NICHOLSON CLINIC

Seminar / Consult Date:_____

(PLEASE PRING 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 PHONE #_____ 2ND CHOICE PHONE # _____

3RD CHOICE PHONE #_____ E-MAIL: _____

SSN: _____ DOB: _____/_____/_____ AGE: _____ GENDER: ☐ F ☐ M

MARITAL STATUS (Optional): ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other _____

Which best describes your ethnicity? Hispanic/Latino Origin Non-Hispanic/Non-Latino Origin

Which best describes your race? Asian Black American Indian/Alaska Native Native American/Pacific Islander White Other

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE #: _____

Emergency contact may receive information about my medical condition? (Please ☑ one) ☐ *Yes* ☐ *No*

PRIMARY CARE PHYSICIAN: _____ Phone: _____

REFERRING DOCTOR: _____ Phone: _____

Address: _____

My physician(s) may receive information from WLS regarding my surgery? (Please ☑ one) ☐ *Yes* ☐ *No*

*****For patient's 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*****

******FOR PATIENT'S ATTENDING SEMINAR, PLEASE INCLUDE A FRONT & BACK COPY OF YOUR INSURANCE CARD/CARDS.***

INSURANCE INFORMATION: (Please be very detailed – incomplete data may delay processing.)

INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

SECONDARY INSURANCE CO.: _____ PLAN TYPE: HMO PPO POS

ADDRESS: _____ ID#: _____

GROUP #: _____ PHONE #: _____

GROUP #: _____ PHONE #: _____

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO PT: _____ SS# (IF OTHER THAN PT): _____

EMPLOYER NAME: _____

PATIENT SIGNATURE OR RESPONSIBLE PARTY **DATE**

HEALTH AND MEDICAL HISTORY (Fill out as completely as possible.)

HEIGHT:_____ CURRENT WEIGHT: _____BMI: _____

Please select the surgery you are interested in: _____ Roux-en-Y Gastric Bypass _____ Lap Band™

_____ Sleeve Gastrectomy _____ Revision Weight Loss Surgery

HAVE YOU EVER HAD (Please check each that apply):

☐ GALLBLADER SURGERY	YEAR_____	TYPE_____
☐ SPLEEN SURGERY	YEAR_____	TYPE_____
☐ ESOPHAGUS SURGERY	YEAR_____	TYPE_____
☐ STOMACH SURGERY	YEAR_____	TYPE_____
☐ HERNIA REPAIR SURGERY	YEAR_____	
☐ CAESARIAN SECTION	YEAR_____	
☐ ABDOMINAL HYSTERECTOMY	YEAR_____	
☐ PRIOR WEIGHT LOSS SURGERY	YEAR_____	

PREVIOUS WEIGHT LOSS SURGERY: (please complete if you are seeking revision surgery)

TYPE ☐ Vertical Banding Gastroplasty YEAR_____

☐ Lap-Band™ YEAR_____

☐ Roux-en-Y Gastric Bypass YEAR_____

☐ Stapling (other restrictive procedure) YEAR_____

☐ Other (please list) _____

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:_____

_____

MEDICALLY SUPERVISED TREATMENT REGIMENS: (Below, Year means Dates)

Please list all diets and medications for weight loss you have used and the treating physician(s):

DID YOU TAKE FEN-PHEN?	☐ Yes	☐ No	Year _____	Physician:_____
PHENTERMINE:	☐ Yes	☐ No	Year _____	Physician:_____
REDUX:	☐ Yes	☐ No	Year _____	Physician:_____
OTHER:	☐ Yes	☐ No	Year _____	Physician:_____

TYPE:_____

OTHER WEIGHT LOSS METHODS ATTEMPTED: (Below, Year means dates)

PROGRAM	YEAR(S)	PROGRAM	YEAR(S)	PROGRAM	YEAR(S)
☐ WEIGHT WATCHERS	_____	☐ JENNY CRAIG	_____	☐ ATKINS DIET	_____
☐ SLIM FAST	_____	☐ METABOLIFE	_____	☐ DEXATRIM	_____
☐ MEDIFAST	_____	☐ OPTIFAST	_____	☐ CAMBRIDGE	_____
☐ NUTRISYSTEMS	_____	☐ LARRY NORTH	_____	☐ MERIDIA	_____
☐ SUGAR BUSTERS	_____	☐ XENICAL	_____	☐ OVEREATERS AN	_____
☐ HERBALIFE	_____	☐ SOUTH BEACH	_____	☐ TOPS	_____
☐ ADVOCARE	_____	☐ GRAPEFRUIT DIET	_____	☐ PRITIKIN DIET	_____
☐ OTHER	_____				

MAXIMUM WEIGHT LOST ON *ANY* PROGRAM:_____ YEAR:_____

HAVE YOU HAD ANY POSITIVE AND/OR NEGATIVE RESPONSES FROM PRIOR OBESITY TREATMENTS?

