NICHOLSON CLINIC
For Weight Loss Surgery

(PLEASE PRINT LEGIBLY, add as much detail as possible, and use BLACK OR DARK BLUE INK.)

PLEASE LIST YOUR FULL LEGAL NAME:

LAST:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:

PLEASE ENTER YOUR CONTACT INFORMATION:				
1ST Choice Contact #	☐ Home ☐ Mobile ☐ Work ( ) -			
2ND Choice Contact #	☐ Home ☐ Mobile ☐ Work ( ) -			
3RD Choice Contact #	☐ Home ☐ Mobile ☐ Work ( ) -			
EMAIL:				
EMERGENCY CONTACT NAME:		RELATIONSHIP:		PHONE#: ( ) -
My emergency contact may receive information about my medical condition. ☐ Yes ☐ No				
SSN: - -	DOB: / /	AGE:		GENDER: ☐ F ☐ M
MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other______				
ETHNICITY: ☐ Hispanic/Latino Origin ☐ Non-Hispanic/Non-Latino Origin				
RACE: ☐Asian ☐ Black ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ White ☐ Other ______				
EMPLOYER:			OCCUPATION:	
PRIMARY CARE PHYSICIAN:			PHONE#: ( ) -	
REFERRING DOCTOR:			PHONE#: ( ) -	
ADDRESS:				
My physician(s) may receive information regarding my surgery. ☐ Yes ☐ No				

TELL US HOW YOU HEARD ABOUT OUR PRACTICE

☐ Internet/Nicholson Clinic Website ☐ PCP/Referring Doctor ☐ Friend/Family Member
☐ TV/Radio/Magazine Advertisement ☐ Insurance Company ☐ True Results
☐ Current Patient, if so who? ______________________

****For patients who intend to self-pay, please note that in the box below and do not complete the insurance information. This will help to avoid delays in processing your application****

INSURANCE INFORMATION:

PRIMARY INSURANCE PLAN:		PLAN TYPE: ☐ HMO ☐ PPO ☐ POS
ADDRESS:		
CITY:	STATE:	ZIP:
ID#:	GROUP#:	PHONE#: ( ) -
NAME OF INSURED:	INSURED'S DOB:	
RELATIONSHIP:	SSN (if other than patient):	
EMPLOYER NAME:		

SECONDARY INSURANCE PLAN:		PLAN TYPE: ☐ HMO ☐ PPO ☐ POS
ADDRESS:		
CITY:	STATE:	ZIP:
ID#:	GROUP#:	PHONE#: ( ) -
NAME OF INSURED:	INSURED'S DOB:	
RELATIONSHIP:	SSN (if other than patient):	
EMPLOYER NAME:		

PATIENT NAME:	DOB:

HEALTH AND MEDICAL HISTORY (Complete as much as possible)

HEIGHT: ____________________ CURRENT WEIGHT: _____________ BMI: ____________________

PLEASE ☑ THE SURGERY YOU ARE INTERESTED IN:

☐ Roux-en-Y Bypass ☐ Lap-Band™ ☐ Sleeve Gastrectomy ☐ Gastric Balloon ☐ Revision

PERVIOUS WEIGHT LOSS SURGERY:

(Please complete if you are seeking revision surgery)

☐ Vertical Banding Gastroplasty	Year:	☐ Lap-Band™	Year:
☐ Roux-en-Y Gastric Bypass	Year:	☐ Stapling (other restrictive procedure)	Year:
☐ Other			
Present complications due to previous weight loss surgery:			
Weight prior to previous weight loss surgery:			
Reason you are in need of a revision weight loss surgery:			

SURGICAL HISTORY:

(Please ☑ all that apply)

☐ Gallbladder Surgery	Year:	☐ Spleen Surgery	Year:
☐ Esophagus Surgery	Year:	☐ Stomach Surgery	Year:
☐ Hernia Repair	Year:	☐ Caesarian Section	Year:
☐ Abdominal Hysterectomy	Year:		

MEDICALLY SUPERVISED TREATMENT REGIMENS:

(Please ☑ all that apply)

				To - From	
Fen-Phen	☐ Yes	☐ No	Year:	-	Physician:
Phentermine	☐ Yes	☐ No	Year:	-	Physician:
Redux	☐ Yes	☐ No	Year:	-	Physician:
Other:____________________	☐ Yes	☐ No	Year:	-	Physician:

OTHER WEIGHT LOSS METHODS:

