Advanced Surgeons

401 Columbus Avenue, Lower Level

Valhalla, NY 10595

914-347-0162

BARIATRIC SURGERY PRE-OP PATIENT INFORMATION SHEET

Welcome to the Bariatric Surgical Program at ADVANCED SURGEONS! This packet has been compiled by our multidisciplinary health care team for you to be an informed and educated patient. Please read each section carefully and feel free to ask any questions or voice concerns that you may have. Once you have read it thoroughly, please sign that you have a clear understanding of all the pre-op guidelines.

PRE-OP PROGRAM REQUIREMENTS

- You will receive a pre-op checklist with all the clearances and requirements you need to have done before we can give you a surgery date. This is given on your first visit to our office. Be sure to keep it as a reference tool in organizing your preparation.
- Clearances required include nutrition, labs, gastroenterology cardiology, pulmonary and psychology. A letter of medical necessity is also required from your Primary Care Physician, this is not limited to additional clearances that may be required due to certain medical conditions.

FEMALE PATIENTS OF CHILD BEARING AGE:

- Our surgeons require abstinence from sex for two weeks prior to your scheduled surgery date. This is due to the fact that a positive pregnancy test result cannot be conclusive until two weeks after conception. Thus, it is possible for you to become pregnant, and undergo general anesthesia without knowledge of the pregnancy.
- Our surgeons strongly advise against pregnancy for at least 18-24 months after having weight loss surgery. You will be losing weight significantly during this time period and should therefore NOT become pregnant.
- Rapid weight loss may deprive a fetus of the nutrients it needs to grow and be healthy
- You must consult with your health care provider before you plan to become pregnant
- If you are going to have a gastric band placed and you become pregnant, you must speak with your surgeon to see if you need to have your band adjusted and fluid removed.
- All women capable of becoming pregnant post weight loss surgery MUST consult with a health care provider regarding the most effective and effective form of birth control
- **ALL BIRTH CONTROL, HORMONAL REPLACEMENT & STEROID MEDICATIONS MUST BE STOPPED 30 DAYS PRIOR TO SURGERY**

BARIATRIC SURGEON EXPERIENCE:

- All our surgeons have extensive experience in many different types of laparoscopic and open surgeries. Our surgeons assist one another during bariatric surgery.
- Your surgeon will speak with you about their individual experience in bariatric surgery

(sign on following page)

Bariatric Surgery Client Contract

HAVING ELECTED TO UNDERGO BARIATRIC SURGERY FOR MY MORBID OBESITY, I AGREE TO THE FOLLOWING:

- On your initial consult, you will meet with your surgeon and other members of our surgical team and the following will be discussed:
  - I have been informed of my personal medical conditions, the dangers of morbid obesity, and the operations available to you
  - The dangers and potential complications of surgery have been completely explained to my satisfaction, including the possibility of death.
  - I am voluntarily electing to undergo your bariatric surgery as a voluntary procedure without the coercion or deception on the part of the surgeons of staff of Surgical Intensivists
  - I am aware of & realize the importance of the lifelong, regular post op follow-up and commit to keeping those appts. These will take place at 2 weeks, 6 weeks, 3, 6, 9, & 12 months post op for the first year. You should be seen every 6 months the second year and annually thereafter. Regular visits with the nutritionist (under physician supervision) after surgery are recommended as well.
  - I am aware that specific vitamins & supplements are necessary after surgery. You must commit to purchasing and taking these as directed for life.
  - I realize the importance of attending monthly support group meetings and understand that they are crucial to your success
  - I am aware the behavior modification is an important part of Bariatric Surgery. This is primarily learned through nutritional counseling and support groups. You understand that this involves exercise, changes in the types of food you eat, liquids you drink, the number of meals you eat each day and how thoroughly you chew your food.
  - I realize that my liver may be sensitive after surgery and you should stay away from alcohol and any drugs that may cause liver damage.
  - I am committed to contact the surgeon and staff should any surgically related medical complications arise.
  - I have read and understand the surgery guide/checklist given to me at the consult and I plan to adhere to all the pre-requisites for my surgery.

I HAVE READ ALL THE INFORMATION CONTAINED ON THIS SHEET. I UNDERSTAND ALL THAT IS REQUIRED BEFORE AND AFTER BARIATRIC SURGERY AND I AGREE TO ABIDE BY THE TERMS OF CONTRACT ABOVE.

CLIENT NAME: (PRINT): _____

CLIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____

(rev 7/17/18)

ADVANCED SURGEONS

Patient Financial Responsibility Agreement

Thank you for choosing **Advanced Surgeons** for your medical needs. Our doctors are committed to providing you with the highest quality healthcare and appreciate the confidence you've shown in choosing us to provide your care. We ask that you read and sign this form to acknowledge your understanding of financial obligations as our patient.

Patient Financial Responsibilities

- The patient (or patient's legal guardian, if patient is a minor) is responsible for the payment for his/her treatment and care.
- **Copays are due at the time of service. We only accept payment by cash, and major credit/debit cards in office.**
- Coinsurance, deductibles, and any non-covered charges are due upon receipt of statement.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - A $25 fee for all returned checks.
  - While we understand there may be times when you miss an appointment due to an emergency or other obligation, we ask that you provide our office with adequate notice of any cancellations. A $25 fee will be applied to your account for any no show appointments, when applicable.

