PATIENT INFORMATION (please print)

DOB: _____ SSN: _____ Marital Status: M S W D Sep

Name: _____ Sex: _____
Last name first name middle initial

Address: _____
Street Name City State Zip Code

Home telephone: _____ Cellular phone: _____

Can we leave a message on these voice mails? YES or NO

Patient's Employer: _____
Business Address: _____
Business Telephone: _____

In case of an emergency please contact:
Name: _____ Relationship: _____
Last name first name middle initial
Home telephone: _____ Alternate phone: _____

Referral Source:

_____ _____ _____
Referring Physician / Family Doctor Review It Magazine Living Magazine

Health Insurance Information

_____
Name of Insurance Co. Telephone Number

Policyholder: _____ Guarantor's DOB: _____
ID Number: _____ Group Number: _____
Guarantor's SSN: _____ Relationship: _____
Policyholder Phone #: _____

Secondary Insurance Information

_____
Name of Insurance Co. Telephone Number

Policyholder: _____ Guarantor's DOB: _____
Policy Number: _____ Group Number: _____
Guarantor's SSN : _____ Relationship: _____

INSURANCE AUTHORIZATION AND MEDICAL RELEASE FORM

I HEREBY AUTHORIZE PETE TURCINOVIC, M.D., F.A.C.S. AND/OR JAMES A. FIELD, M.D.,F.A.C.S.AND/OR JASON BALETTE, M.D., F.A.C.S., AND/OR JAMES R. MAGGART, M.D., F.A.C.S. AND/OR DREW HOWARD, M.D., F.A.C.S., AND/OR TIMOTHY HODGES, M.D., F.A.C.S., AND/OR SAYL BUNYAN, M.D. TO FURNISH OR OBTAIN MEDICAL RECORDS CONCERNING MY ILLNESS AND TREATMENT TO INSURANCE CARRIERS OR MEDICAL FACILITIES.
I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. CO-PAYMENT IS TO BE PAID AT THE TIME OF YOUR OFFICE VISIT; AS WELL AS ANY DEDUCTIBLES.

_____ _____
SIGNATURE DATE

GENERAL & VASCULAR SURGICAL ASSOCIATES
FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete and sign our PATIENT INFORMATION FORM and FINANCIAL POLICY before care is rendered.

- IF NO INSURANCE IS AVAILABLE TO FILE, FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

- The parent (or guardian) of a minor is responsible for full payment at the time of service. Minors can not legally be seen or treated without the written consent of a parent or guardian, unless an emergency exists.

AT THE TIME OF YOUR OFFICE VISIT YOU ARE RESPONSIBLE FOR THE COPAYMENT REQUIRED BY YOUR INSURANCE. We are preferred providers for many insurance companies. You must call the number on your insurance card to check if the Doctor you have an appointment with is a provider for your plan. Please provide insurance cards at the time of visit; if proper insurance information is not received you will be responsible for the cost of your visit. If your insurance company has not paid the FULL BALANCE within 45days after the claim has been filed, you will be notified by our office. Atthis time, you will have 15 days to call your insurance company and then the Physician's office with any information that you receive.

I have read, understand, and been allowed to ask questions regarding this statement and agree to comply with the policy hereunder described.

PATIENT OR RESPONSIBLE PARTY:

Signature: _____ Date: _____

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Patient Name:_____ Age:_____

Reason for Visit:_____

PAST & CURRENT MEDICAL HISTORY

*Please circle any of the following conditions/problems/disease that you either now have or have been diagnosed with in the past: ((**please write NA in other if you do not have a past medical history)***

Abuse (Physical/Mental/Sexual/etc.)	Blood Clots	Glaucoma/Cataract
Lung disease	Abnormal PAP	Cancer/Tumor
Gout/Osteoporosis	Alcoholism/Drugs	Cholesterol(high)
Headaches/Migraine	Serious accident/Injury	
Anemia	Chronic Pain	Heart disease
Sexual disease/VD	Anxiety/Nerves	Depression
Hepatitis (Any)	Stroke	Arthritis
Diabetes/Sugar	High Blood pressure	Thyroid
Tuberculosis	Bleeding disease	Genetic diseases
Kidney or Bladder problems	Ulcers/Stomach disease	PCOS
Disease Asthma/Allergies	Epilepsy/Seizures	HIV/AIDS

Others:_____
_____

PAST SURGICAL HISTORY : *List the year you had any of the following*

*Appendectomy*_____	*Gallbladder*_____
*Hernia*_____	*Tonsillectomy*_____
Blood Transfusion _____	*Heart / Cardiac*_____
Hysterectomy _____	*Tubal / Vasectomy*_____
Stress Test _____	*Orthopedic*_____
*Cardiac Cath*_____	*Other* _____