☐ YES ☐ NO PLEASE EXPLAIN: _____

HAVE YOU EVER BEEN TREATED FOR AN EATING DISORDER? ☐ YES ☐ NO

PLEASE DESCRIBE TREATMENT, DURATION AND YEAR: _____

_____ _____

Patient Name **Date of Birth**

HEALTH AND WELLNESS INFORMATION: (For any "yes" answers list a diagnosing or treating physician.)

DESCRIPTION		YES	NO	YEAR	DIAGNOSING PHYSICIAN
Shortness of Breath		☐	☐		
Snoring		☐	☐		
Sleep Apnea Syndrome		☐	☐		
CPAP		☐	☐		
BiPAP		☐	☐		
Asthma		☐	☐		
Indigestion/Heartburn		☐	☐		
Gastroesophageal Reflux		☐	☐		
Degenerative Joint	☐ Lower Back	☐	☐		
Disease/Pain	☐ Hips	☐	☐		
	☐ Knees	☐	☐		
	☐ Ankles	☐	☐		
Edema/Swelling	☐ Legs	☐	☐		
	☐ Ankles	☐	☐		
Congestive Heart Failure		☐	☐		
Stroke		☐	☐		
Heart Disease		☐	☐		
Heart Attack		☐	☐		
Hypertension (High Blood Pressure)					
	☐ Self	☐	☐		
	☐ Family History	☐	☐		
Diabetes	☐ Self	☐	☐		
	☐ Family History	☐	☐		
High Cholesterol/Hyperlipidemia		☐	☐		
Hernia		☐	☐		
Irregular Menstruation		☐	☐		
Infertility		☐	☐		
Fybrocystic Breast Disease		☐	☐		
Depression		☐	☐		
Bipolar Disorder		☐	☐		
Panic Disorder		☐	☐		
Anorexia		☐	☐		
Bulimia		☐	☐		
Schizophrenia		☐	☐		
Chronic Fatigue		☐	☐		
Chest Pain		☐	☐		
Urinary Incontinence (Leaking when you cough or sneeze)		☐	☐		
Cirrhosis		☐	☐		
Hepatitis		☐	☐		
COPD/Emphysema		☐	☐		
Pulmonary Embolism		☐	☐		
Colitis		☐	☐		
Chron's Disease/Ulcerative Colitis		☐	☐		
Hepatitis B or Hepatitis C		☐	☐		
Migraine Headaches		☐	☐		

DO YOU HAVE A HEART CONDITION: ☐ YES ☐ NO DESCRIBE: _____

DO YOU HAVE ANY OTHER UNDERLYING MEDICAL CONDITIONS? ☐ YES ☐ NO DESCRIBE: _____

IS YOUR FATHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH: _____

IS YOUR MOTHER LIVING? ☐ YES ☐ NO CAUSE OF DEATH: _____

OTHER MEMBERS OF YOUR FAMILY WHO ARE OBESE? _____

Patient Name **Date of Birth**

RECENT TESTING:

PHYSICAL	☐ YES	☐ NO	DATE:	_____
CHEST X-RAY	☐ YES	☐ NO	DATE:	_____
UPPER GI	☐ YES	☐ NO	DATE:	_____
ECHOCARDIOGRAM	☐ YES	☐ NO	DATE:	_____
EKG	☐ YES	☐ NO	DATE:	_____

INDICATE ANY NEGATIVE RESULTS: _____

_____

GENERAL AND LIFESTYLE INFORMATION:

DO YOU SMOKE?	☐ YES	☐ NO	DO YOU USE ALCOHOL?	☐ YES	☐ NO
HAVE YOU SMOKED?	☐ YES	☐ NO	HOW OFTEN?	☐ DAILY	☐ WEEKLY
YEAR QUIT	_____			☐ OCCASIONALLY	☐ RARELY
HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE?				☐ YES	☐ NO
IS YOUR SPOUSE/PARTNER SUPPORTING OF WEIGHT LOSS SURGERY?				☐ YES	☐ NO
IS YOUR FAMILY SUPPORTIVE OF WEIGHT LOSS SURGERY?				☐ YES	☐ NO

PLEASE TAKE A MOMENT AND TELL US HOW YOU HEARD ABOUT OUR PROGRAM:

_____ INTERNET/NICHOLSON CLINIC WEB SITE

_____ PCP/REFERRING DOCTOR

_____ FRIEND/FAMILY MEMBER

_____ INSURANCE COMPANY

_____ TV/RADIO/MAGAZINE ADVERTISEMENT

_____ BAYLOR REFERRAL LINE

_____ CURRENT PATIENT, IF SO WHO?_____

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

☐ **I AGREE THAT I AM PRIMARILY RESPONSIBLE FOR OBTAINING INSURANCE APPROVAL FOR THIS PROCEDURE. I WILL FURNISH ALL RECORDS REQUESTED BY THE PROGRAM IN A TIMELY MANNER. I WILL FOLLOW-UP AND INFORM THE PROGRAM OF ANY ADDITIONAL INFORMATION NEEDED TO OBTAIN APPROVAL.**

☐ **I REALIZE I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.**

_____ _____

PATIENT'S PRINTED NAME **DATE OF BIRTH**

_____ _____

PATIENT SIGNATURE **DATE**

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 Plano Surgical Hospital, Surgery Center of Richardson, Surgery Center of Garland, Forest Park Medical Center, Baylor Medical Center, M3 Sleep Services of Texas, Surgeons of North Texas PA, GNC Medical PA, Premier Surgical Assistants PC, and others. 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, M.D. Thomas Roshek, M.D. Chad Carlton, M.D.
Brian Long, M.D. Julie Kilgore, M.D.

TODAY:_____

MY MEDICATIONS

NAME: _____ **DATE OF BIRTH:**_____ **ALLERGIES:**_____

PHARMACY NAME: _____ **PHARMACY PHONE:** _____

Vitamin Supplements: (please circle all that apply) **Never Occasionally Daily** **Multiple Vitamin Iron Calcium Vitamin D Vitamin B-12** (weekly) **Other:**	
Tobacco: Never Rarely Occasionally Frequently Quit (Month/Year)**:**	
Alcohol: Never Rarely Occasionally Frequently	**CPAP/BIPAP: Never Occasionally Every Night**

MEDICATION NAME/STRENGTH	ROUTE	DOSE	PURPOSE	DATE STARTED	DATE STOPPED	REVIEWED BY MEDICAL STAFF DATE/INITIALS		
SAMPLE 200mg	*By mouth*	*1xday*	*Blood Pressure*	*May 2009*				

NOTICE OF PRIVACY PRACTICES

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.

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

_____

_____

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

_____

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.

I have reviewed and understand the privacy practices of Nicholson Clinic as stated in *the Notice of Privacy Practices* dated April 1, 2003, and hereby consent to the uses and disclosures of my PHI so stated.

_____ _____

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 and Abdominal Surgery Specialists 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 and Abdominal Surgery Specialists strive 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 and Abdominal Surgery Specialists 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 and Abdominal Surgery Specialists 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 Abdominal Surgery Specialists and its employees will make every effort to read and respond promptly to patient emails. **Because** Nicholson Clinic and Abdominal Surgery Specialists **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 and Abdominal Surgery Specialists 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 and Abdominal Surgery Specialists' gross negligence or wanton misconduct.
- If the patient consents to the use of email, the patient is responsible for informing Nicholson Clinic and Abdominal Surgery Specialists 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 and Abdominal Surgery Specialists to protect confidentiality. Nicholson Clinic and Abdominal Surgery Specialists 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 and Abdominal Surgery Specialists, attention:

Stephanie G: HIPAA Compliance Officer
5500 Democracy Dr. #150
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 and Abdominal Surgery Specialists regarding my medical treatment.

Signature of Patient	Date of Signature
Printed Name of Patient	Date of Birth

Segments of this consent were obtained from HIPAA Documents Resource Center CD, 6th ed.

Created 02/24/2016

Sleep Habits / History

Name: _____ **DOB:** _____

Do you have or have you had trouble sleeping? ☐Yes ☐No

Do you clinch or grind your teeth? ☐Yes ☐No

If yes, what symptoms do you experience:

Morning Headache? ☐Yes ☐No

Daytime Drowsiness? ☐Yes ☐No

Snoring? ☐Yes ☐No

Waking Up at Night? ☐Yes ☐No

Number of naps per day: _____

Do you feel rested when you wake up in the morning? ☐Yes ☐No

Have you ever fallen asleep at the wheel? ☐Yes ☐No

Do you ever wake up from a deep sleep choking and coughing? ☐Yes ☐No

Has anyone ever told you that you stopped breathing while you sleep (an observed apnea)? ☐Yes ☐No

If Yes, how often does this occur: _____

Have you been diagnosed with sleep apnea? ☐Yes ☐No

If you have sleep apnea do you use: ☐BiPap ☐CPAP

Have you ever had a sleep study? ☐Yes ☐No

Please indicate the chance of dozing in each situation using the scale below:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**Chances of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes	_____
TOTAL SCORE:	_____

Signature of Patient or Parent of Minor **Date**