(Please ☑ all that apply)

		To - From			To - From
☐ Weight Watchers	Year:	-	☐ Herbalife	Year:	-
☐ Slim Fast	Year:	-	☐ Advocare	Year:	-
☐ Medifast	Year:	-	☐ Jenny Craig	Year:	-
☐ Nutrisystem	Year:	-	☐ South Beach	Year:	-
☐ Atkins Diet	Year:	-	☐ Metabolife	Year:	-
☐ Other:					

Maximum weight lost on <u>ANY</u> program:

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

If Yes, please describe treatment, duration, and year:____

PATIENT NAME:	DOB:

HEALTH AND WELLNESS INFORMATION

(Please ☑ all that apply)

Problem/Symptom	Y	N	Year	Diagnosing Physician	Problem/ Symptom	Y	N	Year	Diagnosing Physician
Shortness of Breath	☐	☐			Snoring	☐	☐		
Sleep Apnea Syndrome	☐	☐			CPAP	☐	☐		
Indigestion/Heartburn	☐	☐			BiPAP	☐	☐		
Gastroesophageal Reflux	☐	☐			Asthma	☐	☐		
Congestive Heart Failure	☐	☐			Stroke	☐	☐		
Pulmonary Embolism	☐	☐			Hernia	☐	☐		
COPD/Emphysema	☐	☐			Infertility	☐	☐		
Migraine Headaches	☐	☐			Anorexia	☐	☐		
Irregular Menstruation	☐	☐			Bulimia	☐	☐		
Bipolar Disorder	☐	☐			Chest Pain	☐	☐		
Schizophrenia	☐	☐			Colitis	☐	☐		
Chronic Fatigue	☐	☐			Cirrhosis	☐	☐		
Fybrocystic Breast Disease	☐	☐			Hepatitis B	☐	☐		
Urinary Incontinence	☐	☐			Hepatitis C	☐	☐		
Chron's Disease	☐	☐			Depression	☐	☐		
High Cholesterol	☐	☐			Heart Attack	☐	☐		
Degenerative Joint	☐	☐			Heart Disease	☐	☐		
Hyperlipidemia	☐	☐			Panic Disorder	☐	☐		
Ulcerative Colitis	☐	☐			Edema/Swelling	☐	☐		
Diabetes	☐	☐			☐ Legs ☐ Ankles				
☐ Self ☐ Family					Disease/Pain	☐	☐		
Hypertension	☐	☐			☐ Hips ☐ Ankles ☐ Knees ☐Lower Back				
☐ Self ☐ Family									

Do you currently smoke/vapor? ☐ Yes ☐ No	Have you ever smoked/vapored? ☐ Yes ☐ No	Year Quit:	
Do you use alcohol? ☐ Yes ☐ No	How often? ☐Daily ☐ Weekly ☐ Occasionally ☐ Rarely		
Have you ever has a problem with substance abuse?	☐ Yes ☐ No		
Do you have a heart condition?	☐ Yes ☐ No	If Yes, Explain:	
Do you have any other underlying medical conditions?	☐ Yes ☐ No	If Yes, Explain:	

RECENT TESTING

Test	Yes	No	DATE	Test	Yes	No	DATE
Physical	☐ Yes	☐ No	DATE:	Upper GI	☐ Yes	☐ No	DATE:
Chest X-Ray	☐ Yes	☐ No	DATE:	EKG	☐ Yes	☐ No	DATE:
Echocardiogram	☐ Yes	☐ No	DATE:				

Indicate any negative results:

PRACTICE EXPECTATIONS/PATIENT AGREEMENT: (Please read carefully before signing)

APPOINTMENT:

- IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CALL TO CANCEL WITH 24 HOURS ADVANCE NOTICE SO THAT ANOTHER PATIENT CAN BE SCHEDULE IN YOUR PLACE.
- IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE.