CURRENT MEDICATIONS : *List all medications that you take routinely or that have been prescribed for you by a doctor (include vitamins, overthe-counter medications, eye drops, herbal medications, etc.)*

MEDS DOSE HOW OFTEN

_____
_____
_____
_____
_____
_____
_____
_____

*Attach a medication list or ask for another sheet of paper if medications exceed the space given

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ALLERGIES: *(circle all allergies that apply and specify on lines given below)*

NONE Antibiotics (please specify) Latex Tape/Adhesive
X-ray Contrast / Iodine Medications (please specify)
Other (please specify)
Specify:_____

FAMILY HISTORY:

Blood Relatives	Living	Age	Obese	illness/cause of death
Mother	YES/NO			
Grandmother	YES/NO			
Grandfather	YES/NO			
Father	YES/NO			
Grandmother	YES/NO			
Grandfather	YES/NO			
Siblings	YES/NO			
Children	YES/NO			

PERSONAL & SOCIAL HISTORY:
Do you use (or have you used) any of the following:

Tobacco Never Now Quit (year)_____
Type Used: *Cigarettes* *Cigars* *Pipe* *Smokeless*
Amount used per day:_____
How many years:_____

Alcohol Never Now Quit (year)_____
Type Used: Beer Wine Liquor Other_____
Amount used per week:__12oz beer___6oz wine__ 2oz shots____

Illegal Drugs Never Now Quit (year)_____
Type used: Cocaine IV Pain Pills Other_____
Amount used per day:_____
How many years:_____

Exercise None # of times/week:_____ Doing what?_____

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Marital Status Married Divorced Single Widowed

Number of Children?_____
Occupation?_____
Are you disabled? YES NO_
If Yes, reason for disability?_____

FEMALES
Age at First Menstrual Cycle_____ Menstrual irregularities YES NO
Number of Pregnancies?_____ # of Live Births_____
Miscarriages / Abortions_____ Infertility YES NO
Date of last period_____ Date of Last _____
Mammogram_____ Facility Done_____

WEIGHT HISTORY
Please estimate as closely as possible for all that apply

Birth Weight_____
Weight at start of high school_____ Age_____
Weight at high school graduation_____ Age_____
Weight at marriage (s)_____ Age_____

Lowest weight in past 5 years_____ Highest weight in past 5 years_____

Using your own word tell us how you believe your life will change if by loosing weight. What are your hopes, dreams and fears:

_____
_____
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PROGRAM	CHECK IF YES	START DATE	DURATION	PHYSICIAN SUPERVISED	MAX LOSS
Jenny Craig					
Nutri-System					
LA weight lose					
Wight watchers					
Atkins Diet					
Sugar buster					
T.O.P.S					
Metabolife					
Herbalife					
South Beach					
Overeaters Annonymous					
Grapefruit Diet					
Slimfast/liquid diet					

List of any weight loss attempts:

_____

_____

For Female Patients ONLY:

Pregnancy #1 Year _____weight at start_____ at deliver_____ lost after 1 yr____

Pregnancy #2 Year_____weight at start_____ at deliver_____ lost after 1 yr_____

Pregnancy #3 year_____weight at start_____ at deliver_____ lost after 1 yr____

Pregnancy #4 year_____weight at start_____ at deliver_____ lost after 1 yr_____

EATING HABITS *(Circle the patterns which best describe your eating habits on a regular basis)*

3 meals/day 2 meals/day Graze all day(5 or more meals/day)

Usually eat breakfast Usually eat Lunch Usually Eat Dinner

Usually skip breakfast Usually Skip Lunch Usually Skil Dinner

Eat very little on some days & a lot on others

Other: _____

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FOOD PREFERENCES *(Circle the top 5 foods which you prefer – which foods most likely to give into temptation)*

Soda/soft drinks	French Fries	Fried Foods
Chips/Snacks	Steak/Chops	Candy
Potatoes	Chocolate	Pasta
Cookies	Pizza	Cakes/Pies
Salad dressings	Mild	Juice
Beer	Wine	Cocktails

MEDICATIONS *(List the weight loss medications you have taken)*

Medication	Check if YES	Start Date	Duration	Physicians Supervised	Max Loss
Amphetamines					
Phentermine					
Phen-Fen					
Dexfenfluramine (redux)					
Xenical (Oristat)					
Meridia					
Lindora					
OTHER Diet Medications					

PROGRAMS *(List any alternative methods you have tried))*

Programs	Check IF Yes	Start Date	Duration	Physicians Supervised	Max LOSS
Acupuncture					
Hypnosis					
Biofeedback					
Behavior Modifications					
Exercise					

List all exercise programs you have tried:

_____
_____
_____

PREVIOUS WEIGHT LOSS SURGERIES

Surgery	Date	Location	Surgeon	Weight lose

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Patient Name: _____ Date: _____

