ Renal/Kidney Disease
□ Renal/Kidney Failure
□ Cirrhosis
□ MRSA
□ Kidney Stones
□ Prostate problems
□ Recent, Urinary Tract Infection
□ Blood in urine
□ Discomfort with urination
□ Joint pain
□ Back pain
□ Swelling in arms and/or legs
□ Leg ulcers
□ Hyperthyroidism
□ Glaucoma

Other Conditions or Concerns:

____
____
____
____
____

Program Policies

- Participation in the Bon Secours St. Francis Comprehensive Weight Management Program, both surgical and medical weight loss, is elective. If at any point, the multidisciplinary team does not feel as though you are an appropriate candidate, we reserve the right to dismiss you from our program. If you are dismissed from the program, no refunds will be provided for services rendered (Ex: psychological evaluation, labs, etc.).

Initial: __________

- Medical visits, labs, clearances, tests, and prescriptions are not always covered by insurance. It is the patient's responsibility to determine if their insurance will cover necessary appointments, labs, clearances, tests, and prescriptions. All fees not covered by insurance are the responsibility of the patient. Remember that insurance benefits can change at any time and are not a guarantee of payment. If a copayment has not been paid for two subsequent visits, any future visits may be cancelled.

Initial: __________

- Being respectful and courteous to office staff is required. Dismissal from our program can occur for problematic behavior, including but not limited to, two missed appointments and rude behavior.

Initial: __________

- No undiagnosed or untreated psychological issues. If you are followed by a Psychiatrist, Psychologist, or Counselor, we may require those medical records. If you have conditions that we deem could be exacerbated by treatment, you will not be a candidate for our program as we do not have comprehensive psychiatric capabilities at our hospital. *see below

Initial: __________

- You are responsible for any fees from professional offices associated with obtaining your medical records for our review. If you are found to not be an appropriate candidate or are dismissed from our program for any reason during completion of the required steps of our program, the medical records you have provided us, from your various practitioners, will not be returned to you or forwarded elsewhere due to HIPPA laws.

Initial: __________

- You must have a reliable way for us to communicate with you and have stable transportation and living conditions. If you are inactive in our Weight Loss Medication program for greater than 4 months, we reserve the right to require you to restart the process or rejoin the waitlist. If you are a 'No Show' for two visits, you will be required to rejoin the waitlist.

Initial: __________

Surgical Weight Loss specific policies:

- All fees not covered by insurance are due prior to your pre-assessment appointment. If you have not paid the full amount by that date, your appointment will be cancelled, and your surgery date may be changed or cancelled.

  Initial: __________

- Nicotine free for 6 months, prior to surgery. Nicotine blood level will be completed prior to surgery.

  Initial: __________

- Drug abuse free for 1 year. Alcohol abuse free for 1 year.

  Initial: __________

- Ages 18-65. If over age 65, your records will be reviewed by the surgeon to determine potential candidacy prior to starting our program.

  Initial: __________

- No failed: psychological, dietitian or other team evaluation from another program.

  Initial: __________

- Psychological evaluation must be within 6 months of surgery.

  Initial: __________

- We do not require a specific amount of weight loss in the pre-operative phase of our program; however, **you must not have a net gain**.

  Initial: _________

- We request that you have a visit with your primary care physician within 6 months prior to surgery. If you do not have a primary care physician, you will need to establish care prior to starting our program.

  Initial: __________

- There is a $35 fee for FMLA and/or Short Term Disability paperwork. This payment will be collected upon receipt of your paperwork.

  Initial: __________

*Potential conditions that could be exacerbated by treatment and may be reason for contraindication of pursuit with Bon Secours St. Francis Comprehensive Weight Loss Program: Active drug abuse, active suicidal ideation, Borderline personality disorder, Schizophrenia, Bipolar disorder, Psychotic disorder, uncontrolled depression or anxiety, defined non-compliance with previous medical care, self-destructive or suicidal behavior, psychiatric hospitalizations

Surgical Weight Loss-Agreement to Requirements

Please read each statement carefully, initial, and sign at the bottom.