INSURANCE AND PAYMENT:

- IF YOUR INSURANCE IS BEING UTILIZED FOR ANY SERVICES THEN PAYMENT WILL BE EXPECTED FOR CO-PAYS, DEDUCTIBLES OR CO-INSURANCE AMOUNTS. THIS INCLUDES YOUR INITIAL CONSULTATION, SURGICAL PROCEDURES OR FOLLOW UP OFFICE VISITS.
- I REALIZE I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.
- PLEASE NOTE THAT ALL MEDICAL PROVIDERS MUST SUBMIT SEPARATE BILLS FOR THEIR SERVICES. YOU AND YOUR INSURANCE COMPANY MAY BE BILLED FOR SERVICES FROM VARIOUS PROVIDERS DURING YOUR COURSE OF TREATMENT. NICHOLSON CLINIC CANNOT ALWAYS TELL WHICH SERVICES YOU WILL NEED BUT WE WANT YOU TO BE AWARE THAT YOU MAY RECEIVE BILLS FROM ANY OF THE FOLLOWING:

SURGEON / ASSISTANT SURGEON	ANESTHESIOLOGIST	RADIOLOGIST
HOSPITAL / SURGICAL FACILITY	PATHOLOGIST	LABORATORY

OTHER PROVIDERS WHILE AT HOSPITAL: INTERNIST, HOSPITALIST, CARDIOLOGIST, PULMONOLOGIST, OR OTHER SPECIALIST

NICHOLSON CLINIC DOES NOT HAVE CONTROL OVER OTHER PROVIDER'S BILLING PRACTICES NOR DO WE HAVE THE ABILITY TO HAVE OTHER PROVIDERS FORGIVE YOUR FINANCIAL RESPONSIBILITIES WITH THEM. PLEASE CONTACT EACH PROVIDER DIRECTLY SHOULD YOU HAVE QUESTIONS ABOUT THEIR BILLS.

REFERRING PROVIDERS AND FACILITIES:

We often make referrals to medical providers that may be out of network with your insurance plan because we believe them to be quality providers. As a standard of this office, we may refer to Baylor Regional Medical Center at Plano, Baylor Surgicare Garland, Crescent Medical Center, Medical City Frisco, Diez Services Anesthesia, Clinical Pathology Labs (CPL), and M3 Sleep Services of Texas. The surgeons associated with this practice may or may not have a personal investment in these or other healthcare facilities. You are invited to discuss this with us or our office staff if you desire.

Nick Nicholson, MD Thomas Roshek, MD Brian Long, MD

By undersigning, the above information is true to the best of my knowledge and I am acknowledging that I have read, understand and agree to all the above policies and expectations of the Nicholson Clinic.

PATIENT'S PRINTED NAME ____________________ DATE OF BIRTH ____________________

PATIENT SIGNATURE OR RESPONSIBLE PARTY ____________________ DATE ____________________

NICHOLSON CLINIC

CURRENT PATIENT MEDICATIONS

DATE:

NAME:	**DATE OF BIRTH:**	**ALLERGIES:**
PHARMACY NAME:	**PHARMACY PHONE #:**	

VITAMIN SUPPLEMENTS: (Please ☑ all that apply)
☐ Multi-Vitamin ☐ Iron ☐ Calcium ☐ Vitamin B12 ☐ Vitamin D Other:

TOBACCO:	☐ Daily	☐ Weekly	☐ Occasionally	☐ Rarely	☐ Never	☐ Quit	Year:
ALCOHOL:	☐ Daily	☐ Weekly	☐ Occasionally	☐ Rarely	☐ Never	☐ Quit	Year:
CPAP/BIPAP:	☐ Every Night	☐ Occasionally	☐ Never				

MEDICATION NAME/STRENGTH	**ROUTE**	**DOSE**	**PURPOSE**	**DATE STARTED**	**DATE STOPPED**	**REVIEWED BY MEDICAL STAFF Date**	**Initials**
Example: Sample 200MG	*By mouth*	*1xday*	*Blood Pressure*	*May 2009*			

OVER THE COUNTER MEDICATIONS	**ROUTE**	**DOSE**	**PURPOSE**	**DATE STARTED**	**DATE STOPPED**	**REVIEWED BY MEDICAL STAFF Date**	**Initials**

DATE UPDATED:	**PATIENT INITIALS:**	**DATE UPDATED:**	**PATIENT INITIALS:**
DATE UPDATED:	**PATIENT INITIALS:**	**DATE UPDATED:**	**PATIENT INITIALS:**
DATE UPDATED:	**PATIENT INITIALS:**	**DATE UPDATED:**	**PATIENT INITIALS:**
DATE UPDATED:	**PATIENT INITIALS:**	**DATE UPDATED:**	**PATIENT INITIALS:**

NOTICE OF PRIVACY PRACTICES

(Updated on February 26, 2016)