How did you hear about us /who referred you to us _____

Was it easy to make an appointment? Yes No

Are you or could you be pregnant? Yes No

Do you attend religious services anywhere? _____

Would you like your doctor to pray with you? Yes No

Last Colonoscopy _____

Last Mammogram _____

Primary Care Physician _____
Address or Fax # _____

Other Physicians _____
Address or Fax # _____

Other Physicians _____
Address or Fax # _____

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Written Agreement to Comply with Therapy

I have reviewed all the information, including reading the bariatric manual and the website, and viewing the bariatric seminar, provided to me by Dr. Howard about my obesity, the Roux-NY Gastric Bypass/Sleeve Gastrectomy/Adjustable Gastric Band, the strict postoperative dietary program, lifestyle modifications including and not limited to increased exercise. I also understand that follow-up clinic visit is an important aspect of care to avoid potential complications and for optimal weight loss. I have been given an opportunity to ask questions about management of my obesity, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information concerning the Roux-NY Gastric Bypass/Sleeve Gastrectomy/Adjustable Gastric Band surgery. I agree to comply, to the best of my ability with all therapy and recommendations made by my physician and healthcare providers including: (Please initial)

□ I will take vitamins and supplements as directed for the rest of my life.
□ I will follow the guidelines of the pre and postoperative diet.
□ I will exercise on a regular basis after surgery.
□ I will not get pregnant for at least 2 years after my surgery.
□ I will quit smoking 2 months before surgery and remain smoke free the rest of my life.
□ I will come in for follow-up appointments at 2 weeks, 3months, 6 months, and 12 months and at least every year after.

_____ _____

(Signature of Patient) Date

Please sign legibly

_____ _____

(Signature of Provider) Date

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PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care options):

NAME **Relationship** **D.O.B**

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____Phone_____

Name_____Phone_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than your home phone number: ( )_____

- ***I am fully aware that a cell phone is not a secure and private line.***

VI. Can confidential messages(i.e.,appointment reminders) be left on your home answering machine or voice mail? YES_____ NO_____

VII. I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet or email.

PATIENT NAME_____(guardian if under 18 years)

_____

PATIENT/GUARDIAN SIGNATURE Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____D.O.B._____

SECTION B: TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your health information. A copy of our Notice is available upon request. It is also posted in our office.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

The Surgical Group of the Woodlands
9200 Pinecroft Suite 250
The Woodlands, TX 77380
(281)419-8400
fax(281)292-1972

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

Houston Bariatric Surgery

NOTICE OF PRIVACY PRACTICES

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

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

At The Surgical Group of the Woodlands we are committed to treating and using protected health information about you responsibly. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including
information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed.
However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your
medical information for any purpose not listed below, without your specific written authorization.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: you name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information bout you by name.

Notification: We may use and disclose medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. We will share information about your location , general condition, or death. If you are present, will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decision in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for nation's security and intelligence activities, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order,warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defector problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigation or proceedings, inspections, license or disciplinary actions or other similar programs.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws(such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders,reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspects of crimes at the request of a law enforcement official , reporting death, crimes on our premises and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives

Consent for Use of Email Address

AUTHORIZATION FOR THE USE OF PATIENT'S EMAIL ADDRESS BY SGOTW PHYSICIANS, ITS AFFILIATED ENTITIES AND BUSINESS ASSOCIATES

SGOTW physicians are committed to protecting information you provide us. SGOTW Physicians creates a record of the information you provide us for use in your care and treatment and for communication with you. These records are maintained in a confidential manner, as required by law. SGOTW physicians, its professional staff and affiliated entities and business associates follow the privacy practices described in this consent and our Joint Notice of Privacy Practices.

You are requested to provide you email address to SGOTW physicians. The provision of your email address is entirely voluntary. Your email address may be used by SGOTW physicians, its affiliated entities and business associates for the following purposes.

- For appointment reminders.
- To inform you of benefits and services related to your health.
- Through the use of online surveys emailed to you by SGOTW physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received.
- As required by law and for certain law enforcement activities.
- As otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) SGOTW physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation.

As the patient email addresses SGOTW Physicians collects will be assembled into a mailing list, group mailings will not be sent in a manner in which recipients are visible to one another.

To the extent permitted by law, the undersigned agrees to indemnify and hold harmless SGOTW physicians, its affiliated entities and business associates from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief , elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by the undersigned arising out of, resulting from, or attributable to any acts or omissions or other conduct of SGOTW physicians, its affiliated entities or business associates. These indemnities shall survive the revocation of this consent.

Declaration: I have read and understand the about agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

Patient's or Patient's Legal Representative's Email Address:_____@_____

Signature of Patient of Patient's Legal Representative: _____

Printed Name of Patient: _____

Printed Name of Legal Representative (if any) _____

Representative's Authority to Act for Patient: _____