CHI Memorial

# New Patient Information Packet

CHI Memorial Metabolic and Bariatric Care
7405 Shallowford Rd. Ste 160, Chattanooga, TN 37421
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The providers and staff at CHI Memorial Metabolic and Bariatric Care would like to welcome you to our practice! We strive to provide the best medical care possible, while maintaining a friendly atmosphere that is sensitive to the challenges of our patient population. We are committed to your success and it is our greatest desire that you feel supported through each and every step of this journey. CHI Memorial Metabolic and Bariatric Care prides itself on education and feels that an educated patient is the most successful patient. We ask that you also commit to our educational process and invest in your own success.

For your convenience, we have compiled a summary of our processes and a list of office guidelines so that you feel the most prepared for your upcoming appointment.

## What to expect from insurance

As a courtesy, a member of our team will call your insurance company to verify benefits for bariatric care prior to scheduling your appointment. This is not a guarantee of coverage and we recommend that patients also call their insurance to confirm bariatric benefits. If there are any changes in your insurance policy please let our office know **immediately**, as this could impact approval for your procedure.

If you have an exclusion to bariatric services on your plan, it means that there is no coverage on your policy, whether we prove the procedure medically necessary, or not. Our practice does not have the means or authority to reverse or change insurance decisions, due to the fact that insurance companies categorize bariatric care as elective treatment.

If your plan does provide bariatric coverage, special documentation or supervised diet visits may be required. When you arrive for your consultation, we will go over all the required documentation needed in order to prove medical necessity to the insurance company so that we can obtain approval. Insurance companies have different guidelines and policies, which we will make sure you fully understand before you leave your consultation.

Once we submit the information to the insurance company, they legally have 30 days to give us a response. While most insurance companies do not take this long, some do take the full 30 days. We ask that you be patient with us as we are awaiting your approval also.

**What to expect at your first appointment**

Please plan to arrive 30 minutes early to your appointment so that we have time to enter all your information into the system. You will receive a text or email reminder regarding your appointment time. Using that link, please also complete your online registration.

List of items to bring to your appointment:

- Your insurance card(s) and photo ID
- Form of payment (we only accept exchange change)
- Completed history and physical form (Please arrive 20 to 30 minutes early for your initial consultation so we can enter this information into your chart prior to you seeing the provider).
- Also, please make sure to watch the informational seminar video prior to the start of your appointment

You will be required to pay your insurance co-pay/con-insurance or an office visit charge if self-pay, prior to seeing the provider.

At your consultation, you will be evaluated as a candidate for surgery. We will discuss the surgical procedure, process, and insurance requirements. All insurance policies are different and each has a varying list of items to complete. Additionally, our practice has its own list of requirements to help promote quality of care and ensure a successful journey both before and after surgery.

Practice requirements:

- Surgical consultation
- Evaluation with our registered dietitian
- Evaluation with a licensed social worker, psychologist, or psychiatrist
- Exercise and physical therapy
- Preoperative preparatory class
- Pre-surgical liver diet
- Medical clearance(s)
- Pre-admission testing (labs, EKG, imaging)

It is important to understand that there may be additional requirements depending upon your health history. Additional testing or clearances may be required to better understand whether you are an appropriate candidate for surgery or if you meet the requirements for surgery. These may include:

- Pre-operative office appointment
- Smoking/Tobacco cessation/Nicotine screening
- Sleep study
- Supervised weight loss
- Additional visits with members of our team
- Medical clearances (Pulmonary, cardiac, nephrology, rheumatology, endocrinology)
- Preoperative weight loss
- Diabetes evaluation and/or treatment
- Psychological testing by a licensed psychologist or psychiatrist

We will discuss these requirements at your first consultation appointment.

**Pre-surgical Payment**

There are 2 pre-surgical payments that will be required prior to surgery. One payment is for the surgeon and the other is for the hospital.

If you are planning to be self pay (no insurance), then you will be required to make all payments in full, prior to your surgery. We will discuss the fees during your initial consultation.

If you are planning to utilize your insurance, then payment will be dependent upon your policies, deductible, coinsurance, and out-of-pocket maximums. Any payments to the surgeon and to the hospital are due one week prior to surgery.

**Office Policies**

All new patients should plan to arrive 30 minutes prior to the appointment time to allow for timely check-in and registration. Please notify us if you are running late. We have a late policy with a 10-minute grace period. Any arrivals after this grace period will result in the appointment being rescheduled. Appointments that are canceled or rescheduled within 24 hours may be subject to a missed appointment charge.

We kindly ask that you leave small children at home or with a loved one. We encourage all our patients to focus on conversations with the provider as there is a lot of information to be reviewed.

If you have any questions prior to your appointment time, please do not hesitate to contact a member of our team. We commend you on the decision you have made to take control of your health. We appreciate the opportunity to serve you and look forward to the partnership that lays ahead. We strive to remain leaders in the bariatric industry as well as in the Chattanooga region and beyond. Thank you for choosing us to play a role in your care!