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

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider; a record of your contact is prepared. This record may contain information such as signs, symptoms, results of examinations or tests, diagnoses, treatment, or future care plans. Your medical record is the physical property of Nicholson Clinic, but you have certain rights regarding the use and disclosure of your private health information (PHI). Nicholson Clinic however, has the right to use and disclose your PHI in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers involved in your care
- Educating healthcare professionals
- Medical Research
- Providing information for government and public health entities
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you
- Conducting other routine healthcare operations

Protecting your privacy and maintaining the security of your PHI is an important responsibility of this practice. We are required by law to maintain privacy and confidentiality of your PHI, notify you of your rights in regards to your PHI, inform you of these privacy practices prior to gaining consent to treat, and notify you of changes/revisions to this Notice of Privacy Practices.

You may file a complaint with the Nicholson clinic if you suspect any privacy rights violation. We will investigate the inquiry and inform you of the finding. In addition, you have the right to file a complaint with the Secretary of the Department of Health and Human Services.

EXAMPLES OF DISCLOSURE OF YOUR (PHI)

Healthcare delivery and treatment:

Your PHI may be provided to other healthcare professionals, such as other physicians, specialists, therapists, hospital based providers, and or other healthcare providers.

Billing and payment:

Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to your payers and other third party administrators.

Other healthcare operations:

You PHI may be disclosed to other businesses in order for my practice to perform its day-to-day operations. These may include business associates such as vendors, contractors used for credentialing and peer review, patient satisfaction surveys, utilization review, billing and claims management, medical research, disease control, quality improvement initiatives, management services organizations, laboratories, free standing diagnostic facilities, transcription services, and legal counsel. All business associates are required to appropriately protect the confidentiality of your PHI.

Treatment:

We may instruct a specialist to contact you to schedule an appointment or to provide you with information on treatment.

Other uses and disclosures:

We may utilize and disclose your PHI with others concerned with your health such as family members, relatives, caregivers, employers, and funeral directors. In addition, we may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, corrections institutions, and workers compensation, where applicable.

Other disclosures of PHI not permitted or required by law will be made only with your written authorization You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Nicholson Clinic has already taken action in reliance on your prior authorization.

PATIENT CONSENT FORM REGARDING PHI

I understand that as part of my healthcare, Nicholson Clinic originates and maintains health records that may describe my health history, symptoms, examination and test results, diagnoses, treatment and/or plans for future care.

Notice of Privacy Practices of Nicholson Clinic provides specific information and description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review this prior to signing this consent.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior consent, except as otherwise provided by law.

Listed below are individual(s) to whom I <u>authorize</u> use and/or disclosure of my PHI.

____

____

I request the following <u>restrictions</u> on the use and/or disclosure of my personal health information.

____

____

By signing below and unless otherwise indicated, I request that information regarding my self-pay procedures not be disclosed to my health insurance company.

I have reviewed and understand the February 26, 2016 version of the privacy practices of Nicholson Clinic, as stated in the *Notice of Privacy Practices*, and hereby consent to the uses and disclosures of my PHI.

________________________	________________
Signature of Patient or Legal Representative	Date of Birth
Print Name of Patient or Legal Representative	Date

I request that changes to the *Notice of Privacy Practices* be sent to me at the following address:

____

____

Email Informed Consent Form

Conditions for the Use of Email

It is the policy of Nicholson Clinic to make all email messages sent or received that concern the protected health information ("PHI"), a part of that patient's medical and financial records. Nicholson Clinic strives to protect and maintain patient PHI. However, there are numerous risks associated with email communication, which may include but not limited to misaddressed or undelivered emails, risk associated with use of employer owned email address, and/or delay in response time. Nicholson Clinic cannot fully guarantee the security and confidentiality of email communications. Thus, patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's records. As a part of medical record, other individuals, such as other physicians, nurses, other entities, such as other health care providers and insurers, may have access to email messages contained in medical records.
- Nicholson Clinic may forward email messages within the facility as necessary for diagnosis, treatment, and reimbursement. However, emails to entities unassociated with the patient's care, will not be forwarded, unless proper patient consent is received,
- Nicholson Clinic and its employees will make every effort to read and respond promptly to patient emails. Because Nicholson Clinic **cannot assure patients that recipients will read email messages promptly, patients must not use email in a medical or other emergency.**
- If a patient's email requires or invites a response, and the recipient does not respond within a reasonable time, the patient is responsible for following up to determine whether the intended recipient has received the email and when the recipient will respond.
- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, **patients should not use email for communications concerning diagnosis or treatment of the following: AIDS/HIV infection; other sexually transmissible or communicable diseases; mental health or developmental disability; or alcohol and drug abuse.**
- Because employees do not have a right of privacy in their employer's email system, patients should not use their employer's email system to transmit or receive confidential medical information.
- Nicholson Clinic will take reasonable steps to protect the confidentiality of patient email, but is not liable for improper disclosure of confidential information not caused by Nicholson Clinic gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Nicholson Clinic of any types of information that the patient does not want to be sent by email other than those set out above.
- Patient is responsible for protecting patient's password or other means of access to email sent or received from Nicholson Clinic to protect confidentiality. Nicholson Clinic is not liable for breaches of confidentiality caused by patient.

