



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 #: \_\_\_\_\_