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**Please complete pages 5-11 and email to memorial_metabolicandbariatriccare@memorial.org**

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# Seminar Attendance Form

Now that you have decided to take the next step in pursuing bariatric care, we encourage you to watch the online seminar located on our website: https://www.memorial.org/locations/metabolic-bariatric-care

The seminar reviews procedural options that may be available to you, as well as provides other bariatric care educational information. We do require that patients watch the seminar prior to the start of their initial consultation with the provider.

Interested in: Gastric Band     Sleeve Gastrectomy     Bypass     Undecided

I, ____________________________ certify that I have watched the online seminar and understand that I will discuss the options available to me during my first appointment.

________________________________     ______________________

Signature of Patient     Date

Please let us know if you have any comments or feedback regarding our online seminar!

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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# Patient History and Physical Form

## Demographics

[Patient]
Last name:_____________________ First name:________________ DOB:_______

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Race: Black White Asian Other:______________________

Marital status: Single Married Divorced Other:____________

Preferred language: English Spanish Other:______________________

Primary care physician: ____________________ Practice name: ___________________

Address: _________________________ City:___________________ State:______

Zip code:________ Phone #:____________________ Fax #:___________________

[Guarantor/responsible party] *(if applicable):*

Last name:_____________________ First name:________________ DOB:_______

Address: _________________________ City:___________________ State:______

Zip code:________ Phone #:____________________ SS:_______________

## Social History

Do you smoke? Yes No How many packs per day? ______ Years smoked: _____

Are you a former smoker? Yes No Year quit:______ Packs per day:______
Years smoked:_______

Do you use vape or oral tobacco? Yes No What kind?:__________________

Do you drink alcohol? Yes No How frequently?:_________________________

Do you use recreational drugs? Yes No How frequently?: ___________________

What is your preferred learning style?__________________________________________

**Surgical History**
**If you need additional space to list surgeries, please let us know.*

| Surgery | Year | Surgeon | City, State |
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**Medical History**

Allergies:_________________________________________________________________

Do you have diabetes? Yes No Year diagnosed:_______ Current A1C:______

Oral Medications: Insulin Diet and exercise Average blood sugar:_________

Do you have hypertension? Yes No Treated with medications? Yes No
Year diagnosed_______

Do you have heart disease? Yes No Angina: Yes No Stroke: Yes No

Have you ever had a heart attack? Yes No What year(s)?:_______________

Congestive heart failure? Yes No

Have you ever undergone any testing on your heart? Yes No When?_________

High cholesterol or triglycerides: Yes No Blood clot(s): Yes No

Sleep apnea: Yes No Do you use a c-pap machine or oxygen? Yes No

Have you undergone a sleep study? Yes No If yes, when?________________

Bone or joint pain: Yes No Areas affected:______________________________

Currently taking pain medications or anti-inflammatory for condition? Yes No

Urinary incontinence: Yes No Reflux or heartburn: Yes No

Have you ever been diagnosed with a hernia? Yes No Type:_________________

Shortness of breath: Yes No Activity included? Yes No

Other:

______________________________________________________________________

______________________________________________________________________

**Family History**

**Please list all medical conditions including obesity for the following family members…*

Mother:________________________________________________________________

______________________________________________________________________

Is your mother still living? Yes No

If not, what was the cause of death?__________________________ Age:_______

Father:________________________________________________________________

______________________________________________________________________

Is your father still living? Yes No

If not, what was the cause of death? _________________________ Age_______

Siblings: ______________________________________________________________

______________________________________________________________________

**Weight History**

*****Please fill out this section in its entirety. You must include the 5 years and list an approximate high weight for each year.*****

What has been your highest weight ever?_______________ When?________________

How long have you been overweight? Years_____________ Age_____________

Current clothing size: Pants__________ Shirt____________ Dress____________

What is your goal weight/size? _______________________________________________

Have you previously had surgery in order to lose weight? Yes No

If yes, what procedure?_______________________________________________________

Year________ Surgeon_________________ Hospital__________________________

**Mental History**

Are you currently taking any medications for depression or anxiety? Yes No

Are you currently being treated by a mental health provider? Yes No

If yes, for what reason?_______________________________________________________

Name of physician or therapist:_________________________________________________

**If you are currently seeing a mental health provider, a clearance letter from your doctor will be required.*

Have you been treated in the past by a mental health provider? Yes No

For what reason?____________________________________________________________

By signing below, I certify that the above information is true and complete to the best of my understanding and knowledge.

______________________________________________ __________________

Signature of responsible party Date

**Medication List**

| Medication Name | Dosage | Frequency |
| --- | --- | --- |
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Please list any vitamins, over the counter medications, etc.

______________________________________________________________________

______________________________________________________________________

Pharmacy name: ______________________________________________________

Address: __________________________ City:___________________ State:______

Zip code:_________ Phone #:____________________

**Weight Loss History**

**Include at least the last 5 years*

| Year | Weight | Weight loss efforts | Amount lost | Amount regained |
|---|---|---|---|---|
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Which diet have you been most successful with?________________________________

How much weight did you lose on that diet? ___________________________________