Any further use of email by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing. You may withdraw consent to the future use of email at any time by email or written communication to Nicholson Clinic, attention:

Stephanie G: HIPAA Compliance Officer
5000 Legacy Dr. #200
Plano, Tx 75024
Stephanie@Nicholsonclinic.com

I have read the above risk factors and conditions for the use of email, and I hereby consent to the use of email for communications to and from Nicholson Clinic regarding my medical treatment.

Signature of Patient	Email Address	Date
Printed Name of Patient	Date of Birth	

Segments of this consent were obtained from HIPAA Documents Resource Center CD, 6th ed.© 2001-2014 Jonathan P. Tomes, Veterans Press, Inc., and EMR Legal, Inc. All rights reserved.

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation.

0 = would never doze or sleep	1 = slight chance of dozing or sleeping	2 = moderate chance of dozing or sleeping	3 = high chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping** *(Circle as appropriate)*			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting inactive in a public place(e.g. a theater or meeting)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**
Score				

Score Results	
1 - 7	Congratulations, you are getting enough sleep!
7 - 8	Your score is average
9 and up	Very sleepy and should seek medical advice

Signature of Patient or Legal Representative

Date of Birth

Print Name of Patient or Legal Representative

Date

“S.T.O.P. – B.A.N.G.” Sleep Apena Questionnaire

Please complete this form to the best of your knowledge

1. Do you **SNORE** loudly?	☐ Yes	☐ No
2. Do you often feel **TIRED** during the daytime?	☐ Yes	☐ No
3. Has anyone ever **OBSERVED** you stop breathing while sleeping?	☐ Yes	☐ No
4. Do you have or are you being treated for high blood **PRESSURE**?	☐ Yes	☐ No
5. Is your **BMI** more than 35kg/m2?	☐ Yes	☐ No
6. **AGE** over 50?	☐ Yes	☐ No
7. **NECK** circumference greater than 17 inches (men)/ 16 in. (women):	☐ Yes	☐ No
8. **GENDER** male?	☐ Yes	☐ No

Symptoms of Sleep Disorders

PLEASE ☑ ALL THAT APPLY

☐ Insomnia or inability to sleep well

☐ Excessive daytime sleepiness / Napping

☐ Loud snoring

☐ Morning Headaches

☐ Uncomfortable sensations or jerking of the limbs

☐ Restless Sleep or "tossing and turning"

☐ Weight Gain/ Obesity

☐ Personality Changes

☐ Irregular breathing during sleep

☐ Loss of Energy/ Fatigue

☐ Lack of Concentration

☐ Confusion

☐ Leg Swelling

☐ Difficulty getting to sleep or staying asleep

☐ Vivid, frightening or violent dreams

Signature of Patient or Legal Representative

Date of Birth

Print Name of Patient or Legal Representative

Date

Authorization Form to Appeal an Insurance Determination

To: ______________________________________

____

____

Member Name: ______________________________ **Date:** ____________________

Member ID #: ______________________________ **Date of Birth:** ______________

I hereby authorize ____________________________ to appeal my insurance carrier's determination concerning all denials of claims or incorrect payment of claims, on my behalf, as my designated representative.

I understand that communication may contain:

> All medical and financial information containing my insurance file, including but not limited to treatment for STD, alcoholism and drug abuse, abortion, mental health disorder and HIV status related to my examination, treatment, and hospital confinement in connection with the determination which is being appealed.

By signing below, I understand this information is privileged and confidential and will only be released as specified in this authorization or as permitted by law. This authorization is valid for a period of one year.

____

Signature of Member or Legal Guardian/Representative

____

Signature of Witness

____

Printed Name and Title of Witness