Dietitian Evaluation:

You are required to complete a dietitian evaluation and assessment with the team at St. Francis Surgical Weight Loss. Your insurance may require a certain number of visits or timeframe for completion of this evaluation. The number of visits necessary is determined by insurance requirements as well as, the team's impression of your understanding of necessary information and ability to change. The information from this evaluation will be used to determine whether or not you are an appropriate candidate for surgery. The dietitian evaluation alone does not determine whether or not you will have surgery. **If you are more than 15 minutes late to an appointment with our team, it counts as a no-show. More than two no-show appointments would be grounds for dismissal from our program.**

I understand the policies set before me regarding the dietitian evaluation at St. Francis Surgical Weight Loss.

Initial: __________

Psychological Evaluation:

You are required to complete a psychological evaluation in order to be considered for surgery. This evaluation will help identify potential concerns that could cause difficulties after surgery. A report from this evaluation will be provided so that the multidisciplinary team can determine whether you are an appropriate candidate for surgery. All associated fees are non-refundable, regardless of the outcome. The psychological evaluation alone does not determine whether you will have surgery.

I understand the policies set before me regarding the psychological evaluation for St. Francis Surgical Weight Loss.

Initial: ___________

General Participation Attestation:

Once all requirements have been completed and all documentation received, the multi-disciplinary team will evaluate your motivation, comprehension, and compliance. If at that time you are deemed to be an appropriate candidate for surgical weight loss, we will make your follow-up appointment with the Surgical Weight Loss Team. If you are not deemed to be an appropriate candidate, you will be notified that your follow-up appointment will not be scheduled at that time. Participation in our program does not guarantee you will be approved for surgery, through our program or through insurance. Insurance benefits can change at any time, without notice. I understand that my insurance eligibility, checked by the program, is not a guarantee of benefits or payment and that it is my responsibility to verify bariatric benefits with my insurance. Please notify us of any changes to your insurance coverage.

I understand the above statement and accept that any out-of-pocket expenses (copays, lab work, psychological evaluation, etc.) are not refundable.

Initial: ___________

I, ______________________________, have read the previous statements and have a full understanding of the guidelines and consents set before me.

Signature: ____ **Date:** ________________

Signature of Patient Date

Navigating Your Insurance

IT IS YOUR RESPONSIBILITY, AS THE MEMBER, TO CONTACT YOUR INSURANCE COMPANY TO OBTAIN THE FOLLOWING INFORMATION. A REPRESENTATIVE OF ST FRANCIS WILL ALSO CONTACT YOUR INSURANCE, HOWEVER, WE ARE NOT RESPONSIBLE FOR ANY INCURRED EXPENSES IN THE EVENT WE ARE GIVEN MISINFORMATION REGARDING YOUR COVERAGE. IT IS ALSO YOUR RESPONSIBILITY TO INQUIRE ABOUT ANY POLICY CHANGES FROM ONE DEDUCTIBLE YEAR TO ANOTHER REGARDING COVERAGE AND/OR BENEFITS.

Easy to Follow Checklist to Determine Your Insurance Benefits:

1. Call the member/customer service number on the back of your card. You will need to know your ID#.
2. Ask the following questions:

*Are E66.01 and E66.09 covered diagnoses? YES NO

If seeking bariatric surgery, ask the following:

*Are these procedures covered by my insurance policy?

43775 Laparoscopic Sleeve Gastrectomy YES NO

43644 Laparoscopic Gastric Bypass YES NO

* Is bariatric surgery an exclusion on my policy? YES NO

* Do I have a cap on the amount of bariatric coverage? YES NO If "YES" how much? ________

* Are there any Medical Policy Requirements for bariatric surgery (ex: BMI, supervised diet, etc.)?

____

*Do I have a deductible that must be satisfied? _______ How much? ______________

*How much of my deductible has been met? ________________________

*When does my deductible year start over? _________________________

*What level (%) does my policy pay after my deductible has been met? __________________

*What is my out of pocket Maximum per year? _____________ How much has been met? __________

Ask to whom you are speaking with? ______________and for a Reference #: __________________

If seeking medical weight loss, ask the following:

*Do I have coverage for weight loss medications or Obesity Medications? YES NO

*Do I have mental health benefits with a mental health professional? YES NO

Is there a co-pay? YES NO _____________

*Do I have a deductible that must be satisfied? _______ How much? ______________

*How much of my deductible has been met? ________________________

*When does my deductible year start over? _________________________

*What level (%) does my policy pay after my deductible has been met? __________________

*What is my out of pocket Maximum per year? _____________ How much has been met? __________

Ask to whom you are speaking with? _______________and for a Reference #: _________________