Insurance and Demographic Update Policy

The patient is responsible for the following:

- Patient must bring insurance card to every visit.
- Notify our office of **any change in insurance, address, phone number, etc.**
- Knowing your copay and understanding your benefits and coverage.
- Determining if doctor(s) are in-network or out-of-network providers **PRIOR** to first visit and each new year thereafter, to verify current participation in your plan.

Out-of-Network Policy

If the patient chooses to utilize their out-of-network benefits they are acknowledging that any balance remaining after the insurance payment is their responsibility, as previously discussed and outlined to you by our billing department. In addition, any payments made directly to you by your insurance should be endorsed and mailed to our office. If not, you will be held responsible for the entire balance for the service date.

Please check one of the following boxes before continuing:

☐ **YES.** I elect to use my out-of-network benefits.
☐ **NO.** I do not want to use my out-of-network benefits.
☐ **N/A.** This does not apply to me.

Workers Compensation

We require our patients to provide us with all of the workers compensation information prior to their first visit. This includes your claim number, claim adjuster's name and contact information, as well as any other related information. If this is not provided, you may be held responsible for the full amount of services provided that day. We reserve the right to postpone or reschedule treatment until all necessary documents are obtained. Additionally, if your workers compensation claim is denied, you are responsible for all these charges.

Financial Assistance

For patient's facing financial hardships, we offer extended payment plans. Please call and ask to speak to one of our billing representatives to discuss your options.

Unpaid Account Balances

In the event that you fail to make payments on any outstanding balance, your account may be turned over to a collection agency. You will then be held responsible for paying your balance and any additional fees that were incurred during the process of collecting said balance. As previously mentioned, we offer many payment plan options to avoid the collection process.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Agreement.

_____

Patient/Responsible Party Signature

_____

Print Patient/Responsible Party Name

_____

Date _____

ADVANCED SURGEONS
401 COLUMBUS AVENUE
LOWER LEVEL
VALHALLA NY 10595
(914)347-0162

Patient's Name:_____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that your insurance will not pay for the item(s) or service(s) that are described below. Your insurance only pays for covered items and services when their rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance probably will not pay for:

Items or Services:

Post op nutrition visits

Because:

May NOT be a covered benefit

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** $75.00) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these items or services. I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

Option 2. NO. I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

_____

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with the insurance. Your health information which your insurance sees will be kept confidential by the insurance plan.

(Revised 10/11/2017)

Photography Authorization

The use of photographs is essential to the planning and evaluation of cosmetic surgery. Your surgery will be photographically documented before, during and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons your doctor is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well.

I recognize that prospective patients, such as me, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. I authorize the anonymous use of my photographs for this purpose by my doctor. _____initial

I authorize the anonymous use of my photographs in seminars, health fairs and conferences for interested and/or prospective patients. _____initial

I authorize the anonymous use of my photographs on the internet. _____initial

I understand that every attempt will be made to represent me and my doctor accurately and with integrity and dignity in all media.

I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ADVANCED SURGEONS
NYGETFIT.COM

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Valhalla, NY 10595
Phone: 914-347-0162 – Fax: 914-347-4401

Jonathan Giannone M.D.
Thomas Cerabona M.D.
Anthony Maffei M.D
Ashutosh Kaul M.D.

Records Release Request

To Whom It May Concern:

I, _____, D.O.B. _____, am requesting copies of my medical records to be released to the following physician (and/or) myself.

Date of Service: _____, or All Medical Records_____

TO: _____
_____
_____
_____

_____
PRINT NAME

_____
PATIENT'S SIGNATURE

_____
DATE

- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibility

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information.
- We must follow the duties and privacy practices described in the notice and give you a copy of it.
- We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of the Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our new website.

WE are required by law to maintain the privacy of, and provided individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgement of Receipt of the Notice of Privacy Practices

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Name of patient or representative Date

ADVANCED SURGEONS

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Please answer the following questions completely:

Full Name: _____

Pharmacy Name: _____ Phone Number: _____

Primary Care Doctor: _____ Phone Number: _____

Occupation: _____ Referral: _____

CURRENT MEDICATION LIST AND DOSAGES: please provide a copy of your medication list and/or list below

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CURRENT ALLERGIES:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CURRENT MEDICAL CONDITIONS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

FAMILY HISTORY: Parents, Grandparents, Siblings, Aunts/Uncles. Please Circle One

1. Obesity YES or NO Who? _____
2. Heart Disease/High Blood Pressure YES or NO Who? _____
3. High Cholesterol YES or NO Who? _____
4. Diabetes YES or NO Who? _____
5. Cancer YES or NO Who? _____

LIST ALL PAST SURGICAL PROCEDURES:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

SOCIAL HISTORY: Please circle one

1. Do you smoke currently? YES or NO
    a. Have you smoked in the past? YES or NO
        i. If yes- please provide date you stopped _____
2. Illicit Drug Use? YES or NO
3. Alcohol? YES or NO